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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

Jeffrey A. Meyers
Commissioner

129 PLEASANT STREET, CONCORD, NH 03301
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December 4, 2018

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

Retroactive

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend two existing **sole source** agreements with the State's managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116. The contract for SFY 2019 synchronizes the existing Medicaid Care Management (MCM) Program re-procurement as legislatively required, adjusts for operational and program changes, including the transition of the New Hampshire Health Protection Program to the Granite Advantage Healthcare Program effective January 1, 2019.

The adjusted actuarially certified rate structure under the **sole source contracts** is $803,103,161. This request, if approved, will increase the amount by $147,676,924, due to the transition of the Medicaid expansion group from qualified health plans under the NH Health Protection Program to coverage under the two managed care health plans. The SFY capitation rate for SFY 19 decreases by 1.7% and the pre-existing aggregate average administrative cost allowance of 8% remains in place, as does the operating margin allowance of up to 1.5%. The combined aggregate total is $3,705,598,325 for all Medicaid Care Management program contracts, effective upon approval by the Governor and Executive Council.

The Governor and Executive Council approved the original agreements on May 9, 2012, Item #54A, and approved subsequent amendments on June 19, 2013, Item #67A; February 12, 2014, Item #25; April 9, 2014, Item #44; June 18, 2014, Item #65A; July 16, 2014, Late Item "A"; December 23, 2014, Item #11; June 24, 2015, Item #30; August 5, 2015, Tabled Item 'A'; December 16, 2015, Late Item 'A3'; January 27, 2016, Item #7B; March 9, 2016, Item #10A; June 29, 2016. Late Item 'A2'; October 5, 2016, Item #12A; June 21, 2017, Tabled Item #18, December 6, 2017, Item #7B, and June 6, 2018, Item #6A.

Funds are 50% Federal and 50% General Funds for the currently eligible Medicaid population except for the NH Health Protection Program services funds are 94% Federal and 6% Other for Calendar Year 2018; and for the Granite Advantage Health Care Program 93% Federal and 7% Other for Calendar Year 2019.

Funds to support this request are available in the following accounts in SFY 2019:

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18 (Amend 15)	SFY19 Amendment 15	SFY19 Amendment 16	SFY19 Amendment 17	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000	$460,000,000	$490,897,701	$538,601,671	$539,100,917	$548,245,172	$581,336,172	$576,374,554	$2,854,974,843
NHHPP Trust Fund: 010-047-3099-102	$0	$0	$193,000,000	$218,624,348	$134,015,404	$78,255,123	$42,381,032	$74,090,064	$73,315,043	$697,209,918
Granite Advantage Health Care Trust Fund 010-047-2358-101									$153,413,564	$153,413,564
TOTAL	$0	$250,000,000	$653,000,000	$709,522,049	$672,617,075	$617,356,040	$590,626,204	$655,426,236	$803,103,161	$3,705,598,325

EXPLANATION

The purpose of these amendments is to change the actuarial certified rate structure as required annually under the Centers for Medicare and Medicaid (CMS) approvals for operating a managed care program under the two managed care health plan agreements. In addition to rate changes, other key contract changes follow in the next two sections.

Table One represents the decrease in the capitation rates to the standard Medicaid and the NH Health Protection Program Medically Frail capitation rates and Table Two illustrates the fiscal impact decrease by change for the period July 2018 to December 2018:

Table 1
New Hampshire Department of Health and Human Services
SFY 2019 Capitation Rate Change
July 2018 to December 2018 Time Period
Based on March 2018 MCO Enrollment by Rate Cell

Population	SFY 2019 Capitation Rate	July 2018 to December 2018 Capitation Rate	Percentage Change
Medicaid Care Management Program			
Base Population Rate Cells	$268.49	$262.20	-2.34%
NF Resident and Waiver Population Rate Cells	600.94	598.28	-0.44%
Behavioral Health Population Rate Cells	1,321.59	1,308.49	-0.99%
Total MCM	**$380.39**	**$373.94**	**-1.70%**
New Hampshire Health Protection Program			
Medically Frail	$1,028.83	$1,007.86	-2.04%
Transitional	509.37[1]	510.62	0.24%
Total NHHPP	**$986.31**	**$967.15**	**-1.94%**
All Programs	**$409.33**	**$402.27**	**-1.72%**

[1] *The original Transitional population capitation rate is effective July 2018 to December 2018 because the program ends with the implementation of the Granite Advantage Health Care Program.*

Table 2
New Hampshire Department of Health and Human Services
July 2018 to December 2018 Capitation Rate Change by Component
Based on March 2018 Enrollment by Rate Cell

	MCM Program		NHHPP Medically Frail	
Rate Component	Rate Change	Annualized Dollar Impact	Rate Change	Annualized Dollar Impact
Medical trend time period	-0.26%	-$753,683	-0.27%	-$103,575
Prescription drug trend time period and seasonality	-0.79%	-2,241,002	-0.80%	-301,938
Sununu Youth Center Implementation Change	-0.12%	-355,715	n/a	n/a
Updated ABA Funding Assumptions	0.30%	847,317	n/a	n/a
Other	-0.83%	-2,351,482	-0.98%	-369,508
Total Rate Change for July 2018 to December 2018	**-1.70%**	**-$4,854,566**	**-2.04%**	**-$775,021**

These revised rates include adjustments to the medical and prescription drug trend, an updated implementation schedule, and rates for the treatment of adolescents with substance use disorder at the Sununu Youth Center. The revised rates also include updated trend adjustments for Applied Behavioral Analysis (ABA) to help children with autism as ABA transitions from fee for service to the MCM program, to better integrate services and manage the cost of care. The revised rates also reflect provision for a one year fee schedule adjustment and directed payments to Community Mental Health Centers (CMHCs) for maintaining and enhancing the access, utilization, and delivery of services to individuals enrolled in the MCM program.

Table Three represents the decrease in the capitation rates to the standard Medicaid and the Granite Advantage Health Care Program, and Table Four illustrates the fiscal impact decrease by change for the period January 2019 to June 2019:

Table 3
New Hampshire Department of Health and Human Services
SFY 2019 Capitation Rate Change
January 2019 to June 2019 Time Period
Based on March 2018 MCO Enrollment by Rate Cell

Population	SFY 2019 Capitation Rate	January 2019 to June 2019 Capitation Rate	Percentage Change
Medicaid Care Management Program			
Base Population Rate Cells	$261.93	$260.39	-0.59%
NF Resident and Waiver Population Rate Cells	591.26	597.26	1.01%
Behavioral Health Population Rate Cells	1,311.59	1,318.46	0.52%
Total MCM	**$371.52**	**$371.34**	**-0.05%**
Granite Advantage Health Care Program			
Medically Frail	$1,028.83	$993.36	-3.45%
Non-Medically Frail	N/A	423.21	N/A
Total GAHCP	**N/A**	**769.52**	**N/A**
All Programs	**N/A**	**404.36fa**	**N/A**

Table 4
New Hampshire Department of Health and Human Services
January 2019 to June 2019 Capitation Rate Change by Component
Based on March 2018 Enrollment by Rate Cell

	MCM Program		NHHPP Medically Frail	
Rate Component	**Rate Change**	**Annualized Dollar Impact**	**Rate Change**	**Annualized Dollar Impact**
Medical trend time period	0.25%	$702,772	0.26%	$126,286
Prescription drug trend time period and seasonality	0.78%	2,217,573	0.85%	407,044
Sununu Youth Center Implementation Change	0.20%	552,334	n/a	n/a
Updated ABA Funding Assumptions	0.41%	1,148,585	n/a	n/a
Next Day Enrollment	-0.79%	-2,241,119	-5.33%	-2,566,580
Other	-0.86%	-2,487,197	0.87%	419,565
Total Rate Change for January 2019 to June 2019	**-0.05%**	**-$107,052**	**-3.45%**	**-$1,613,684**

These revised rates for the period January 1, 2019 to June 30, 2019 include updates for the provider fee for substance use disorder and next day enrollment impact.

The Department is amending the existing individual agreements with the state's two managed care health plans to commence January 1, 2019 and to reflect an updated actuarially certified rate structure, retroactively to July 1, 2018.

Exhibit B to the Agreement reflects the adjusted capitated rate information for SFY 2019.

Please note that only one copy of Exhibit A and Exhibit B are attached for previous amendments as the Exhibits are voluminous and identical for both vendors.

Area Served: Statewide.

Source of funds: Federal financial participation rates for the currently eligible population will be 50% Federal Funds as appropriated by Congress for the entire period of this amendment, and 50% General Funds. Federal financial participation rates for the New Hampshire Health Protection Program services are 94% Federal Funds and 6% Other Funds in Calendar Year 2018, and for the Granite Advantage Health Care Program 93% Federal Funds and 7% Other Funds in Calendar Year 2019, as appropriated by Congress.

In the event that Federal funds become no longer available or are decreased below the 94% level for the New Hampshire Health Protection Program population in CY 2018 or for the Granite Advantage Health Care Program CY 2019, consistent with RSA 126-A: 5-b, c,

General Funds will not be requested to support this program; and medical services for the new adult population would end consistent with RSA 126-A:5-b,c and the Special Terms and Conditions of the Premium Assistance Program Demonstration.

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #17 to the
Medicaid Care Management Contract

This 17th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment #17") dated this 3rd day of December, 2018, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Granite State Health Plan, Inc., (hereinafter referred to as "the Contractor"), a New Hampshire Corporation with a place of business at 2 Executive Park Drive, Bedford, NH 03110.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013 (Item #, 67A), Amendment #2 February 12, 2014 (Item #25), Amendment #3 April 9, 2014 (Item #44), Amendment #4 June 18, 2014 (Item #65A), Amendment #5 July 16, 2014(Late Item A), Amendment #6 December 23, 2014 (Item #11), Amendment #7 June 24, 2015 (Item #30), Amendment #8 August 5, 2015 (Tabled Item A), Amendment #9 December 16, 2015 (Late Item A3), Amendment #10 January 27, 2016 (Item #7B), Amendment #11 March 9, 2016 (Item #10A) Amendment #12 June 29, 2016 (Late Item A2), Amendment #13 October 5, 2016, (Item #12A), Amendment #14 June 21, 2017 (Tabled Item #18), Amendment #15 December 6, 2017 (Item #7B), and Amendment #16 June 6, 2018 (Item #6A), 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to modify the price limitation, modify the scope of services to support continued delivery of these services, and modify the capitation rates, 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 to amend as follows:

1. Form P-37, General Provisions, Block 1.8, Price Limitation to increase the Price Limitation by $147,676,924.60 from $3,557,921,400.41 to read: $3,705,598,325.01 for a cumulative contract value for all Medicaid Care Management contracts.
2. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read: Nathan D. White, Director.
3. Form P-37, General Provisions, Block 1.10, State Agency Telephone Number, to read: 603-271-9631.
4. Delete Exhibit A Amendment #14 in its entirety and replace with Exhibit A Amendment #15.
5. Delete in its entirety Exhibit B Amendment #16 and replace with Exhibit B Amendment #17.

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

12/7/18
Date

Name: Jeffrey A. Meyers
Title: Commissioner

Granite State Health Plan, Inc.

12-7-18
Date

Name: Jennifer Wilson
Title: CEO

Acknowledgement of Contractor's signature:

State of New Hampshire, County of Merrimack on December 7, 2018 before the undersigned officer, personally appeared the person identified directly 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.

Lisa Marie Malanga
Signature of Notary Public or Justice of the Peace

LISA MARIE MALANGA, Notary Public
State of New Hampshire
My Commission Expires December 20, 2022
Name and Title of Notary or Justice of the Peace

My Commission Expires: 12/20/22

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

OFFICE OF THE ATTORNEY GENERAL

12/10/2018
Date

Name: Nancy J. Smith
Title: Sr. Asst. Attorney General

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

Medicaid Care Management Contract
Exhibit A - Amendment 15

Table of Contents

1. Introduction

1.1. Purpose

1.1.1. The purpose of this Agreement is to set forth the terms and conditions for the MCO's participation in the NH Medicaid Care Management Program.

1.2. Type of Agreement

1.2.1. This is a comprehensive full risk prepaid capitated contract. The MCO is responsible for the timely provision of all medically necessary services as defined under this Agreement. In the event the MCO incurs costs that exceed the capitation payments, the State of New Hampshire and its agencies are not responsible for those costs and will not provide additional payments to cover such costs.

1.3. Agreement Period

1.3.1. The Department of Health and Human Services (DHHS) and the MCO agree to extend this Agreement by 12 months to June 30, 2019 at which point this Agreement is targeted to end.

2. Glossary of Terms and Acronyms

Abuse

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. 455.2]

Administrative Review Committee

Applies appropriate risk management principles to ensure due diligence and oversight to protect the patient, community and hospital in treating high risk or high profile patients.

Acquired Brain Disorder (HCBC-ABD) Waiver

"Acquired Brain Disorder (HCBC-ABD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of services and supports to individuals age 22 years and older with traumatic brain injuries or neurological disorders who are financially eligible for Medicaid and medically qualify for institutional level of care provided with a need for specialized nursing care or specialized rehabilitation services. Covered services are identified in He-M 522.

Adequate Network of Providers

A network sufficient in numbers, types and geographic location of providers, as defined in the Agreement, to ensure that covered persons will have access to health care services without unreasonable delay.

Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of New Hampshire, relating to the provision of health care when an individual is incapacitated (42 CFR 438.6, 438.10, 422.128, and 489.100).

Agreement

"Agreement" means the entire written Agreement between DHHS and the MCO, including any Exhibits, documents, and materials incorporated by reference.

Agreement Period

Dates indicated in the P-37 of this Agreement.

Agreement Year

NH State Fiscal Year.

Appeal

"Appeal" means a request for review of an action as described in this Agreement (42 CFR 438.400(b)).

Auxiliary aids

"Auxiliary aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of programs or activities conducted by the MCO. Such aids shall include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Behavioral Health Crisis Treatment Center

"Behavioral Health Crisis Treatment Center" (BHCTC) means a treatment service center that provides 24/7 intensive, short term stabilization treatment services for individuals experiencing a mental health crisis, including those with co-occurring substance use disorder. The BHCTC accepts individuals for treatment on a voluntary basis who walk-in, are transported by first responders, or as a stepdown treatment site post emergency department visit or inpatient psychiatric treatment site. The BHCTC delivers an array of services to de-escalate and stabilize individuals at the intensity and for the duration necessary to quickly and successfully discharge, via specific after care plans, the individual back into the community or to a step-down treatment site.

Care coordination

"Care coordination" is the deliberate organization of patient care activities between two or more participants (including the individual) involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial, and long term services and supports. Organizing care involves the marshalling of personnel and other resources needed to carry out all required services and supports, and requires the exchange of information among participants responsible for different aspects of care. (42 CFR 438.208).

Effective care coordination includes the following:

- Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Employs evidence-based clinical practices;
- Coordinates care across health care settings and providers, including tracking referrals;
- Actively assists patients to take personal responsibility for their health care;
- Provides education regarding avoidance of inappropriate emergency room use;

- Emphasizes the importance of participating in health promotion activities; Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- Uses appropriate community resources to support individual patients, families and caregivers in coordinating care.
- Adheres to conflict of interest guidelines set forth by the health plan and contractor (State of NH)
- Ensures the patient is aware of all appeal and grievance processes including how to request a different care coordinator.
- Facilitates ready and consistent access to long term supports and services that are, to the extent possible, integrated with all other aspects of the member's health care.

Centers for Medicare and Medicaid Services (CMS)

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare program.

Children's Health Insurance Program

"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009.

Children with Special Health Care Needs

Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Choices for Independence (HCBC-CFI) Waiver

"Choices for Independence (HCBC-CFI) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities. This term is also known as home and community based care for the elderly and chronically ill (HCBC-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and covered services are identified in He-E 801.

Chronic Condition

"Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence and includes, but is not limited to: a mental health condition; a substance use disorder; asthma; diabetes; heart disease; or obesity, as evidenced by a body mass index over twenty-five.

Cold Call Marketing

"Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential member or a member with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

Communications Plan

"Communications Plan" means a written strategy for timely notification to DHHS regarding expected or unexpected interruptions or changes that impact MCO policy, practice, operations, members or providers. The Communications Plan shall define the purpose of the communication, the paths of communication, the responsible MCO party required to communicate, and the time line and evaluation of effectiveness of MCO messaging to DHHS and to affected parties. The Communications Plan shall also provide for the MCO to communicate with DHHS and respond to correspondence received from DHHS within one (1) business day on emergent issues and five (5) business days on non-emergent issues.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under federal or state law. Confidential Information includes, but is not limited to, Personal Information.

Conflict Free Care Coordination

"Conflict Free Care Coordination" separates clinical or non-financial eligibility determination from direct service provision. Care Coordinators and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual, their paid caregivers or to anyone financially responsible for the individual; robust monitoring and oversight are in place to promote consumer-direction and beneficiaries are clearly informed about their right to appeal or submit a grievance decisions about plans of care, eligibility determination and service delivery. State level oversight is provided to measure the quality of care coordination services and to ensure meaningful stakeholder engagement. In circumstances when one entity is responsible for providing care coordination and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

Conflict Free Care Management

(see Care Coordination)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

"Consumer Assessment of Healthcare Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey used to measure member experience of health care.

Consumer Direction

"Consumer Direction", also known as participant direction or self-direction, means a service arrangement whereby the individual or representative, if applicable, directs the services and makes the decisions about how the funds available for the individual's services are to be spent. It includes assistance and resources available to individuals in order to maintain or improve their skills and experiences in living, working, socializing, and recreating.

Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through member transitions between: facilities and home; facilities; providers; service areas; managed care contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.

Contracted Services

"Contracted Services" means covered services that are to be provided by the MCO under the terms of this Agreement.

Covered Services

"Covered Services" means health care services as defined by DHHS and State and Federal regulation.

Debarment

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Developmental Disabilities (HCBC-DD) waiver

"Developmental Disabilities (HCBC-DD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports in non-institutional settings to individuals of any age with mental retardation and/or developmental disabilities who are financially eligible for Medicaid and medically qualify for institutional level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Division for Children, Youth & Families (DCYF) Services

"Division of Children, Youth & Families (DCYF) Services" means community based services and residential treatment services as indicated in Section 8.2 Covered Services Matrix as DCYF..

Early, Periodic Screening, Diagnostic and Treatment (EPSDT)

"EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of services in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r), 42 CFR 441.50, and DHHS EPSDT program policy and billing instructions. Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The MCO shall be responsible for all services found to be medically necessary services during the EPSDT exam.

Eligible Members

"Eligible Members" means individuals determined eligible by DHHS and eligible to enroll for health care services under the terms of this Agreement.

Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

Emergency Services

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

Equal Access

"Equal Access" means Steps 1 and 2, and NHHPP members having the same access to providers and services for those services common to both populations.

Execution Date

Date Agreement approved by Governor and Executive Council.

External Quality Review (EQR)

"External Quality Review (EQR" means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the MCO or its subcontractors furnish to members (42 CFR 438.320).

External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358.

Fraud

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 C.F.R. 455.2]

Granite Advantage Health Care Program

"Granite Advantage Health Care Program" means the program for coverage of the newly eligible adult population that replaces the New Hampshire Health Protection Program beginning on January 1, 2019 as established in Senate Bill 313, 2018 NH Laws Chap. 342.

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights (42 CFR 438.400(b)).

Grievance Process

"Grievance Process" means the procedure for addressing member grievances (42 CFR 438.400(b)).

Grievance System

"Grievance System" means the overall system that includes grievances and appeals handled by the MCO and access to the State fair hearings (42 CFR 438, Subpart F).

Healthcare Effectiveness Data and Information Set (HEDIS)

"Healthcare Effectiveness Data and Information Set (HEDIS)" means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes a standardized survey of members' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

Health Home

"Health Home" means coordinated health care provided to members with special health care needs. At minimum, health home services include:

- Comprehensive care coordination including, but not limited to, chronic disease management;

- Self-management support for the member, including parents of caregivers or parents of children and youth;
- Care coordination and health promotion;
- Multiple ways for the member to communicate with the team, including electronically and by phone;
- Education of the member and his or her parent or caregiver on self-care, prevention, and health promotion, including the use of patient decision aids;
- Member and family support including authorized representatives;
- The use of information technology to link services, track tests, generate patient registries and provide clinical data;
- Linkages to community and social support services;
- Comprehensive transitional health care including follow-up from inpatient to other settings;
- A single care plan that includes all member's treatment and self-management goals and interventions ; and
- Ongoing performance reporting and quality improvement.

Home and Community Based Care (HCBC)

"Home and Community Based Care (HCBC)", also known as Home and Community Based Services (HCBS), means the waiver of sections 1902 (a) (10) and 1915 (c) of the Social Security Act which allows the federal Medicaid funding of long term services and supports in non-institutional settings for individuals who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility. This includes services provided under the Choices for Independence Waiver (HCBC-CFI) waiver program, Developmental Disabilities (HCBC-DD) waiver program, Acquired Brain Disorders (HCBC-ABD) waiver program, and In Home Supports (HCBC-IHS) waiver program.

Implementation Period

"Implementation Period" means each period of time prior to Program Start Date for the following segments: Step 1, NHHPP, SUD Phases 1, 2 and 3, and Step 2 Phase 1.

Implementation Plan

"Implementation Plan" means a proposed and agreed upon written and detailed listing of all objectives, tasks, activities, time allocation, deliverables, dependencies and responsible parties required to design, develop and implement the steps and phases of the Care Management Program. The Implementation Plan(s) shall include documentation of approvals as well as document change history.

In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver

"In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to families with children diagnosed with autism and other developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization. Covered services are identified in He-M524.

Long Term Services and Supports (LTSS)

"Long Term Services and Supports (LTSS)" means nursing facility services, all four of New Hampshire's Home and Community Based Care Waivers, and services provided to children and families through the Division for Children, Youth & Families.

Managed Care Organization (MCO)

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible DHHS members under the DHHS Care Management Program.

Marketing

"Marketing" means any communication from the MCO to a potential member or member with another DHHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the MCO or to either not enroll or end enrollment with another DHHS contracted MCO (42 CFR 438.104(a)).

Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).

Medically Frail

"Medically frail" means a member who identifies as having a physical, mental, or emotional health condition that causes limitations in activities (e.g. bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Medically Necessary Services

"Medically Necessary Services" means services that are "medically necessary" as is defined in Section 23.2.2.

Member

"Member" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having an Agreement with DHHS (42 CFR 438.10(a)).

Member Handbook

"Member Handbook" means the handbook published by the Managed Care Organization (MCO) which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Member participation in Medicaid Managed Care and which means all informing requirements as set forth in 42 CFR 438.10.

Mental Health Court

A "Mental Health Court" is a specialized court docket for certain defendants with mental illnesses that substitutes a problem solving model for traditional criminal court processing.

National Committee for Quality Assurance (NCQA)

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

Necessary Services

"Necessary Services" means services to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term service and support.

New Hampshire Community Passport (NHCP) Program or Money Follows the Person (MFP) Demonstration

"Money Follows the Person (MFP)" means a federal demonstration that assists individuals residing in nursing institutions who meet CMS eligibility requirements find suitable healthcare programs to support them in the community and then assists them to transition from nursing institution care to community care. The program's intent is to help strengthen and improve community based systems of long term care for low-income seniors and individuals with disabilities. "New Hampshire Community Passport (NHCP) Program" means the MFP program specific to New Hampshire.

New Hampshire Health Protection Program (NHHPP)

Coverage provided through the MCOs for individuals newly eligible for Medicaid based the new income levels established in Senate Bill 413, Chapter 3, Laws of 2014; provided, however, that on and after January 1, 2016, coverage under this program shall be limited to said individuals who are Medically Frail and who choose to participate in the New Hampshire Health Protection Program and those MCO members who transition from an eligibility category other than the New Hampshire Health Protection Program who have not yet begun their coverage in the Premium Assistance Program.

New Member

"New Member" means a member transferring from FFS to an MCO, or transferring from another MCO.

Non-Participating Provider

"Non-Participating Provider" means a person, health care provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with the MCO to participate in a managed care organization's provider network, but provides health care services to members.

Participating Provider

"Participating Provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice and licensure, and who is under a written contract with the MCO to provide services to members under the terms of this Agreement.

Payment Reform Plan

"Payment Reform Plan" means an MCO's plan to engage its provider network in health care delivery and payment reform activities such as pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements, and shall contain information on the anticipated impact on member health outcomes, providers affected.

Physician Group

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Provider Incentive Plan

"Provider Incentive Plan" means any compensation arrangement between the MCO and a provider or provider group that may directly or indirectly improve the delivery of healthcare services as directed by a provider under the terms of this Agreement.

Program Management Plan

"Program Management Plan" means a proposed and agreed upon written detailed plan that includes a framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program as provided for in the Agreement. Includes documentation of approvals as well as document change history.

Program Start Date

Each date when MCO is responsible for coverage of services to its members with respect to the steps and phases of the Medicaid Care Management program.

Post-stabilization Services

"Post-stabilization Services" means contracted services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition (42 CFR 438.114 and 422.113).

Primary Care Provider (PCP)

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Agreement.

Provider

"Provider " means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Referral Provider

"Referral Provider" means a provider, who is not the member's PCP, to whom a member is referred for covered services

Regulation

"Regulation" means any federal, state, or local regulation, rule, or ordinance.

Risk

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a provider incentive plan, as defined herein.

Special Needs

Special Needs include chronic physical, developmental, behavioral or emotional conditions or adverse social circumstances resulting in need for help with related services of a type or amount beyond that required by members generally. Members with Special Needs include both Children and Adults.

Start Date of the Program

Date initial member enrollment begins.

Start of Program

Date initial member enrollment begins.

State

"State" or "state" means the State of New Hampshire

Step 1

Services as indicated in Section 8.2 Covered Services Matrix as Step 1.

Step 2

Services as indicated in Section 8.1 Covered Populations Matrix and Section 8.2 Covered Services Matrix as Step 2.

Subcontract

"Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") which relates directly or indirectly to the performance of all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

Substance Use Disorder

"Substance Use Disorder" is marked by a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. The cluster of symptoms includes tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substance or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol, tobacco and/or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use; craving or strong desire to use. Specific diagnostic criteria are specified in "Substance-Related and Addictive Disorders", in the Diagnostic and Statistical Manual of Disorders, 5th Edition, American Psychiatric Association, 2013.

Willing Provider

"Willing Provider" is a provider credentialed according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's provider agreement, including rates, and policy manual.

2.1. Acronyms

Unless otherwise indicated acronyms used in this Agreement are as follows:

Acronym	Description
ABD	Acquired Brain Disorders Waiver

Acronym	Description
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ANB	Aid to the Needy Blind
ANSA	Adult Needs and Strengths
APTD	Aid to the Permanently and Totally Disabled
ASC	Accredited Standards Committee
ASL	American Sign Language
BCCP	Breast and Cervical Cancer Program
BMH	Bureau of Mental Health
CAD	Coronary Artery Disease
CANS	Child and Adolescent Needs and Strengths Assessment
CDC	Centers for Disease Control and Prevention
CFI	Choices for Independence Waiver
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CLA	Community Living Assessment
CLAS	Cultural and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
DCYF	Division of Children, Youth & Families
DD	Developmental Disabilities Waiver
DHHS	Department of Health and Human Services (New Hampshire)
DOB	Date of Birth

Acronym	Description
DME	Durable Medical Equipment
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospitals
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EST	Eastern Standard Time
ETL	Extract Transformation Load
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HC-CSD	Home Care for Children with Severe Disabilities
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ICF	Intermediate Care Facility
IHS	In Home Supports for Children with Developmental Disabilities Waiver
IME	Indirect Medical Education
LTSS	Long term services and supports
MCO	Managed Care Organization
MCIS	Managed Care Information System
MFP	Money Follows the Person Program
MIC	Medicaid Integrity Contractor
MEAD	Medicaid for Employed Adults with Disabilities
MMIS	Medicaid Management Information System
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NHCP	New Hampshire Community Passport Program

Acronym	Description
NF	Nursing Facility
NHHPP	New Hampshire Health Protection Program
NHID	New Hampshire Insurance Department
NPI	National Provider Identifier
OAA	Old Age Assistance
OBRA	Omnibus Budget Reconciliation Act
PBM	Pharmacy Benefit Management
PCP	Primary Care Provider
PE	Presumptive Eligibility
PIN	Personal Identification Number
POA	Present on Admission
QAPI	Quality Assessment and Performance Improvement
QIP	Quality Incentive Program
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
RAC	Recovery Audit Contractors
RBC	Risk-Based Capital
RFP	Request for Proposal
RHC	Rural Health Center
RIMP	Risk Identification Mitigation Plan
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse and Mental Health Services Administration
SLMB	Special Low-Income Medicare Beneficiaries
SLRC	ServiceLink Resource Center network under the New Hampshire Aging and Disability Resource Center model
SNF	Skilled Nursing Facility
SSA	Social Security Act

Acronym	Description
SSI	Supplemental Security Income
SSAE	Statement on Standards for Attestation Engagements
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TQM	Total Quality Management
USC	United States Code
VA	Veteran's Administration

3. General Terms and Conditions

3.1. Agreement Elements

The Agreement between the parties shall consist of the following:

3.1.1. P-37 Agreement General Provisions.

3.1.2. 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 MCO.

3.1.3. Exhibit B – Capitation Rates.

3.1.4. Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS that must be adhered to in addition to those outlined in the P-37.

3.1.5. Exhibit D – Certification Regarding Drug Free Workplace Requirements – MCO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988.

3.1.6. Exhibit E – Certification Regarding Lobbying – MCO's Agreement to comply with specified lobbying restrictions.

3.1.7. 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.

3.1.8. Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – MCO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act.

3.1.9. Exhibit H – Certification Regarding Environmental Tobacco Smoke – MCO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities.

3.1.10. Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the MCO in reference to the Health Insurance Portability and Accountability Act.

3.1.11. Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.

3.1.12. Exhibit K – MCO's Program Management Plan approved by DHHS in accordance with Section 7.4 of this Agreement.

3.1.13. Exhibit L – MCO's Implementation Plan approved by DHHS in accordance with Sections 7.6-7.8 of this Agreement.

3.1.14. Exhibit M – MCO's RFP (#12-DHHS-CM-01) Technical Proposal, including any addenda, submitted by the MCO.

3.1.15. Exhibit N – Encounter Data.

3.1.16. Exhibit O –Quality and Oversight Reporting.

3.1.17. Exhibit P – Substance Use Disorder (SUD) Services.

3.2. Order of Documents.

In the event of any conflict or contradiction between or among the Agreement documents, the documents shall control in the above order of precedence.

3.3. 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 unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS and NHID.

3.4. Authority of the New Hampshire Insurance Department

Wherever, by any provision of this Agreement or by the laws and rules of the State of New Hampshire the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a Managed Care Organization in the State of New Hampshire.

3.5. Errors & Omissions

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

3.6. Time of the Essence

In consideration of the need to ensure uninterrupted and continuous Medicaid Managed Care services, time is of the essence in the performance of the Scope of Work under the Agreement.

3.7. CMS Approval of Agreement & Any Amendments

3.7.1. This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to the prior approval of the Centers for Medicare and Medicaid Services ("CMS."). Notwithstanding any other provision of this Agreement, DHHS agrees that enrollment for any step or phase will not commence until DHHS has received required CMS approval.

3.7.2. At the time of this Amendment, the application of the State of New Hampshire under section 1115(a)(2) of the Social Security Act to replace the New Hampshire Health Protection Program with the Granite Advantage Health Care Program for the coverage of the newly eligible adult population by the MCO beginning on January 1, 2019 for the six month period ending on June 30, 2019 is currently pending with CMS. Upon the granting of the State's waiver, the special terms and conditions of the Granite Advantage Health Care Program shall replace the existing waiver approval entitled "New Hampshire Health Program Premium Assistance" (Project Number 11-W-00298/1) in all respects and the amended waiver shall apply as any other waiver under Section 28.1.3.12 of this Agreement.

3.8. Cooperation with Other Vendors and Prospective Vendors

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. The MCO 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.

3.9. Renegotiation and Reprocurement Rights

3.9.1. Renegotiation of Agreement Terms

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

3.9.2. Reprocurement of the Services or Procurement of Additional Services

3.9.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO'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 MCO under the Agreement. DHHS shall give the MCO ninety (90) calendar days notice of intent to replace another MCO participating in the Medicaid Managed Care program or to add an additional MCO to the Medicaid Managed Care program.

3.9.3. Termination Rights Upon Reprocurement.

3.9.3.1. 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, the MCO shall have the rights and responsibilities set forth in Section 32 ("Termination"), Section 33 ("Agreement Closeout") and Section 35 ("Dispute Resolution Process").

4. Organization

4.1. Organization Requirements

4.1.1. Registrations and Licenses

The MCO shall be licensed by the New Hampshire Department of Insurance to operate as an Managed Care Organization in the State as required by New Hampshire RSA 420-B, and shall have all necessary registrations and licensures as required by the New Hampshire Insurance Department and any relevant federal and state laws and regulations. An MCO must be in compliance with the requirements of this section in order to participate in any Steps and Phases of the Medicaid Care Management program.

4.2. Articles & Bylaws

4.2.1. The MCO shall provide by the beginning of each Agreement year or at the time of any substantive changes written assurance from MCO's legal counsel that the MCO 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.

4.3. Relationships

4.3.1. Ownership and Control

4.3.1.1. The MCO shall notify DHHS of any person or corporation that has five percent (5%) or more ownership or controlling interest in the MCO, parent organization, subcontractors, and/or affiliates and shall provide

a. financial statements;

b. Date of Birth in the case of an individual;

c. Social Security numbers in the case of an individual; and

d. In the case of corporations primary business address, every business location, P.O. Box address, and tax identification number 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]. The MCO shall certify by its Chief Executive Officer that this information provided to DHHS is accurate to the best of the officer's information, knowledge, and belief [42 CFR 438.606].

4.3.1.2. The MCO shall inform DHHS and the New Hampshire Insurance Department (NHID) of its intent for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of the action.

4.3.1.3. The MCO shall inform key DHHS and NHID staff by phone and by email within one business day of when any key MCO staff learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement with DHHS.

4.3.2. Prohibited

4.3.2.1. The MCO shall not knowingly have a relationship with the following:

4.3.2.1.1. 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

4.3.2.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 4.3.2.1.

4.3.2.1.3. An individual is described as follows:

a. A director, officer, or partner of the MCO;

b. A subcontractor of the MCO;

c. A person with beneficial ownership of five percent (5%) or more of the MCO's equity; or

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

4.3.3. The MCO shall retain any data, information, and documentation regarding the above described relationships for a period no less than 10 years [42 CFR 438.3(u)].

4.3.4. The MCO shall conduct background checks on all employees actively engaged in the Care Management Program. 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.

4.3.5. The MCO shall not and shall certify it does not employ or contract, directly or indirectly, with:

4.3.5.1. 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;

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

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

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

4.3.5.5. 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.

5. Subcontractors

5.1. MCO Obligations

5.1.1. The MCO remains fully responsible for the obligations, services and functions performed by its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by MCO employees, and for the purposes of this Agreement such work will be deemed performed by the MCO. DHHS reserves 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 or use of a subcontractor.

5.1.2. The MCO shall provide written policies for all employees and subcontractors describing in detail the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the SSA including information about rights of employees to be protected as whistleblowers.

5.1.3. The MCO regardless of its written agreements with any subcontractors maintains ultimate responsibility for complying with this Agreement.

5.1.4. The MCO shall inform all subcontractors at the time of entering into an agreement with the MCO about the grievance and appeal system as described in 42 CFR 438.10(g).

5.1.5. The MCO shall have a written agreement between the MCO and each subcontractor in which the subcontractor:

5.1.5.1. Agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and MCO contract provisions;

5.1.5.2. Agrees to hold harmless DHHS and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO;

5.1.5.3. Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors;[

5.1.5.4. Agrees that the State, CMS, the HHS Inspector General, or their designees shall have the right to audit, evaluate, and inspect any premises, physical facilities, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO Managed Care activities;

5.1.5.5. Agrees that it can be audited for ten years from the final date of the contract period or from the date of any completed audit, whichever is later; and

5.1.5.6. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk [42 CFR 438.230].

5.1.4 The MCO shall notify DHHS in writing within 10 business days if a subcontractor is cited for corrective action by any federal or state regulatory authority.

5.2. Notice and Approval

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

5.2.2. The MCO 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.

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

5.2.4. DHHS may grant a written exception to the notice requirements of 5.2.1 and 5.2.2 if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period or deems that the subcontractor is not a material subcontractor.

5.2.5. The MCO shall notify DHHS within twenty four (24) hours after receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

5.2.6. The MCO shall notify DHHS of any material breach of an agreement between the MCO and the subcontractor within twenty four (24) hours of validation that such breach has occurred.

5.3. MCO's Oversight

5.3.1. The MCO shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor in accordance with 42 CFR 438.230 and SMM 2087.4, including:

5.3.1.1. The MCO shall have a written agreement between the MCO and the subcontractor that specifies the activities and responsibilities delegated to the subcontractor and its transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's

performance is inadequate as determined by the MCO or NH DHHS. In such written agreement, the subcontractor shall also agree to perform the delegated activity and related reporting responsibilities as specified in the subcontractor agreement and the applicable responsibilities in this Agreement.

5.3.1.2. All subcontracts related to any aspect of the MCO Managed Care activities shall fulfill the applicable requirements of 42 CFR Part 438 for those responsibilities delegated to the subcontractor.

5.3.1.3. The MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

5.3.1.4. The MCO shall monitor the subcontractor's performance on an ongoing basis consistent with industry standards and State and Federal laws and regulations.

5.3.1.5. The MCO shall audit the subcontractor's care systems at least annually and when there is a substantial change in the scope or terms of the subcontract agreement.

5.3.1.6. The MCO shall identify deficiencies or areas for improvement, if any, with respect to which the MCO and the subcontractor shall take corrective action.

5.3.1.7. The MCO shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the Agreement between the MCO and DHHS.

5.3.1.8. If the MCO identifies deficiencies or areas for improvement are identified, the MCO shall notify DHHS and take corrective action within seven (7) calendar days of identification. The MCO shall provide DHHS with a copy of the Corrective Action Plan, which is subject to DHHS approval.

5.4. Transition Plan

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

6. Staffing

6.1. Key Personnel

6.1.1. The MCO shall commit key personnel to the New Hampshire Care Management program on a full-time basis. Positions considered to be key personnel are listed below, along with any specific requirements for each position:

6.1.1.1. Executive Director: Individual has clear authority over the general administration and day-to-day business activities of this Agreement.

6.1.1.2. Finance Officer: Individual is responsible for accounting and finance operations, including all audit activities.

6.1.1.3. Medical Director: Physician licensed by the NH Board of Medicine shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health). The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

6.1.1.4. The MCO will also have a physician available to the New Hampshire Care Management program with experience in the diagnosis and treatment of SUD.

6.1.1.5. Quality Improvement Director: Individual is responsible for all Quality Assessment and Performance Improvement (QAPI) program activities. This person shall be a licensed clinician with relevant experience in quality management for physical and/or behavioral healthcare.

6.1.1.6. Coordinators for the following five (5) functional areas shall be responsible for overseeing care coordination activities for MCO members with complex medical, behavioral health, developmental disability and long term care needs. They shall also serve as liaisons to DHHS staff for their respective functional areas:

6.1.1.6.1. Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

6.1.1.6.2. Behavioral Health Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within community mental health services.

6.1.1.6.3. Developmental Disabilities Coordinator: The individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

6.1.1.6.4. Substance Use Disorder Coordinator: The individual will have a minimum of a Master's Degree in a SUD related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to substance use disorders.

6.1.1.6.5. Long Term Services and Supports Coordinator: The individual will have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a LTSS related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care.

6.1.1.7. Network Management Director: Individual is responsible for development and maintenance of the MCO's provider network.

6.1.1.8. Member Services Manager: Individual is responsible for provision of all MCO member-services activities. The manager shall have prior experience with Medicaid or Medicare populations.

6.1.1.9. Utilization Management (UM) Director: Individual is responsible for all UM activities. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services and Necessary Services.

6.1.1.10. Systems Director/Manager: Individual is responsible for all MCO information systems supporting this Agreement including, but not limited to, continuity and integrity of operations, continuity flow of records with DHHS' information systems and providing necessary and timely reports to DHHS.

6.1.1.11. Claims/Encounter Manager: Individual is responsible for and is qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

6.1.1.12. Grievance Coordinator: Individual is responsible for overseeing the MCO's Grievance System.

6.1.1.13. Fraud, Waste, and Abuse Coordinator: Individual is responsible for tracking, reviewing, monitoring, and reducing fraud, waste, and abuse.

6.1.1.14. Compliance Officer: Individual is responsible for MCO's compliance with the provisions of this Agreement and all applicable state and federal regulations and statutes.

6.1.2. The MCO shall have an on-site presence in New Hampshire. The following key personnel shall be located in New Hampshire:

6.1.2.1. Executive Director

6.1.2.2. Medical Director

6.1.2.3. Quality Improvement Director

6.1.2.4. Special Needs Coordinator

6.1.2.5. Behavioral Health Coordinator

6.1.2.6. Developmental Disabilities Coordinator

6.1.2.7. Long Term Services and Supports Coordinator

6.1.2.8. Network Management Director

6.1.2.9.Fraud, Waste, and Abuse Coordinator

6.1.2.10.Grievance Coordinator

6.1.2.11.Substance Use Disorder Coordinator

6.1.2.12.Claim Encounter Manager

6.1.2.13.Provider Relations Manager

6.1.3. The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) days prior to start of program.

6.1.4. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.

6.1.5. DHHS may grant a written exception to the notice requirements of this Section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

6.2. General Staffing Provisions

6.2.1. The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 34.

6.2.2. The MCO shall ensure that all staff have appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

6.2.3. All key staff shall be available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

6.2.4. The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in New Hampshire with DHHS.

6.2.5. The MCO shall notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

6.2.6. If a member of the MCO's key staff is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit proposed alternate staff to DHHS for review and approval, which approval shall not be unreasonably withheld.

6.3. Staffing Contingency Plan

6.3.1. The MCO shall, deliver to DHHS a Staffing Contingency Plan within thirty (30) calendar days of signing this Agreement and after any substantive changes to the Staffing Contingency Plan. The Plan shall include but is not limited to:

6.3.1.1. The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the Agreement;

6.3.1.2. Allocation of additional resources to the Agreement in the event of inability to meet any performance standard;

6.3.1.3. Replacement of key personnel with staff with similar qualifications and experience;

6.3.1.4. Discussion of time frames necessary for obtaining replacements;

6.3.1.5. MCO's capabilities to provide, in a timely manner, replacements/additions with comparable experience; and

6.3.1.6. The method of bringing replacements/additions up-to-date regarding this Agreement.

7. Program Management and Planning

7.1. General

7.1.1. The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to members enrolled in the New Hampshire Medicaid Program and provide for all aspects of managing such program, including claims processing and operational reports. The MCO shall establish and demonstrate audit trails for all claims processing and financial reporting carried out by the MCO's staff, system, or designated agents.

7.2. Representation and Warranties

7.2.1. The MCO warrants that all Managed Care 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.

7.2.2. The MCO acknowledges that in entering this Agreement, DHHS has relied upon representations made by the MCO in its RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda, with respect to delivery of Managed Care. In reviewing and approving the program management and planning requirements of this Section, DHHS reserves the right to require the MCO to develop plans that are substantially and materially consistent with the representations made in the MCO's RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda.

7.3. Audit Requirements

7.3.1. No later than forty (40) business days after the end of the State Fiscal Year each June 30, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period. DHHS will share the report with internal and external auditors of the State of New Hampshire and federal oversight agencies. The SSAE 16 Type 2 report shall include:

7.3.1.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period.

7.3.1.2. Written assertion by the MCO's management about whether:

7.3.1.2.1. The aforementioned description fairly presents the system in all material respects;

7.3.1.2.2. The controls were suitably designed to achieve the control objectives stated in that description; and

7.3.1.2.3. The controls operated effectively throughout the specified period to achieve those control objectives.

7.3.1.3. Report of the MCO's auditor, which:

7.3.1.3.1. Expresses an opinion on the matters covered in management's written assertion; and

7.3.1.3.2. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

7.3.2. The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO. If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

7.3.3. The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

7.3.4. DHHS, CMS, the Office of the Inspector General, the Comptroller General, and their designees have the right to inspect and audit any records of the MCO, or its subcontractors and conduct on-site reviews of the MCO's operations at the MCO's expense. These on-site visits may be unannounced. The MCO shall fully cooperate with DHHS' on-site reviews. This right exists for ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

7.3.5. DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing Corrective Action Plans and review MCO compliance with requirements and standards as specified in this Agreement.

7.3.6. The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.

7.4. Program Management and Communications Plans

7.4.1. The MCO shall submit a Program Management Plan (PMP) to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Annually, thereafter, the MCO shall submit an updated PMP to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.4.1.1. The PMP shall elaborate on the general concepts outlined in the MCO's proposal and the section headings of Exhibit A;

7.4.1.2. The PMP shall describe how the MCO will operate in New Hampshire by outlining management processes such as communications, workflow, overall systems as detailed in the section headings of Exhibit A, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to member and provider experiences; and

7.4.1.3. The PMP shall outline the MCO integrated organizational structure including New Hampshire-based resources and its support from corporate, subcontractors, and workgroups or committees.

7.4.1.4. The MCO shall submit a Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the scheduled start date of the program. Thereafter, the MCO shall submit an updated Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5. Emergency Response Plan

7.5.1. The MCO shall submit an Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Thereafter, the MCO shall submit an updated Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5.2. The plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

7.5.2.1. Employee training;

7.5.2.2. Essential business functions and key employees within the organization necessary to carry them out;

7.5.2.3. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; and

7.5.2.4. Communication with staff, members, providers, subcontractors and suppliers when normal systems are unavailable;

7.5.2.5. Plans to ensure continuity of services to providers and members;

7.5.2.6. How the MCO will coordinate with and support DHHS and the other MCOs; and

7.5.2.7. How the plan will be tested, updated and maintained.

7.6. Step 1 Program Implementation Plan

7.6.1. Submission and Contents of the Plan

7.6.1.1. The MCO shall submit a "Step 1 Program Implementation Plan" (Step 1 Implementation Plan) to DHHS for review and approval no later than fourteen (14) calendar days after the signing of this Agreement. The Step 1 Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for implementation of the Plan:

7.6.1.1.1. Provider credentialing/contracting;

7.6.1.1.2. Provider payments;

7.6.1.1.3. Member Services;

7.6.1.1.4. Member Enrollment;

7.6.1.1.5. Pharmacy Management;

7.6.1.1.6. Care Coordination;

7.6.1.1.7. Utilization Management;

7.6.1.1.8. Grievance System;

7.6.1.1.9. Fraud, Waste, and Abuse;

7.6.1.1.10. Third-Party Liability;

7.6.1.1.11. MCIS ;

7.6.1.1.12. Financial management; and

7.6.1.1.13. Provider and member communications.

7.6.1.2. The Step 1 Program Implementation Plan shall become an addendum to this Agreement as Exhibit L.

7.6.2. Implementation

7.6.2.1. Upon approval of the Step 1 Implementation Plan, the MCO shall implement the Plan as approved covering the Step 1 populations and services identified in Sections 8.1 and 8.2 of this Agreement.

7.6.2.2. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.6.2.3. The MCO must obtain prior written approval from DHHS for any changes or deviations from the submitted and approved Plan.

7.6.2.4. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.6.2.4.1. Progress on Step 1 Implementation Plan;

7.6.2.4.2. Risks/Issues and mitigation strategy;

7.6.2.4.3. Modifications to the Step 1 Implementation Plan;

7.6.2.4.4. Progress on any Corrective Action Plans;

7.6.2.4.5. Program delays; and

7.6.2.4.6. Upcoming activities.

7.6.2.5. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.6.3. Readiness Reviews

7.6.3.1. DHHS intends to conduct two (2) readiness reviews of the MCO during the implementation phase prior to the Program Start Date. The first review shall take place thirty (30) days after contract effective date or scheduled after DHHS has verified that at least two MCOs have satisfied the DHHS Substantial Provider Network reporting requirements, whichever comes later, and will take place ninety(90) calendar days prior to the Program Start Date. The second review shall take place thirty (30) calendar days prior to the Program Start Date. The MCO shall fully cooperate with DHHS during these readiness reviews. During the readiness reviews, DHHS shall assess the MCO's progress towards a successful program implementation through regular reporting activities. The review shall include validation of readiness in multiple areas, including but not limited to:

7.6.3.1.1. MCO's ability to pay a claim;

7.6.3.1.2. MCO's network adequacy;

7.6.3.1.3. MCO's member transition plan;

7.6.3.1.4. MCO's system preparedness;

7.6.3.1.5. MCO's member experience procedures;

7.6.3.1.6. Grievance System; and

7.6.3.1.7. MCO subcontracts.

7.6.3.2. DHHS may adjust the timing, number and requirements of Readiness Reviews at its sole discretion.

7.6.3.3. Should the MCO fail to pass either readiness review, the MCO shall submit a Corrective Action Plan to DHHS sufficient to ensure the MCO passes the readiness review and shall complete implementation on schedule. This Corrective Action Plan shall be integrated into the overall program Step 1 Implementation Plan as a modification subject to review and approval by DHHS. DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified and/or apply liquidated damages as provided in Section 34.

7.6.3.4. During the first one hundred and eighty (180) days following the effective date of this Agreement or within ninety (90) days prior to the Program Start Date, whichever comes later, DHHS may give tentative approval of the MCO's required policies and procedures.

7.6.3.5. DHHS may at its discretion suspend application of the remedies specified in Section 34, except for those required under 42 CFR 700 and Section 1903(m) or Section 1932 of the Social Security Act, provided that the MCO is in compliance with any Corrective Action Plans developed during the readiness period, unless the MCO fails to meet the start date of the NH Medicaid Care Management program.

7.6.3.6. The start date of the Medicaid Care Management program shall be when at least two MCOs have met the readiness requirements 7.6.3.1.

7.7. Step 2 Program Implementation Plans

7.7.1. Implementation of Step 2 will take place as follows:

7.7.1.1. Phase 1. Mandatory Enrollment populations indicated in Section 8.1 – Program Start Date February 1, 2016.

7.8. NHHPP Program Implementation Plan

7.8.1. Submission and Contents of the NHHPP Implementation Plan

7.8.1.1. The MCO shall submit a NHHPP Implementation Plan to DHHS for review and approval no later than fourteen days (14) calendar days after signing the related contract amendment. The Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for the implementation of the Plans:

7.8.1.1.1. Provider credentialing/contracting for SUD and chiropractic providers;

7.8.1.1.2. Provider agreements and or amendments for services provided to NHHPP members;

7.8.1.1.3. Paying NHHPP providers according to the methodology prescribed by DHHS Section 21.2.10.4;

7.8.1.1.4. Sufficient provider capacity to serve NHHPP population without compromising access for Step 1 members;

7.8.1.1.5. Production of new Member handbooks or updates to reflect the differences for the NHHPP plan members;

7.8.1.1.6. Implementation of a process by which to reduce inappropriate emergency room utilization;

7.8.1.1.7. Implementation of new member co-payments and cost sharing as required in Medicaid Care Management; and

7.8.1.1.8. Call center training for NHHPP related inquiries.

7.8.2. NHHPP Implementation

7.8.2.1. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.8.2.2. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.8.2.2.1. Progress on NHHPP Implementation Plan;

7.8.2.2.2. Risks/Issues and mitigation strategy;

7.8.2.2.3. Modifications to the NHHPP Implementation Plan;

7.8.2.2.4. Progress on any Corrective Action Plans;

7.8.2.2.5. Program delays; and

7.8.2.2.6. Upcoming activities.

7.8.2.3. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.8.3. NHHPP Readiness Review

7.8.3.1. DHHS intends to conduct one (1) readiness review no sooner than thirty (30) days prior to the enrollment of NHHPP members. The MCO shall fully cooperate with DHHS during this review.

8. Covered Populations and Services

8.1. Covered Populations Matrix

The MCO shall provide managed care services to population groups deemed by DHHS to be eligible for managed care. The planned phase-in of population groups is depicted in the matrix below.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[1]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Beckett) - With Member Opt Out	X			
HC-CSD (Katie Beckett) - Mandatory Enrollment		X		
Children with special health care needs (enrolled in Special Medical Services / Partners in Health) - Mandatory Enrollment		X		
Children with Supplemental Security Income (SSI) - Mandatory Enrollment		X		
M-CHIP	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			

[1] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
Pregnant Women	X			
Native Americans and Native Alaskans w/ member opt out[2]	X			
Native Americans and Native Alaskans - Mandatory Enrollment (w/CMS waiver)		X		
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
Members with VA Benefits				X
NHHPP Enrollees			X	
Medically Frail			X	
Family Planning Only Benefit				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X
Health Insurance Premium Payment Program (HIPP)				X

8.2. Covered Services Matrix Overview

The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with CMS-approved Medicaid State Plan, to its members, reflecting the planned phase-in.

[2] Per 42 USC §1396u-2(a)(2)(c); however, NH has no recognized tribes.

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Maternity & Newborn Kick Payments	x	x	x	
Inpatient Hospital	x	x	x	
Outpatient Hospital[3]	x	x	x	
Inpatient Psychiatric Facility Services Under Age 21[4]	x	x	x	
Physicians Services	x	x	x	
Advanced Practice Registered Nurse	x	x	x	
Rural Health Clinic & FQHC	x	x	x	
Prescribed Drugs[5]	x	x	x	
Community Mental Health Services	x	x	x	
Psychology	x	x	x	
Ambulatory Surgical Center	x	x	x	
Laboratory (Pathology)	x	x	x	
X-Ray Services	x	x	x	
Family Planning Services	x	x	x	
Medical Services Clinic (mostly methadone clinic)	x	x	x	
Physical Therapy[6]	x	x	x	
Occupational Therapy[7]	x	x	x	

[3] Including facility and ancillary services for dental procedures

[4] Under age 22 if individual admitted prior to age 21

[5] Except as indicated in Section 14.1.15

[6] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Speech Therapy[8]	x	x	x	
Audiology Services	x	x	x	
Podiatrist Services	x	x	x	
Home Health Services	x	x	x	
EPSDT Services[9]	x	x	x	
Private Duty Nursing	x	EPSDT only	x	
Adult Medical Day Care	x	EPSDT only	x	
Personal Care Services	x	EPSDT only	x	
Hospice	x	x	x	
Optometric Services Eyeglasses	x	x	x	
Furnished Medical Supplies & Durable Medical Equipment	x	x	x	
Non-Emergent Medical Transportation [10]	x	x	x	
Ambulance Service	x	x	x	
Wheelchair Van	x	x	x	
Independent Care Management	x	EPSDT only	x	

[7] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[8] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[9] EPSDT includes Applied Behavioral Analysis Services.

[10] Also includes mileage reimbursement for medically necessary travel

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Home Visiting Services	x	x[11]		
Acquired Brain Disorder Waiver Services				
Developmentally Disabled Waiver Services				
Choices for Independence Waiver Services				
In Home Supports Waiver Services				
Skilled Nursing Facility				
Skilled Nursing Facility Atypical Care				
Inpatient Hospital Swing Beds, SNF				
Intermediate Care Facility Nursing Home				
Intermediate Care Facility Atypical Care				
Inpatient Hospital Swing Beds, ICF				
Glencliff Home				
Developmental Services Early Supports and Services				
Home Based Therapy – DCYF				
Child Health Support Service – DCYF				
Intensive Home and Community Services – DCYF				
Placement Services – DCYF				
Private Non-Medical Institutional For Children – DCYF				
Crisis Intervention – DCYF				
Substance use disorder services as per He-W	x	x	x	

[11] Provided within the SUD benefit

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
513				
Chiropractic services (NHHPP population only)		x		
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)[12]				
Medicaid to Schools Services				x
Dental Benefit Services[13]				x
Behavioral Health Crisis Treatment Center	x	x	x	
Services provided in an IMD pursuant to an approved waiver[14]	x	x	x	

8.3. Covered Services Additional Provisions

8.3.1. While the MCO may provide a higher level of service and cover additional services than required by DHHS, the MCO shall, at a minimum, cover the services identified at least up to the limits described in N.H. Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by informing the MCO [42 CFR 438.210(a)(1) and (2)]. Changes to the Medicaid State Plan, state statutes and rules shall be done in accordance with Federal and state requirements.

8.3.2. Pursuant to 42 CFR 438.3, the MCO shall provide enrollees with services or settings that are in lieu of services or settings described in 8.2 that are authorized by DHHS, which include, Medical Nutrition & Diabetes Self Management. The MCO shall not require the enrollee to use these alternate services.

8.3.3. Pursuant to 42 CFR 438.6, the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any enrollee that is receiving treatment in an institution for

[12] e.g. Cedarcrest

[13] except facility and ancillary services for dental procedures

[14] The Department anticipates that the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver will be approved by July of 2018.

mental disease (IMD) for the primary treatment of a psychiatric disorder that is not a state owned or operated facility. The MCO shall not pay for any days in a given month if the enrollee exceeds fifteen (15) days in an IMD for that month. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for in lieu of services at 42 CFR 438.3(e)(2)(i) through (iii).

8.3.4. Effective November 1, 2014, with the exception of HCBC waiver participants and nursing facility residents, the MCO shall require co-payment for services for members deemed by DHHS to have annual incomes at or above 100% of the FPL as follows:

8.3.4.1. Co-payments for drug prescriptions of up to $1 for generic drugs and $2 for brands and compound drugs for Step 1 members with annual incomes higher than 100% of the FPL, and for Step 2 members with annual incomes higher than 100% of the FPL consistent with the beneficiary and service exemptions as found in federal regulations and the approved Medicaid State Plan; and

8.3.4.2. Co-payments for drugs prescriptions of up to $1 for generic drugs and $4 for brands and compound drugs for NHHPP members with annual incomes higher than 100% of the FPL.

8.3.5. Effective 3/1/2016, the MCO Shall require point-of-service copayment for services for members deemed by DHHS to not be exempt from cost-sharing and have incomes above 100 percent of the federal poverty level as follows:

8.3.6. For Medicaid recipients subject to copayments:

8.3.6.1. A copay of $1.00 will be required for each preferred prescription drug and each refill of a preferred prescription drug.

8.3.6.2. A copay of $2.00 will be required for each non-preferred prescription drug and each refill of a nonpreferred prescription drug, unless the prescribing provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the copay for the non-preferred drug will be $1.00.

8.3.6.3. A copay of $1.00 will be required for a prescription drug that is not identified as either a preferred or nonpreferred prescription drug.

8.3.6.4. Copays are not required for family planning products or for Clozaril (Clozapine) prescriptions. All Cost sharing shall be applied consistent with beneficiary and service exemptions as found at 42 USC §§ 1396-o and 1396o-1, 42 C.F.R. §447.50 - 447.90, and New Hampshire's Medicaid State Plan.

8.3.7. Those individuals, who meet the definition of an Indian in 42 CFR 438.14(a), are exempt from any premiums or cost-sharing including copayments.

8.3.8. The MCO may, with DHHS approval, require co-payment for services that do not exceed current Medicaid co-payment amounts established by DHHS.

8.3.9. The MCO shall with no disruption in service delivery to members or providers transition these services into managed care from fee-for-service (FFS).

8.3.10. All services shall be provided in accordance with 42 CFR 438.210.

8.3.11. The MCO shall adopt written policies and procedures to verify that services are actually provided [42 CFR 455.1(a)(2)].

8.3.12. The MCO shall comply with provisions of RSA 167:4-d by providing access to telemedicine services to Medicaid members for specialty care only.

8.3.13. The MCO shall cover services consistent with 45 CFR 92.207(b) including gender reassignment surgery.

8.4. Emergency Services

8.4.1. The MCO shall cover and pay for emergency services at rates that are no less than the equivalent DHHS fee-for-service rates if the provider that furnishes the services has an agreement with the MCO [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98].

8.4.2. If the provider that furnishes the emergency services has no agreement with the MCO, the MCO shall cover and pay for the emergency services in compliance with 1932(b)(2)(D) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98.

8.4.3. In accordance with the Deficit Recovery Act of 2005, the MCOs will cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall pay non-contracted providers of Emergency and Post-Stabilization services an amount no more than the amount that would have been paid under the DHHS Fee-For-Service system in place at the time the service was provided.

8.4.4. The MCO shall not deny treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(ii)(A); SMD letter 2/20/98].

8.4.5. The MCO shall not deny payment for treatment obtained when a representative, such as a network provider, of the MCO instructs the member to seek emergency services [42 CFR 438.114(c)(1)(ii)(B); SMD letter 2/20/98].

8.4.6. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

8.4.7. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or DHHS of the member's screening and treatment within ten (10) calendar days of presentation for emergency services [42 CFR 438.114(d)(1)(ii)].

8.4.8. The MCO may not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient [42 CFR 438.114(d)(2)].

8.4.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment [42 CFR 438.114(d)(3)].

8.5. Post-Stabilization Services

8.5.1. Post-stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for post-stabilization services obtained within or outside the MCO that are pre-approved by a MCO provider or other MCO representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i); SMD letter 8/5/98]

8.5.2. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii); SMD letter 8/5/98.]

8.5.3. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain, improve or resolve the member's stabilized condition if:

8.5.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

8.5.3.2. The MCO cannot be contacted; or

8.5.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with a MCO physician and the treating physician may continue with care of the patient until a MCO physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)].

8.5.4. The MCO shall limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the MCO. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv); SMD letter 8/5/98]

8.5.5. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

8.5.5.1. A MCO physician with privileges at the treating hospital assumes responsibility for the member's care;

8.5.5.2. A MCO physician assumes responsibility for the member's care through transfer;

8.5.5.3. A MCO representative and the treating physician reach an agreement concerning the member's care; or

8.5.5.4. The member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3); SMD letter 8/5/98]

9. Payment Reform Plan

9.1. Payment Reform Plan Timeline

9.1.1. The MCO shall submit within sixty (60) calendar days from a Program Start Date and sixty (60) calendar days prior to the start of each Agreement year, its Payment Reform Plan to engage its provider network in health care delivery and payment reform activities, subject to review and approval by DHHS. These activities may include, but are not limited to, pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements.

9.1.1.1. DHHS shall respond to the MCO regarding the Payment Reform Plan within thirty (30) calendar days of receipt.

9.1.2. The MCO shall submit a report to DHHS describing its performance against the MCO's healthcare delivery and Payment Reform Plan within ninety (90) calendar days of the end of each year of the Agreement.

9.1.2.1. The report shall indicate, by provider type, the number and percentage participating in each type of payment reform activities.

9.1.2.2. DHHS will evaluate the MCO's performance and make payments to the MCO, if warranted, within ninety (90) calendar days of receipt of the report. DHHS shall provide the MCO with a written explanation of DHHS's evaluation of the MCO's performance within thirty (30) days of the MCO's request.

9.1.2.3. In the event that MCO disputes DHHS's evaluation of MCO's performance, MCO will have thirty (30) calendar days from receipt of DHHS's written explanation to submit a written request for reconsideration along with a description of MCO's reasons for the dispute, after which DHHS shall meet with the MCO within a reasonable time frame to achieve a good faith resolution of the disputed matter.

9.2. Payment Reform Plan Content

9.2.1. The Payment Reform Plan shall contain:

9.2.1.1. Information on the anticipated impact on member health outcomes of each specific activity, providers affected by the specific activity, outcomes anticipated as a result of the implementation of a process by which to reduce inappropriate emergency room use, an implementation plan for each activity and an implementation milestone to be met by the end of each year of the Agreement for each activity;

9.2.1.2. A process to ensure Equal Access to services; and

9.2.1.3. A process for engaging LTSS providers in health care delivery and payment reform activities.

9.3. Payment Reform Plan Compliance Requirements

9.3.1. The MCO's Payment Reform Plan(s) shall be in compliance with the following requirements:

9.3.1.1. FQHCs and RHCs will be paid at minimum the encounter rate paid by DHHS at the time of service.

9.3.1.2. The Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

9.3.1.3. The MCO's provider incentive plan shall comply with requirements set forth in 42 CFR 422.208 and 42 CFR 422.210 [42 CFR 438.6(h)].

9.3.1.4. The MCO's payment reform plan must comply with state and federal laws requiring nonpayment to a Contracted Provider for hospital-acquired conditions and for provider preventable conditions. The MCO shall report to NH DHHS all provider-preventable conditions in a form and frequency as specified by the State [42 CFR 438.3(g)].

9.3.1.5. The MCO may not make payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.6. The MCO shall provide information on its provider incentive program to any New Hampshire recipient upon request (this includes the right to adequate and

timely information on the plan) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.6(h)].

9.3.1.7. The MCO shall report whether services not furnished by physician/group are covered by an incentive plan. No further disclosure is required if the incentive plan does not cover services not furnished by the physician/group [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.7.1. The MCO shall report the type of incentive arrangement (e.g., withhold, bonus, capitation) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.8. The MCO shall report the percent of withhold or bonus (if applicable) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.9. The MCO shall report panel size, and if patients are pooled, the approved method used [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.10. If the physician/group is at substantial financial risk, the MCO shall report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss [§1903(m)(2)(A)(x)of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.11. Primary Care reimbursement to follow DHHS policy and to comply with 42 CFR 438, 42 CFR 441 and 42 CFR 447 II.A.5

9.3.1.11.1. MCO shall pass on the full benefit of the payment increase to eligible providers; and

9.3.1.11.2. MCO shall adhere to the definitions and requirements for eligible providers and services as specified in Section 1902(a)(13)(C), as amended by the Affordable Care Act of 2010 (ACA) and federal regulations; and

9.3.1.11.3. MCO shall submit sufficient documentation, as per DHHS policy, to DHHS to validate that enhanced rates were made to eligible providers.

10. Care Coordination Program

10.1. Minimum Care Coordination Program Components

10.1.1. The MCO shall implement a comprehensive care array of care coordination services that have at a minimum the following components:

10.1.1.1.Care Coordination

10.1.1.2.Support of Patient-Centered Medical Homes and Health Homes

10.1.1.3.Non-Emergent Medical Transportation

10.1.1.4.Wellness and Prevention programs

10.1.1.5.Chronic Care Coordination programs

10.1.1.6.High Risk/ High Cost Member Management programs

10.1.1.7.A Special Needs program

10.1.1.8.Coordination and Integration with Social Services and Community Care

10.1.1.9.A Long Term Services and Supports Program

10.2. Care Coordination: Role of the MCO

10.2.1. The MCO shall develop a strategy for coordinating all care for all members. Care coordination for its members includes coordination of primary care, specialty care, and all other MCO covered services as well as services provided through the fee-for-service program and non-Medicaid community based services. Care coordination shall promote and assure service accessibility, focus attention to individual needs, actively assist members or their caregiver to take personal responsibility for their health care, provide education regarding the use of inappropriate emergency room care, emphasize the importance of participating in health promotion activities, provide for continuity of care, and assure comprehensive coordinated and integrated culturally appropriate delivery of care.

10.2.2. The MCO shall ensure that services provided to children are family driven and based on the needs of the child and the family. The MCO shall support the family in having a primary decision making role in the care of their children utilizing the Substance Abuse and Mental Health Services Administration (SAMHSA) core elements of a children's services system of care. The MCO shall employ the SAMHSA principles in all children's behavioral health services assuring they:

10.2.2.1.Are person centered;

10.2.2.2. Include active family involvement;

10.2.2.3. Deliver behavioral health services that are anchored in the community;

10.2.2.4. Build upon the strengths of the member and the family;

10.2.2.5. Integrate services among multiple providers and organizations working with the child; and

10.2.2.6. Utilize a wraparound model of care within the context of a family driven model of care.

10.2.2.6.1. MCO shall submit a written policy to DHHS describing the integrated model of care including but not limited to the involvement of each member and family in the development of the plan.

10.2.3. The MCO will ensure that its providers are providing services to children, youth members, and their families in accordance with RSA 135-F.

10.2.4. The MCO shall provide a written policy to DHHS for approval that ensures that services to individuals who are homeless are to be prioritized and made available to those individuals.

10.3. Care Coordination: Role of the Primary Care Provider

10.3.1. MCO Cooperation with Primary Care Provider

10.3.1.1. The MCO shall implement procedures that ensure that each member has access to an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with 42 CFR 438.208(b)(1) through (6).

10.3.1.2. The MCO shall submit a written plan that describes the development, implementation and evaluation of programs to assess and support, wherever possible, primary care providers to act as a patient centered medical home. A patient centered medical home shall include all of the five key domains outlined by the Agency for Healthcare Research and Quality (AHRQ):

10.3.1.2.1. Comprehensive care;

10.3.1.2.2. Patient-centered care;

10.3.1.2.3. Coordinated care;

10.3.1.2.4. Accessible services; and

10.3.1.2.5. Quality and safety.

10.3.1.3.DHHS recognizes that there is a variety of ways in which these domains can be addressed in clinical practices. External accreditation is not required by DHHS to qualify as a medical home. The MCO's support to primary care providers acting as patient centered medical homes shall include, but is not limited to, the development of systems, processes and information that promote coordination of the services to the member outside of that provider's primary care practice.

10.4. Care Coordination: Role of Obstetric Providers

10.4.1. If, at the time of entering the MCO as a new member, the member is transferring from another MCO within the state system, is in her first trimester of pregnancy and is receiving, medically necessary covered prenatal care services, as defined within this Agreement as covered services, before enrollment the MCO shall be responsible for the costs of continuation of medically necessary prenatal care services, including prenatal care, delivery, and postpartum care.

10.4.2. If the member is receiving services from an out-of-network provider prior to enrollment in the MCO, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services until such time as the MCO can reasonably transfer the member to a network provider without impeding service delivery that might be harmful to the member's health.

10.4.3. If the member, at the time of enrollment, is receiving services from a network provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider through the postpartum period.

10.4.4. In the event a member entering the MCO, either as a new member or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services at the time of enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider, whether an out-of-network or in network provider, through the postpartum period.

10.4.5. Postpartum care includes the first postpartum visit, any additional visits necessary to manage any complications related to delivery, and completion of the medical record.

10.4.6. The MCO shall develop and maintain policies and procedures, subject to DHHS approval, regarding the transition of any pregnant members.

10.5. Non-Emergent Transportation (NEMT)

10.5.1. The MCO shall be required to arrange for the non-emergent medical transportation of its members to ensure members receive medically necessary services covered by the New Hampshire Medicaid program regardless of whether those medically necessary services are covered by the MCO. The MCO shall ensure that a member's lack of personal transportation is not a barrier to accessing care.

10.5.2. The MCO and/or any subcontractors shall be required to perform background checks on all non-emergent medical transportation providers.

10.5.3. The MCO shall provide quarterly reports to DHHS on its non-emergent medical transportation activities to include but not be limited to:

10.5.3.1.NEMT requests delivered by mode of transportation;

10.5.3.2.NEMT request authorization approval rates by mode of transportation;

10.5.3.3.NEMT scheduled trip results by outcome;

10.5.3.4.NEMT services delivered by type of medical service;

10.5.3.5.NEMT service use by population; and

10.5.3.6.Number of transportation requests that were delivered late and not on time.

10.5.3.6.1. On-time shall be defined as less than or equal to fifteen (15) minutes after the appointed time; and

10.5.3.6.2. Transportation requests for methadone services will be excluded from the calculation of late and not-on-time services.

10.5.3.7.Member cancellations of scheduled trips by reason for member cancellations.

10.6. Wellness and Prevention

10.6.1. The MCO shall develop and implement wellness and prevention programs for its members.

10.6.2. The MCO shall, at a minimum, develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs in consultation with DHHS.

10.6.3. The MCO shall, at minimum, provide primary and secondary preventive care services, rated A or B, in accordance with the recommendations of the U.S.

Preventive Services Task Force, and for children, those preventive services recommended by the American Academy of Pediatrics Bright Futures Program.

10.6.4. The MCO may substitute generally recognized accepted guidelines for the requirements set forth in 10.6.3, provided that such substitution is approved in advance by DHHS. The MCO shall provide members with a description of preventive care benefits to be used by the MCO in the member handbook and on the MCO's website.

10.6.5. The MCO shall provide members with general health information and provide services to help members make informed decisions about their health care needs. The MCO shall encourage patients to take an active role in shared decision making.

10.6.6. The MCO shall also participate in other public health initiatives at the direction of DHHS.

10.7. Member Health Education

10.7.1. The MCO shall develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of empowering patients to actively participate in their healthcare.

10.7.2. The MCO shall conduct a Health Needs Assessment for all new members within the following timeframes from the date of enrollment in the MCO:

10.7.2.1. thirty (30) calendar days for pregnant women, children with special health care needs, adults with special health care needs; and

10.7.2.2. ninety (90) calendar days for all other members, including members residing in a nursing facility longer than 100 days.

10.7.2.3. The MCO shall document at least three attempts to conduct the screen. If unsuccessful, the MCO shall document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.

10.7.3. The MCO will submit their Health Needs Assessment forms to DHHS for review and approval.

10.7.4. The MCO shall report quarterly, with reports due the last day of the month following the reporting quarter, with the first report due January 31, 2015. Reports shall include:

10.7.4.1. the number of members and the percentage of eligible members who completed a Health Needs Assessment in the quarter;

10.7.4.2.the percentage of eligible members who completed the Health Needs Assessment in the prior year; and

10.7.4.3.the percentage of members eligible for chronic care coordination, high cost/high risk care coordination, complex care coordination and/or the MCO's special needs program who completed a Health Needs Assessment in the prior year.

10.7.5. The MCO shall actively engage members in both wellness program development and in program participation and shall provide additional or alternative outreach to members who are difficult to engage or who utilize the emergency room inappropriately.

10.8. Chronic Care Coordination, High Risk/High Cost Member and Other Complex Member Management

10.8.1. The MCO shall develop effective care coordination programs that assist members in the management of chronic and complex health conditions, as well as those clients that demonstrate high utilization of services indicating a need for more intensive management services. The MCO may delegate the chronic and complex care member management to a patient centered medical home or health home provided that all the criteria for qualifying as a patient centered medical home or a health home and the additional conditions of this section have been met. These programs shall incorporate a "whole person" approach to ensure that the member's physical, behavioral, developmental, and psychosocial needs are comprehensively addressed. The MCO or its delegated entity shall ensure that the member, and/or the member's care giver, is actively engaged in the development of the care plan.

10.8.2. The MCO shall submit status reports to DHHS on MCO care coordination activities and any delegated medical home or health home activities as requested or required by DHHS.

10.8.3. The MCO shall at, a minimum, provide chronic care coordination services for members with the following or other chronic disease states who are appropriate for such care coordination services based on MCO's methodologies, which have been approved by DHHS, for identifying such members:

10.8.3.1.Diabetes, in coordination with the forthcoming federal diabetes initiative;

10.8.3.2.Congestive Heart Failure (CHF);

10.8.3.3.Chronic Obstructive Pulmonary Disease (COPD);

10.8.3.4.Asthma;

10.8.3.5.Coronary Artery Disease (CAD), in coordination with the Million Hearts Campaign;

10.8.3.6.Obesity;

10.8.3.7.Mental Illness;

10.8.3.8.Requiring wound care.

10.8.4. The MCO shall report on the number and types of members receiving chronic care coordination services.

10.9. Special Needs Program

10.9.1. The MCO shall create an organizational structure to function as patient navigators to:

10.9.1.1.Reduce any barriers to care encountered by members with special needs

10.9.1.2.Ensure that each member with special needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists as appropriate

10.9.1.3.Support in accessing all covered services appropriate to the condition or circumstance.

10.9.2. The MCO shall identify special needs members based on the member's physical, developmental, behavioral condition, or adverse social circumstances, including but not limited to:

10.9.2.1.A member with at least two chronic conditions;

10.9.2.2.A member with one chronic condition and is at risk for another chronic condition;

10.9.2.3.A member with one serious and persistent mental health condition;

10.9.2.4.A member living with HIV/AIDS;

10.9.2.5.A member who is a child in foster care;

10.9.2.6.A member who is a child and a client of DCYF receiving services through a court order; and

10.9.2.7.A member who is homeless.

10.9.3. The MCO shall assess, pursuant to 42 CFR 438.208(c)(2), and reach out to members identified with special needs and their PCP to inform them of additional services and supports available to them through the MCO's special needs program.

10.9.4. The MCO shall share the results of its identification and assessment of any enrollee with special health care needs as described in this section with the State so that those activities will not be duplicated.

10.9.5. The MCO shall ensure enrollees determined to have special health care needs as described in this section and who need a course of treatment or regular care monitoring, will have direct access to a specialist as appropriate for the enrollee's condition and identified needs.

10.9.6. For enrollees with special health needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.9.7. The MCO shall report on the number and types of members in the special needs program.

10.10.Coordination and Integration with Social Services and Community Care

10.10.1.The MCO shall develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including not limited to:

10.10.1.1.Juvenile Justice and Adult Community Corrections;

10.10.1.2.Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

10.10.1.3.Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

10.10.1.4.Public Health Agencies;

10.10.1.5.Schools;

10.10.1.6.Step 2 Programs and Services;

10.10.1.7.The court system;

10.10.1.8.ServiceLink Resource Network; and

10.10.1.9.Housing

10.10.1.9.1.Veterans Administration Hospital and other programs and agencies serving service members, veterans and their families.

10.10.2.The MCO shall report on the number of referrals for social services and community care provided to members by member type.

10.11.Long Term Services and Supports (LTSS)

10.11.1.Navigators. The MCO shall create an organizational structure to function as navigators for members in need of LTSS to:

10.11.1.1.Reduce any barriers to care encountered by members with long term care needs;

10.11.1.2.Ensure that each member with long term care needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists, as appropriate; and

10.11.1.3.Ensure that each member with long term care needs receives conflict free care coordination that facilitates the integration of physical health, behavioral health, psychosocial needs, and LTSS through person-centered care planning to identify a member's needs and the appropriate services to meet those needs; arranging, coordinating, and providing services; facilitating and advocating to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

10.11.2.Integrated Care. The MCO shall ensure that LTSS are delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation, based on the member's preferences and pursuant with 28 C.F.R. Pt. 35, App. A (2010), the Americans with Disabilities Act (ADA) [42 USC 126.12101] and Olmstead v. L.C., 527 U.S. 581 (1999).

10.11.2.1.The MCO shall support accessing all covered services appropriate to the medical, behavioral, psychosocial, and/or LTSS condition or circumstance.

10.11.2.2.The MCO shall identify members with long term care needs based on the member's physical, developmental, psychosocial, or behavioral conditions including but not limited to:

10.11.2.2.1.Children with DCYF involvement;

10.11.2.2.2.Children with special needs other than DCYF;

10.11.2.2.3.Children with Waiver, NF or CMHC services;

10.11.2.2.4.Adults with Special Needs with Waiver, NF or CMHC services;

10.11.2.2.5.Adults with Waiver, NF or CMHC services;

10.11.2.2.6.Older Adults with Waiver or CMHC services; or

10.11.2.2.7.Older adults with NF services.

10.11.2.3.The MCO shall reach out to members identified with long term care needs and their PCP to:

10.11.2.3.1. Assess them and identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring; and

10.11.2.3.2.Inform them of additional services and supports available to them through the MCO; and

10.11.2.3.3.Identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

10.11.2.4.For enrollees with long term care needs determined through an assessment or through regular care monitoring to need services, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.11.2.5.For enrollees with long term care needs determined through an assessment or regular care monitoring, the MCO must have a mechanism in place to assist enrollees to access medically necessary services.

11. EPSDT

11.1. Compliance

11.1.1. The MCO shall provide Early Periodic Screening Diagnostic Treatment (EPSDT) services to members less than twenty-one (21) years of age in compliance with all requirements found below:

11.1.1.1. The MCO shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the SSA and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The MCO shall comply with all EPSDT requirements pursuant to the New Hampshire Medicaid Rules.

11.1.1.2. The MCO shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through Health Check screens and exams and follow-up on any abnormal screening exams. The EPSDT Plan shall also include procedures for referral, tracking, and follow up for annual dental examinations and visits, upon receipt of dental claims information from DHHS. The EPSDT Plan shall consider and be consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists to the extent that such policy statements relate to the role of the primary care provider in coordinating care for infants, children and adolescents. The MCO shall submit its EPSDT Plan to DHHS for review and approval ninety (90) days prior to program start and annually sixty (60) calendar days prior to the first day of each Agreement year.

11.1.1.3. The MCO shall ensure providers perform a full EPSDT visit according to the periodic schedule approved by DHHS and the American Academy of Pediatrics periodicity schedule. The visit shall include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements §1902(a)(43) of the SSA, §1905(a)(4)(B) of the SSA and 42 CFR 441.50-.62, and health education/anticipatory guidance. All five (5) components shall be performed for the visit to be considered an EPSDT visit.

12. Behavioral Health

12.1. Behavioral Health - General Provisions

12.1.1. This section applies to individuals who have been determined to be eligible for community mental health services based on diagnosis, level of impairment and the requirements outlined in N.H. Code of Administrative Rules, chapter He-M 401.

12.1.2. Community mental health services, as set forth in Section 8.2, shall be provided in accordance with the NH Medicaid State Plan, He-M 426, He-M 408 and all other applicable state and federal regulations.

12.1.3. All clinicians providing community mental health services are subject to the requirements of He-M 426 and any other applicable state and federal regulations.

12.1.4. All individuals approved to provide community mental health services through a waiver granted by NH DHHS shall be recognized as qualified providers under the MCO plan subject to NCQA credentialing requirements.

12.1.5. All other behavioral health services shall be provided to all NH Medicaid-eligible recipients in accordance with the NH Medicaid State Plan.

12.1.6. The MCO shall pay for all NH Medicaid State Plan Services for its members as ordered to be provided by the Mental Health Court.

12.1.7. The MCO shall continue to support and ensure that culturally and linguistically competent community mental health services currently provided for people who are deaf continue to be made available. These services shall be similar to services currently provided through the Deaf Services Team at Greater Nashua Mental Health Center.

12.2. Community Mental Health Services

12.2.1. The MCO shall ensure, through review of individual service plans and quarterly reviews, that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall inform DHHS of their findings on a monthly basis.

12.2.2. The MCO shall employ a trauma informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan, pursuant to He-M 401, that will effectively address the individual's trauma history.

12.2.3. The MCO shall make Community Mental Health Services available to all members who have a severe mental disability. DHHS encourages agreement between the MCO and CMHCs to develop a capitated payment program with the intent to establish payment mechanisms to meet the goals of DHHS to strengthen the State's outpatient community health service system and the requirements of the Community Mental Health Agreement, and to further payment reform. In the event that any CMHC fails to sign a contract with the MCO within thirty (30) days before the current contract end date, the MCO shall notify DHHS of the failure to reach agreement with a CMHC and DHHS shall implement action steps to designate a community mental health program to provide services in the designated community mental health services region.

12.2.3.1. The MCO shall submit to DHHS a plan to assure continuity of care for all members accessing a community mental health agency.

12.2.4. In the event that an alternative community mental health program is approved and designated by DHHS, a transition plan shall be submitted for approval by DHHS including implementation strategy and timeframes. State Administrative Rule He-M 426, Community Mental Health Services, details the services available to adults with a severe mental illness and children with serious emotional disturbance. The MCO shall, at a minimum, make these services available to all members determined eligible for community mental health services under State Administrative Rule He-M 401.

12.2.4.1. The MCO shall be required to continue the implementation of evidence based practices across the entire service delivery system.

12.2.4.2. Behavioral Health Services shall be recovery and resiliency oriented, based on SAMHSA's definition of recovery and resiliency.

12.2.4.3. The MCO shall ensure that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans.

12.2.4.4. The MCO shall ensure that community mental health services to individuals who are homeless continue to be prioritized and made available to those individuals.

12.2.4.5. The MCO shall maintain or increase the ratio of community based to office based services for each region in the State, as specified in He-M 425, to be greater than or equal to the regional current percentage or 50%, whichever is greater.

12.2.4.6.The MCO shall monitor the ratio of community based to office based services for each region in the State, as specified in He-M 425.

12.2.4.7.The Department of Health and Human Services (DHHS) will issue a list of covered office and community based services annually, by procedure code, that are used to determine the ratio outlined in 12.2.4.5.

12.2.4.8.The MCO shall submit a written report to the Department of Health and Human Services DHHS every six (6) months, by region, of the ratio of community based services to office based services.

12.2.5. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

12.2.5.1.Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web-based training and certification system.

12.2.5.1.1. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member eligibility renewal following clinician certification to utilize the CANS and the ANSA and upon eligibility determination for newly evaluated consumers effective July 1, 2015.

12.2.5.1.2. The community mental health long term care eligibility tool, specified in He-M 401, and in effect on January 1, 2012 shall continue to be utilized by a clinician until such time as the Department of Health and Human Services implements web-based access to the CANS and the ANSA, the clinician is certified in the use of the CANS and the ANSA, and the member annual review date has passed.

12.2.6. The MCO shall ensure that community mental health service providers operate in a manner that enables the State to meet its obligations under Title II of the Americans with Disabilities Act, with particular attention to the "integration mandate" contained in 28 CFR 35.130(d).

12.2.7. The MCO shall continue the implementation of New Hampshire's 10-year Olmstead Plan, as updated from time to time, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration."

12.2.7.1.The MCO shall include in its written Program Management Plan:

12.2.7.1.1. Screening criteria for Assertive Community Treatment Teams for all persons with serious mental disabilities.

12.2.7.1.2. A needs assessment, capacity analysis and access plan for Community Residential and Supported Housing.

12.2.7.1.3. New and innovative interventions that will reduce admissions and readmissions to New Hampshire Hospital and increase community tenure for adults with a severe mental illness and children with a serious emotional disturbance.

12.2.8. The MCO shall work collaboratively to support the implementation of the Medicaid-funded services described in the Class Action Settlement Agreement in the case of Amanda D. et al. v. Hassan, et al., US v. State of New Hampshire, Civ. No. 1:12-cv-53-SM in conjunction with DHHS and the Community Mental Health Centers.

12.2.8.1. Adult Assertive Community Treatment Teams (ACT). The MCO shall ensure that ACT teams are available twenty-four (24) hours per day, seven (7) days per week, with on-call availability from midnight to 8:00 am. At a minimum, ACT teams shall deliver comprehensive, individualized, and flexible services, supports, treatment, and rehabilitation in a timely manner as needed, onsite in the individuals homes and in other natural environments and community settings, or alternatively, via telephone where appropriate to meet the needs of the individual. Each ACT team shall be composed of a multi-disciplinary group of between seven (7) and ten (10) professionals, including, at a minimum, a psychiatrist, a nurse, a Masters-level clinician (or functional equivalent therapist), functional support worker and a peer specialist. The team also will have members who have been trained and are competent to provide substance abuse support services, housing assistance and supported employment. Caseloads for ACT teams serve no more than ten (10) to twelve (12) individuals per ACT team member (excluding the psychiatrist who will have no more than seventy (70) people served per 0.5 FTE psychiatrist).

12.2.8.2. Evidence-based Supported Employment (EBSE). The MCO shall ensure that EBSE is provided to eligible consumers in accordance with the Dartmouth model. The MCO shall ensure that the penetration rate of individuals receiving EBSE increases to 18.6 percent by June 30, 2017. The penetration rate is determined by dividing the number of adults with severe mental illness (SMI) receiving EBSE by the number of adults who have SMI being served.

12.2.9. The Department of Health and Human Services will lead regional planning activities in each community mental health region to develop and refine community mental health services in New Hampshire. The MCO shall support and actively participate in these activities.

12.2.9.1.The focus of the regional planning process will be on reducing the need for inpatient care and emergency department utilization, and on increasing community tenure.

12.2.10.The MCO shall develop a Training Plan each year of the Agreement for how it will support the New Hampshire community mental health service system's effort to hire and train qualified staff. The MCO shall submit this Training Plan to DHHS sixty (60) calendar days prior to program start and annually ninety (90) calendar days prior to beginning of each Agreement year.

12.2.10.1.The MCO shall submit a report summarizing what training was provided, a copy of the agenda for each training, a participant registration list for each contracted CMHC and a summary, for each training provided, of the evaluations done by program participants, within ninety (90) calendar days of the conclusion of each Agreement year.

12.2.10.2.As part of that Training Plan, the MCO shall promote provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

12.2.10.3.The MCO Training Plan outlined in 12.2.10.1 shall be designed to sustain and expand the use of the Evidence Based Practices of Illness Management and Recovery (IMR), Evidence Based Supported Employment (EBSE), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Treatment (DBT) and Assertive Community Treatment (ACT), and to improve NH's penetration rates for Illness Management and Recovery (IMR) and Supported Employment, by 2% each year of the Agreement. The baseline measure for penetration rates shall be the NH submission to the SAMHSA Uniform Reporting System for 2011.

12.2.10.4.The MCO shall offer a minimum of 2 hours of training each contract year to all contracted community mental health center staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the State's objective of reducing the number of suicides in New Hampshire.

12.2.10.5.The MCO shall submit an annual report no later than ninety (90) calendar days following the close of each Agreement year with a summary of the trainings provided, a list of attendees from each contracted community mental health program, and the proposed training for the next fiscal year.

12.3. Emergency Services

12.3.1. The MCO shall ensure, through its contracts with local providers, that regionally based crisis lines and Emergency Services as defined in He-M 403 and He-M 426 are in place 24 hours a day/ 7 days a week for individuals in crisis. These crisis lines and Emergency Services Teams shall employ clinicians who are trained in managing crisis intervention calls and who have access to a clinician available to evaluate the member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

12.3.2. The MCO shall submit for review to the DHHS MCM Account Manager and the Director of the Bureau of Mental Health an annual report identifying innovative and cost effective models of providing crisis and emergency response services that will provide the maximum clinical benefit to the consumer while also meeting the State's objectives in reducing admissions and increasing community tenure.

12.4. Care Coordination

12.4.1. The MCO shall develop policies governing the coordination of care with primary care providers and community mental health programs. These policies shall be submitted to DHHS for review and approval ninety (90) calendar days prior to the beginning of each Agreement year, including Year 1.

12.4.2. The MCO shall ensure that there is coordination between the primary care provider and the community mental health program.

12.4.3. The MCO shall ensure that both the primary care provider and community mental health program request written consent from the member to release information to coordinate care regarding mental health services, primary care, and in the case of alcohol and drug abuse services written consent from the member and a notice to the recipient of the records stating 42 CFR Part 2 prohibits unauthorized disclosure of records regarding or substance abuse services.

12.4.4. The MCO shall monitor instances in which consent was not given, and if possible the reason why, and submit this report to DHHS no later than sixty (60) calendar days following the end of the fiscal year.

12.4.5. The MCO shall review with DHHS the approved policy, progress toward goals, barriers and plans to address identified barriers.

12.4.6. The MCO shall ensure integrated care coordination by requiring that providers accept all referrals for its members from the MCO that result from a court order or a request from DHHS.

12.5. New Hampshire Hospital

12.5.1. The MCO shall maintain a collaborative agreement with New Hampshire Hospital, the State of New Hampshire's state operated inpatient psychiatric facility. This collaborative agreement subject to the approval of DHHS shall at a minimum address the Americans with Disabilities Act requirement that individuals be served in the most integrated setting appropriate to their needs, include the responsibilities of the community mental health program in order to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.

12.5.2. It is the policy of the State to decrease discharges from inpatient care at New Hampshire Hospital to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning from New Hampshire Hospital. The MCO shall utilize the collaborative agreement to track any discharges that the MCO, through its provider network, was unable to place into the community and who instead were discharged to a shelter or into homelessness. The MCO shall submit a report to the Department of Health and Human Services DHHS, quarterly, detailing the reasons why members were placed into homelessness and include efforts made by the MCO to arrange appropriate placements.

12.5.3. The MCO shall designate a liaison with privileges, as required by New Hampshire Hospital, to continue members' care coordination activities, and assist in facilitating a coordinated discharge planning process for adults and children admitted to New Hampshire Hospital. Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital treatment team meetings and discharge planning meetings to ensure that individuals receive treatment in the least restrictive environment complying with the Americans with Disabilities Act and other applicable federal and State regulations.

12.5.3.1. The liaison shall actively participate, and assist New Hampshire Hospital staff in the development of a written discharge plan within twenty-four (24) hours of admission.

12.5.3.2. The MCO shall ensure that the final NHH Discharge Instruction Sheet shall be provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of members discharged. The MCO shall ensure that the discharge progress note shall be provided to the aftercare provider within 7 calendar days of member discharge for at least ninety percent (90%) of members discharged.

12.5.3.3.The MCO shall make at least three (3) attempts to contact members for whom the MCO has record of a telephone number within three (3) business days of discharge from New Hampshire Hospital in order to review the discharge plan, support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the member may have. The performance metric shall be that at least ninety-five percent (95%) of members discharged shall have been attempted to be contacted within three (3) business days.

12.5.3.4.The MCO shall ensure an appointment with a community mental health program or other appropriate mental health clinician for the member is scheduled prior to discharge. Such appointment shall occur within seven (7) calendar days after discharge.

12.5.3.4.1. Persons discharged from psychiatric hospitalization and new to a CMHC must have an intake appointment within seven (7) days.

12.5.3.5.The MCO shall work with DHHS to review cases of members that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

12.5.3.6.The MCO shall establish a reduction in readmissions plan, subject to approval by DHHS, to monitor the 30-day and 180-day readmission rates to New Hampshire Hospital, review member specific data with each of the community mental health programs, and implement measurable strategies within 90 days of the execution of this Agreement to reduce 30-day and 180-day readmission. The MCO shall include benchmarks and reduction goals in the Program Management Plan.

12.5.4. The MCO shall perform in-reach activities to New Hampshire Hospital designed to accomplish transitions to the community.

12.6. In Shape Program

12.6.1. The MCOs shall promote community mental health service recipients' whole health goals. Functional support services may be utilized to enable recipients to pursue and achieve whole health goals within an In Shape program or other program designed to improve health.

12.7. Parity

12.7.1. The MCO and its subcontractors must comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which requires the MCOs

to not discriminate based upon an enrollee's health status of having a mental health or substance use disorder.

12.7.1.1. The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.

12.7.1.2. The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

12.7.1.3. The MCO shall not impose Non- Quantitative Treatment Limits for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

12.7.1.4. Annual Certification with Federal Mental Health Parity Law: The MCOs must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the Federal Mental Health Parity Law, regulations and guidance issued by state and federal entities.

12.7.1.4.1. The MCO must submit a certification signed by the chief executive officer and chief medical officer stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.2. If the MCO determines that all administrative, clinical, and utilization practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will affirmatively state, that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.3. If the MCO determines that any administrative, clinical, and utilization practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law or guidance issued by state and federal entities during the calendar year, the certification will state that not all practices were in compliance with Federal Mental Health Parity Law or any guidance issued by state or federal entities and will include a list of the practices not in compliance and the steps the managed care entity has taken to bring these practices into compliance.

12.7.1.5.The MCO shall complete the DHHS Parity Compliance Report annually and shall include:

12.7.1.5.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCOs pursuant to DHHS criteria;

12.7.1.5.2. All member grievances and appeals regarding a parity violation and resolutions;

12.7.1.5.3. The processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification; and

12.7.1.5.4. Any other requirements identified by DHHS.

12.7.1.6.A member enrolled in any MCO may file a complaint with the New Hampshire Insurance Department at **https://www.nh.gov/insurance/consumers/complaints.htm** if services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance.

13. Substance Use Disorder

13.1. Substance Use Disorder - General Provisions

13.1.1. The MCO will offer contracts to Medicaid enrolled SUD providers who meet the MCO's credentialing standards. The MCO will reimburse those SUD providers in accordance with Section 21.2.10.

13.1.2. The MCO will submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of SUD service providers so that services are accessible without reasonable delays.

13.1.2.1. If the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours this provider is required to provide interim substance use disorder counselors services until such a time that the clients starts receiving the identified level of care. If the type of service is not provided by this agency they are then responsible for making an active referral to a provider of that type of service (for the identified level of care) within fourteen (14) days from initial contact and to provider interim substance use disorder counselors services until such a time that the member is accepted and starts receiving services by the receiving agency.

13.1.3. The MCO shall provide data, reports and plans in accordance with Exhibit O.

13.2. Compliance Metrics for Access to SUD Services

13.2.1. Agencies under contract with MCOs to provide SUD services shall respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The SUD provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face to face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but not later than two (2) business days following the date of first contact.

13.2.2. Members who have screened positive for SUD services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation (as identified in the He-W 513 administrative rules) as soon as possible following the ASAM Level of Care Assessment and no later than (3) days after admission.

13.2.3. Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed. Members identified for Partial

Hospitalization (PH) or Rehabilitative Residential (RR) Services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

13.2.3.1. Pregnant women shall be admitted to the identified level of care within 24 hours of the ASAM Level of Care Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor shall:

13.2.3.1.1. Assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance must include actively reaching out to identify providers on the behalf of the client; and

13.2.3.1.2. Provide interim services until the appropriate level of care becomes available at either the contractor agency or an alternative provider. Interim services shall include:

a. At least one 60 minute individual or group outpatient session per week;

b. Recovery support services as needed by the client; and

c. Daily calls to the client to assess and respond to any emergent needs.

13.2.4. If the type of service identified in the ASAM Level of Care Assessment will not be available from the provider that conducted the initial assessment within the fourteen (14) business day period, or if the type of service is not provided by the agency that conducts the ASAM Level of Care Assessment, this agency is responsible for making an active referral to a provider of that type of services (for the identified level of care) within fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

14. Pharmacy Management

14.1. Pharmacy Management – General Provisions

14.1.1. The MCO's, including any pharmacy subcontractors, shall create: formulary and pharmacy prior authorization criteria and other point of service edits (i.e. prospective drug utilization review edits and dosage limits), pharmacy policies and pharmacy programs subject to DHHS approval, and in compliance with §1927 of the SSA [42 CFR 438.3(s)]. The MCO shall not include drugs by manufacturers not enrolled in the OBRA 90 Medicaid rebate program on its formulary without DHHS consent.

14.1.2. The MCO shall adhere to New Hampshire law with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, law 2004, SB 383-FN, Sect. IVa. Specifically, a MCO member shall continue to be treated, or, if newly diagnosed, may be treated with a non-preferred drug based on any one of the following criteria:

14.1.2.1. Allergy to all medications within the same class on the preferred drug list;

14.1.2.2. Contraindication to or drug-to-drug interaction with all medications within the same class on the preferred drug list;

14.1.2.3. History of unacceptable or toxic side effects to all medications within the same class on the preferred drug list;

14.1.2.4. Therapeutic failure of all medications within the same class on the preferred drug list;

14.1.2.5. An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal Food and Drug Administration-approved indication;

14.1.2.6. Age specific indication;

14.1.2.7. Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or

14.1.2.8. Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

14.1.3. The MCO shall submit all of its policies, prior authorizations, point-of-sale and drug utilization review edits and pharmacy services procedures related to its maintenance drug policy, specialty pharmacy programs, and any new pharmacy service program proposed by the MCO to DHHS for its approval at least 60 calendar days prior to implementation.

14.1.4. The MCO shall submit the items described in 14.1.1 and 14.1.3 to DHHS for approval sixty (60) calendar days prior to the program start date of Step 1.

14.1.5. Any modifications to items listed in 14.1.1 and 14.1.3 shall be submitted for approval at least sixty (60) calendar days prior to the proposed effective date of the modification.

14.1.6. The MCO shall notify members and providers of any modifications to items listed in 14.1.1 and 14.1.3 thirty (30) calendar days prior to the modification effective date.

14.1.7. Implementation of a modification shall not commence prior to DHHS approval.

14.1.8. At the time a member with currently prescribed medications transitions to an MCO: upon MCO's receipt of (written or verbal) notification validating such prescribed medications from a treating provider, or a request or verification from a pharmacy that has previously dispensed the medication, or via direct data from DHHS, the MCO shall continue to cover such medications through the earlier of sixty (60) calendar days from the member's enrollment date, or until completion of a medical necessity review. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

14.1.9. The MCO shall adjudicate pharmacy claims for its members utilizing a point of service (POS) system where appropriate. System modifications, including but not limited to systems maintenance, software upgrades, implementation of International Classification of Diseases- 10 (ICD-10) code sets, and NDC code sets or migrations to new versions of National Council for Prescription Drug Programs (NCPDP) transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

14.1.10. In accordance with Section 1927 (d)(5)(A and B) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization and reimburse for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation when prior authorization cannot be obtained.

14.1.11. The MCO shall develop or participate in other State of New Hampshire pharmacy related quality improvement initiatives. At minimum, the MCO shall routinely monitor and address:

14.1.11.1. Polypharmacy (physical health and behavioral health medications);

14.1.11.2. Adherence to the appropriate use of maintenance medications, such as the elimination of gaps in refills;

14.1.11.3. The appropriate use of behavioral health medications in children by encouraging the use of and reimbursing for consultations with child psychiatrists;

14.1.11.4. For those beneficiaries with a diagnosis for substance use disorder (SUD) and all infants with a diagnosis of neonatal abstinence syndrome (NAS), or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall evaluate these patients needs for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment;

14.1.11.5. For those beneficiaries who enter the MCO lock-in program, the MCO shall evaluate the need for SUD treatment.

14.1.11.6. The MCO shall require prior authorization documenting the rationale for the prescription of more than 200 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective April 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescription of more than 120 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective October 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescriptions of more than 100 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries effective upon NH Board Administrative Rule MED 502 Opioid Prescribing;

14.1.12. In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 (CMS) rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process, in accordance with section 1927(b) of the SSA, and the MCO shall submit the encounter data file within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment.

14.1.13. The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for members for medications covered by other payers.

14.1.14.Specialty Drugs. The MCO shall pay for all specialty drugs consistent with the MCO's formulary and pharmacy edits and criteria.

14.1.15. DHHS will be directly responsible for the pharmacy benefit for Carbaglu and Ravicti, and those Hepatitis C and Hemophilia drugs specifically excluded from the actuarial rate calculations.

14.1.16.Other specialty and orphan drugs.

14.1.16.1.Other currently FDA approved specialty and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

14.1.16.2.When medically necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

14.1.17.Polypharmacy medication review. The MCO shall provide an offer for medication review and counseling to address polypharmacy.

14.1.17.1.MCO shall offer a medication review and counseling no less than annually by a pharmacist or other health care professional as follows:

14.1.17.1.1. To the primary care provider and care taker for children less than 19 years dispensed four (4) or more drugs per month (or prescriptions for 90 day supply covering each month); and

14.1.17.1.2.To adult beneficiaries dispensed more than 10 drugs each month (or prescriptions for 90 day supply covering each month).

14.1.18.The MCO shall adhere to federal regulation with respect to providing pharmacy data required to complete the Annual Drug Utilization Review Report to CMS:

14.1.18.1. The MCO must provide a detailed description of its drug utilization review program to DHHS on an annual basis in accordance with the Medicaid Drug Utilization Review Annual Report format and requirements; and

14.1.18.2. The MCO must operate a drug utilization review program in accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, which includes:

14.1.18.2.1. Prospective drug utilization review;

14.1.18.2.2.Retrospective drug utilization review; and

14.1.18.2.3. An educational program for providers including prescribers and dispensers.

14.2. Continuity of Care

14.2.1. The MCO shall provide continuity of care for current beneficiaries after the transition of the PDL to the MCO. For existing beneficiaries, the MCO shall provide coverage for all drugs for each current beneficiary for six months beginning September 1, 2015 for those drugs dispensed to the beneficiary within the six months prior to September 1, 2015.

14.3. Use of Psychotropic Medicines for Children in Foster Care – DCYF's SafeRx Program

14.3.1. The MCO shall assist in the oversight and management of the use of psychotropic medicines for children and youth in DCYF placement in accordance with PL (Public Law 112-34) and in accordance with DCYF policy 1653. Assistance includes:

14.3.1.1.Psychiatry review of Medications when requested by DCYF staff, with Peer To Peer discussion if warranted to include:

14.3.1.1.1. Pharmacy claims;

14.3.1.1.2. Provider progress notes;

14.3.1.1.3. Telephone contact with the providers, if necessary;

14.3.1.1.4. Current Diagnoses, DSM I-III;

14.3.1.1.5. Current Behavioral Functioning; and

14.3.1.1.6. Information from the placement provider, either foster care or residential re: behaviors and medication response.

14.3.1.2.Edits in pharmacy systems for outlying red flag criteria that would require further explanation and authorization including:

14.3.1.2.1. Children 5 and under being prescribed antipsychotics;

14.3.1.2.2. Children 3 and under on any psychotropic medicine; and

14.3.1.2.3. A child or youth being prescribed 4 or more psychotropic medicines, allowing for tapering schedules for ending one medicine and starting a new medicine.

15. Reserved.

16. Member Enrollment and Disenrollment

16.1. Eligibility

16.1.1. The State has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether he/she will be enrolled in the Care Management program. The State shall maintain its current responsibility for determining member eligibility. The MCO shall comply with eligibility decisions made by DHHS.

16.1.2. The MCO shall ensure that ninety-five percent (95%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. Data received Monday-Friday is to be uploaded Tuesday-Saturday between 12 AM EST and 8AM EST. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded by 10 AM EST. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond 10 AM EST.

16.1.3. The ASCX12 834 enrollment file will limit enrollment history to eligibility spans reflective of any assignment of the member with the MCO.

16.1.4. To ensure appropriate continuity of care, DHHS will provide up to two (2) years (as available) of all fee-for-service paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all fee-for-service Medicaid beneficiaries assigned to MCO. For members transitioning from another MCO, DHHS will also provide such claims data as well as available encounter information regarding the member supplied by other MCOs.

16.2. Relationship with Enrollment Services

16.2.1. DHHS or its designee shall be responsible for member enrollment and passing that information along to the MCO for plan enrollment [42 CFR 438.3(d)(2)].

16.2.2. The MCO shall accept individuals into its plan from DHHS or its designee in the order in which they apply without restriction, (unless authorized by the regional administrator), up to the limits set in this Agreement [42 CFR 438.3(d)(1)].

16.2.3. The MCO will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll [42 CFR 438.3(d)(3)].

16.2.4. The MCO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has a discriminatory effect [42 CFR 438.3(d)(4].

16.2.5. The MCO shall furnish information to DHHS or its designee so that it may comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the recipient receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; State Medicaid Manual (SMM) 2090.1; SMM 2101].

16.2.6. The MCO shall provide information, within five (5) business days, to DHHS or its designee that allows for a determination of a possible change in eligibility of members (for example, those who have died, been incarcerated, or moved out-of-state).

16.3. Enrollment

16.3.1. The MCO shall accept members who choose to enroll in the MCO:

16.3.1.1. During the initial enrollment period;

16.3.1.2. During an annual enrollment period;

16.3.1.3. During a renegotiation or reprocurement enrollment period;

16.3.1.4. If the member requests to be assigned to the same plan in which another family member is currently enrolled; or

16.3.1.5. Who have disenrolled with another MCO at the time described in 16.5.3.1.

16.3.2. The MCO shall accept that enrollee enrollment is voluntary, except as described in 42 CFR 438.50.

16.3.3. The MCO shall accept for automatic re-enrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less.

16.3.4. The MCO shall accept members who have been auto-assigned by DHHS to the MCO.

16.3.5. The MCO shall accept members who are auto-assigned to another MCO but have an established relationship with a primary care provider that is not in the network of the auto-assigned MCO. The member can request enrollment any time during the first twelve (12) months of auto-assignment.

16.4. Auto-Assignment

16.4.1. DHHS will use the following auto-assignment methodology:

16.4.1.1. Preference to an MCO with which there is already a family affiliation;

16.4.1.2.Equal assignment among the MCOs.

16.4.2. DHHS reserves the right to change the auto assignment process at its discretion.

16.4.3. DHHS may also revise its auto-assignment methodology during the Contract Period for new Medicaid members who do not select an MCO (Default Members). The new assignment methodology would reward those MCOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. DHHS will also consider other appropriate factors.

16.4.4. DHHS may revise its auto-assignment methodology when exercising renegotiation and reprocurement rights under section 3.9.1 of this Agreement.

16.5. Disenrollment

16.5.1. Disenrollment provisions of 42 CFR 438.56(d)(2) apply to all members, regardless of whether the member is mandatory or voluntary [42 CFR 438.56(a); SMD letter 01/21/98].

16.5.2. A member may request disenrollment with cause at any time when:

16.5.2.1.The member moves out of state;

16.5.2.2.The member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the member to unnecessary risk; or

16.5.2.3.Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to providers experienced in dealing with the member's health care needs [42 CFR 438.56(d)(2)]

16.5.3. A member may request disenrollment without cause, at the following times:

16.5.3.1.During the ninety (90) calendar days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later;

16.5.3.2.For members who are auto-assigned to a MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO, the member can request disenrollment during the first twelve (12) months of enrollment at any time;

16.5.3.3.Any time for members who enroll on a voluntary basis;

16.5.3.4.During open enrollment every twelve (12) months;

16.5.3.5. During open enrollment related to renegotiation and reprocurement under Section 3.9.

16.5.3.6. For sixty (60) calendar days following an automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual enrollment/disenrollment opportunity (This provision applies to re-determinations only and does not apply when a member is completing a new application for Medicaid eligibility); and

16.5.3.7. When DHHS imposes the intermediate sanction on the MCO specified in 42 CFR 438.702(a)(3) [§1932(a)(4)(A) of the SSA; §1932(e)(2)(C) of the SSA; 42 CFR 438.56(c)(1); 438.56(c)(2)(i), (ii), (iii), and (iv); 42 CFR 438.702(a)(3); SMD letter 02/20/98; SMD letter 01/21/98]

16.5.4. The MCO shall provide members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period.

16.5.5. If a member is requesting disenrollment, the member (or his or her representative) shall submit an oral or written request to DHHS or its agent.

16.5.6. The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS' request for information.

16.5.7. The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons [42 CFR 438.56(b)(1); SMM 2090.12]:

16.5.7.1. Member has established out of state residence;

16.5.7.2. Member death;

16.5.7.3. Determination that the member is ineligible for enrollment based on the criteria specified in this Agreement regarding excluded populations; or

16.5.7.4. Fraudulent use of the member ID card.

16.5.8. The MCO shall not request disenrollment of a member for any reason not permitted in this Agreement [42 CFR 438.56(b)(3)].

16.5.9. The MCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular

member or other members) or abuse of substances, prescribed or illicit, and any legal consequences resulting from substance abuse. [42 CFR 438.56(b)(2)].

16.5.10. The MCO may request disenrollment in the event of threatening or abusive behavior that jeopardizes the health or safety of members, staff, or providers.

16.5.11. If an MCO is requesting disenrollment of a member, the MCO shall:

16.5.11.1. Specify the reasons for the requested disenrollment of the member; and

16.5.11.2. Submit a request for involuntary disenrollment to DHHS (or its agent) along with documentation and justification, for review and approval

16.5.12. Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member or the MCO files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); SMM 2090.6; SMM 2090.11].

16.5.13. DHHS (or its agent) shall provide for automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less [42 CFR 438.56(g)].

17. Member Services

17.1. Member Information

17.1.1. The MCO shall maintain a Member Services Department to assist members and their family members, guardians or other authorized individuals in obtaining covered services under the Care Management program.

17.1.2. The MCO shall have a 'No Wrong Door' approach, consistent with the DHHS Balancing Incentive Program, to member calls and inquiries, and shall have one toll-free number for members to contact.

17.1.3. The MCO shall have in place a mechanism to help members and potential members understand the requirement and benefits of the plan [42 CFR 438.10(c)(7)].

17.1.4. The MCO shall make a welcome call to each new member within thirty (30) days of the member's enrollment in the MCO. A minimum of three (3) attempts should be made at various times of the day, on different days, for at least ninety-five percent (95%) of new members. The welcome call shall at a minimum:

17.1.4.1. Assist the member to select a Primary Care Provider (PCP) or confirm selection of a PCP;

17.1.4.2. Include a brief Health Needs Assessment;

17.1.4.3. Screen for special needs and /or services of the member; and

17.1.4.4. Answer any other member questions about the MCO and ensure that members can access information in their preferred language.

17.1.5. Welcome calls shall not be required for members residing in a nursing facility longer than 120 days. The MCO shall:

17.1.5.1. Meet with each nursing facility no less than annually to provide an orientation to the MCM program and instructions regarding completion of the Health Needs Assessment for each member residing in a nursing facility longer than 120 days; and

17.1.5.2. Send letters to members residing in nursing facilities longer than 120 days or their authorized representatives describing welcome calls and how a member or their authorized representative can request a welcome call.

17.1.6. The MCO shall send a letter to a member upon initial enrollment, and anytime the member requests a new Primary Care Provider (PCP), confirming the member's PCP and providing the PCP's name address and telephone number.

17.1.7. The MCO shall issue an Identification Card (ID Card) to all new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. The ID Card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the ID card:

17.1.7.1. The member's name;

17.1.7.2. The member's date of birth;

17.1.7.3. The member's Medicaid ID number assigned by DHHS at the time of eligibility determination;

17.1.7.4. The name of the MCO; and

17.1.7.5. The name of MCO's NHHPP product;

17.1.7.6. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

17.1.7.7. How to file an appeal or grievance.

17.1.8. The MCO shall reissue a Member ID card if:

17.1.8.1. A member reports a lost card;

17.1.8.2. A member has a name change; or

17.1.8.3. Any other reason that results in a change to the information disclosed on the ID card.

17.1.9. The MCO shall publish member information in the form of a member handbook available at the time of member enrollment in the plan for benefits effective January 1, 2018. The member handbook shall be based upon the model enrollee handbook developed by DHHS.

17.1.9.1. Two weeks in advance of open enrollment, the MCOs shall inform all members by mail of their right to receive at no cost to any member a written copy of the member handbook effective for the new benefit year.

17.1.10. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives.

17.1.11. The MCO shall submit the member handbook to DHHS for approval at the time it is developed and after any substantive revisions, prior to publication and distribution

17.1.12.Pursuant to the requirements set forth in 42 CFR 438.10, the Member Handbook shall include, in easily understood language, but not be limited to:

17.1.12.1.A table of contents;

17.1.12.2. DHHS developed definitions so that enrollees can understand the following terminology: appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, grievance, habilitation services and devices, home health care, hospice services, hospitalization, hospital, outpatient care, physician services, prescription drug coverage, prescription drugs, primary care physician, PCP, rehabilitation services and devices, skilled nursing care, and specialist.

17.1.12.3.Information about the role of the primary care provider (PCP);

17.1.12.4.Information about choosing and changing a PCP;

17.1.12.5.Appointment procedures;

17.1.12.6.[Intentionally left blank.]

17.1.12.7.Description of all available benefits and services, including information on out-of-network providers;Information on how to access services, including EPSDT services, non-emergency transportation services, and maternity and family planning services. The handbook should also explain that the MCO cannot require a member to receive prior approval prior to choosing a family planning provider;

17.1.12.8.An explanation of any service limitations or exclusions from coverage;

17.1.12.9.A notice stating that the MCO shall be liable only for those services authorized by or required of the health plan;

17.1.12.10.Information on where and how members may access benefits not available from or not covered by the MCO;

17.1.12.11.The Necessity definitions used in determining whether services will be covered;

17.1.12.12.Detailed information regarding the amount, duration, and scope of benefits so that enrollees understand the benefits to which they are entitled.

17.1.12.13.A description of all pre-certification, prior authorization, or other requirements for treatments and services;

17.1.12.14.Information regarding prior authorization in the event the member chooses to transfer to another MCO and the member's right to continue to utilize a provider specified in a prior authorization regardless of whether the provider is participating in the MCO network;

17.1.12.15.The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;

17.1.12.16.Information on how to obtain services when the member is out of the State and for after-hours coverage;

17.1.12.17.Cost-sharing requirements;

17.1.12.18.Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including an inclusion of the MCO's toll-free telephone line and website;

17.1.12.19.A description of Utilization Review policies and procedures used by the MCO;

17.1.12.20.A description of those member rights and responsibilities, described in 17.3 of this Agreement, but also including but not limited to notification that:

17.1.12.20.1.Oral interpretation is available for any language, and information as to how to access those services;

17.1.12.20.2.Written translation is available in prevalent languages, and information as to how to access those services;

17.1.12.20.3.Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and information as to how to access those services;

17.1.12.21.The policies and procedures for disenrollment;

17.1.12.22.Information on Advance Directives;

17.1.12.23.A statement that additional information, including information on the structure and operation of the MCO plan and provider incentive plans, shall be made available upon request;

17.1.12.24.Member rights and protections;

17.1.12.25.Information on the Grievance, Appeal, and Fair Hearing procedures and timeframes in a DHHS-approved description, including:

17.1.12.25.1.The right to file grievances and appeals;

17.1.12.25.2.The requirements and timeframes for filing a grievance or appeal;

17.1.12.25.3.The availability of assistance in the filing process;

17.1.12.25.4.The right to request a State fair hearing after the MCO has made a determination on an enrollee's appeal which is adverse to the enrollee; and

17.1.12.25.5.An enrollee's right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however if the enrollee receives an adverse decision then the enrollee may be required to pay for the cost of service furnished while the appeal or State fair hearing is pending as specified in 42 CFR 438.10(g)(2);

17.1.12.26.Member's right to a second opinion from a qualified health care professional within the network, or one outside the network arranged by the MCO at no cost to the member. [42 CFR 438.206(b)(3)].

17.1.12.27.The extent to which, and how, after hours and emergency coverage are provided including:

17.1.12.27.1.What constitutes an emergency and emergency medical care; and

17.1.12.27.2.The fact that prior authorization is not required for emergency services; and

17.1.12.27.3.The enrollee's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)];

17.1.12.28.Information on how to access the New Hampshire Office of the Long Term Care Ombudsman;

17.1.12.29. Information on how to access auxiliary aids and services, including additional information in alternative formats or languages;

17.1.12.30. Information and guidance as to how the enrollee can effectively use the managed care program as described in 42 CFR 438.10(g)(2);

17.1.12.31.Information on how to report suspected fraud or abuse;

17.1.12.32.Information on how to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center who can provide all enrollees and potential enrollees choice counseling and information on managed care; and

17.1.12.33. Disenrollment information.

17.1.13.The MCO shall produce a revised member handbook, or an insert informing members of changes to covered services, upon DHHS notification of any change in covered services, and at least thirty (30) calendar days prior to the effective date of such change. In addition to changes to documentation, the MCO shall notify all existing members of the covered services changes at least thirty (30) calendar days prior to the effective date of such changes.

17.1.14.The MCO shall mail the handbook to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment [42 CFR 438.10(g)(1)].

17.1.15.The MCO shall notify all enrollees of their disenrollment rights, at a minimum, annually [42 CFR 438.10 (f)].

17.1.16. [Intentionally left blank.]

17.1.17.The MCO shall notify all enrollees, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the plan's website.The member information appearing on the website shall include the following, at a minimum:

17.1.17.1.Information contained in the Member Handbook

17.1.17.2.The following information on the MCO's provider network:

17.1.17.2.1.Names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English languages (including American Sign Language) spoken by current contracted providers, including identification of providers that are not accepting new patients. This shall include, at a minimum: information on PCPs, specialists, Family Planning Providers, pharmacies, Federally

Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals;

17.1.17.2.2. Any restrictions on the member's freedom of choice among network providers; and

17.1.17.2.3. How to file an appeal and/or a grievance.

17.1.18. For any change that affects member rights, filing requirements, time frames for grievances, appeals, and State fair hearing, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each member written notice of the change at least thirty (30) days before the intended effective date of the change.

17.1.19. Should the MCO not cover a covered service because of moral/ethical or religious reasons, the MCO shall provide a list of these services to the Department. This list shall be used by the Department to provide information to members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

17.1.20. Should the MCO contract with providers and/or subcontractors to deliver services to members pursuant to the MCO's obligations under this Contract and the providers or subcontractors cannot provide a covered service because of moral/ethical or religious reasons, the MCO shall provide a list of these services to the Department. This list shall be used by the MCO and Department to provide information to members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

17.1.21.

17.1.22. The MCO shall submit a copy of all information intended for members to DHHS for approval ten (10) business days prior to distribution.

17.2. Language and Format of Member Information

17.2.1. The MCO shall develop all member materials at or below a sixth (6th) grade reading level, as measured by the appropriate score on the Flesch reading ease test.

17.2.2. The MCO shall use the DHHS developed definitions consistently throughout its user manual, notices, and in any other form of client communication.

17.2.3. The MCO shall develop enrollee notices in accordance with the DHHS model notices.

17.2.4. The MCO shall provide all enrollment notices, information materials, and instructional materials relating to members and potential members in a manner and

format that may be easily understood in a font size no smaller than 12 point [42 CFR 438.10(d) / SMD Letter 2/20/98].

17.2.5. The MCO's written materials shall be developed to meet all applicable Cultural Considerations requirements in Section 18 so that they are communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The MCO shall inform members that information is available in alternative formats and how to access those formats [42 CFR 438.10(d)(6)].

17.2.6. The MCO shall make all written member information available in English, Spanish, and the commonly encountered languages of New Hampshire. All written member information shall include at the bottom a tagline explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the MCO's Customer Service Center. The MCO shall also provide all written member information in large print with a font size no smaller than 18 point upon request [42 CFR 438.10(d)(3)].

17.2.6.1. Written member information shall include at a minimum provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.

17.2.7. The MCO shall also make oral interpretation services available free of charge to each member or potential member for MCO covered services. This applies to all non-English languages, not just those that DHHS identifies as languages of other Major Population Groups. The beneficiary shall not to be charged for interpretation services. The MCO shall notify members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services [42 CFR 438.10(d)].The MCO shall provide auxiliary aids such as TTY/TDY and American Sign Language interpreters available free of charge to each member or potential member who requires these services [42 CFR 438.10(d)].

17.3. Member Rights

17.3.1. The MCO shall have written policies which shall be included in the member handbook and posted on the MCO website regarding member rights [42 CFR 438.100] including:

17.3.1.1.Each managed care member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;

17.3.1.2.Each managed care member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

17.3.1.3. Each managed care member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment;

17.3.1.4. Each managed care member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

17.3.1.5. Each managed care member is guaranteed the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 42 CFR 438.100; and

17.3.1.6. Each managed care member has a right to a second opinion. [42 CFR 438.206].

17.3.2. Each member is free to exercise his/her rights, and that the MCO shall assure that the exercise of those rights shall not adversely affect the way the MCO and its providers or DHHS treat the member [42 CFR 438.100(c)].

17.3.3. Each managed care member has the right to request and receive any MCO's written physician incentive plans.

17.4. Member Call Center

17.4.1. The MCO shall operate a NH specific call center Monday through Friday, except for state approved holidays. The call center shall be staffed with personnel who are knowledgeable about the MCOs plan in NH to answer member inquiries.

17.4.2. At a minimum, the call center shall be operational:

17.4.2.1. Two days per week: 8:00 am EST to 5:00 pm EST;

17.4.2.2. Three days per week: 8:00 am EST to 8:00 pm EST; and

17.4.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

17.4.3. The member call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

17.4.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

17.4.3.2. Average Speed of Answer: Ninety percent (90%) of calls will be answered with live voice within thirty (30) seconds; and

17.4.3.3. Voicemail messages shall be responded to no later than the next business day.

17.4.4. The MCO shall develop a means of coordinating its call center with the DHHS Customer Service Center.

17.4.5. The MCO shall develop a warm transfer protocol for members who may call the incorrect call center to speak to the correct representative and provide monthly reports to DHHS on the number of warm transfers made and the program to which the member was transferred.

17.5. Member Information Line

17.5.1. The MCO shall establish a member hotline that shall be an automated system that operates outside of the call center standard hours, Monday through Friday, and at all hours on weekends and holidays.

17.5.2. The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for callers to leave messages.

17.5.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages.

17.5.4. A representative of the MCO shall return messages no later than the next business day.

17.6. Marketing

17.6.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing to potential members [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.2. The MCO shall submit all MCO marketing material to DHHS for approval before distribution [§1932(d)(2)(A)(1) of the SSA; 42 CFR 438.104(b)(1)(i); SMD letter 12/30/97]. DHHS will identify any required changes to the marketing materials within fifteen (15) business days. If DHHS has not responded to a request for review by the fifteenth (15th) business day, the MCO may proceed to use the submitted materials.

17.6.3. The MCO shall comply with federal requirements for provision of information that ensures the potential member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

17.6.4. The MCO marketing materials shall not contain false or materially misleading information.

17.6.5. The MCO shall not offer other insurance products as inducement to enroll.

17.6.6. The MCO shall ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients of DHHS [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.7. The MCO's marketing materials shall not contain any written or oral assertions or statements that:

17.6.7.1. The recipient must enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

17.6.7.2. That the MCO is endorsed by CMS, the Federal or State government, or similar entity [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101]

17.6.8. The MCO shall distribute marketing materials to the entire state in accordance with §1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1 and SMM 2101. The MCO's marketing materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.7. Member Engagement Strategy

17.7.1. The MCO shall develop and facilitate an active member advisory board that is composed of members who represent its member population. At least twenty-five percent (25%) of the members of the advisory board should be receiving an LTSS service or be a support person, who is not a paid service provider or employed as an advocate, to a member receiving an LTSS service. Representation on the consumer advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. The advisory board shall meet at least quarterly. The advisory board shall meet in-person or through interactive technology including but not limited to a conference call or webinar and provide a member perspective to influence the MCO's quality improvement program,

program changes and decisions. All costs related to the member advisory board shall be the responsibility of the MCO.

17.7.2. The MCO shall hold in-person regional member meetings for two-way communication where members can provide input and ask questions and the MCO can ask questions and obtain feedback from members. Regional meetings shall be held at least twice each Agreement year. The MCO shall make efforts to provide video conferencing opportunities for members to attend the regional meetings. If video conferencing is not available then, the MCO shall use alternate technologies as available for all meetings.

17.7.3. The MCO shall report on the activities of the meetings required in Sections 17.7.1 and 17.7.2 including meeting dates, board members, topics discussed and actions taken in response to Board contributions to DHHS in the Medicaid Care Management Program Comprehensive Annual Report.

17.7.4. The MCO shall conduct a member satisfaction survey at least annually in accordance with National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) requirements to gain a broader perspective of member opinions. The MCO survey instrument is subject to DHHS approval. The results of these surveys shall be made available to DHHS to be measured against criteria established by DHHS, and to the MCO's membership [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.10(f)(6); 42 CFR 438.10(g); 42 CFR 438.6(h)].

17.7.5. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

17.8. Provider Directory

17.8.1. The MCO shall publish a Provider Directory that shall be approved by DHHS prior to publication and distribution. The MCO shall submit the draft directory and all substantive changes to DHHS for approval.

17.8.2. The Provider Directory shall include names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English language (including American Sign Language) spoken by, current contracted providers. This shall include, at a minimum; information on PCPs, specialists, Family Planning Providers, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals.

17.8.3. The Provider Directory shall provide all information according to the requirements of 42 CFR 438.10(h).

17.8.4. The MCO shall send a letter to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the member to the Provider Directory on the MCO's website and informing the member of the right to a printed version of provider directory information upon request [42 CFR 438.10(h)].

17.8.5. The MCO shall notify all members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the plan's website in a machine readable file and format as specified by the Secretary. The MCO shall update the paper copy of the Provider Directory at least monthly and shall update no later than thirty (30) calendar days after the MCO receives updated information. [42 CFR 438.10(h)(4)].

17.8.6. The MCO shall post on its website a searchable list of all contracted providers. At a minimum, this list shall be searchable by provider name, specialty, and location.

17.8.7. Thirty (30) calendar days after contract effective date or ninety (90) calendar days prior to the Program start date, whichever is later, the MCO shall develop and submit the draft Provider Directory template to DHHS for approval and thirty (30) calendar days prior to each Program Start Date the MCO shall submit the final provider directory.

17.8.8. Upon the termination of a contracted provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify enrollees who received their primary care from, or was seen on a regular basis by, the terminated provider.

17.9. Program Website

17.9.1. The MCO shall develop and maintain, consistent with DHHS standards and other applicable Federal and State laws, a website to provide general information about the MCO's program, its provider network, the member handbook, its member services, and its grievance and appeals process.

17.9.2. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes.

17.9.3. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory. The Provider Directory shall identify all providers, including primary care, specialty care, behavioral health, substance abuse, home health, home care, rehabilitation, hospital, and other providers, and include the following information for each provider:

17.9.3.1.Address of all practice/facility locations;

17.9.3.2.Gender;

17.9.3.3. Office hours;

17.9.3.4. Telephone numbers;

17.9.3.5. Website (if applicable);

17.9.3.6. Accommodations provided for people with disabilities;

17.9.3.7. Whether the provider has completed cultural competence training;

17.9.3.8.Hospital affiliations, if applicable;

17.9.3.9.Open/close status for MCO members;

17.9.3.10.Languages spoken (including American Sign Language) in each provider location;

17.9.3.11.Medical Specialty; and

17.9.3.12.Board certification, when applicable.

17.9.3.13.The MCO program content included on the website shall be:

17.9.3.14.Written in English, Spanish, and any other of the commonly encountered languages in the State;

17.9.3.15.Culturally appropriate;

17.9.3.16.Written for understanding at the 6th grade reading level; and

17.9.3.17.Geared to the health needs of the enrolled MCO program population.

17.9.3.18.The MCO shall maintain an updated list of formulary drug lists on its website. Such information shall include:

17.9.3.19.Which medications are covered (both generic and name brand); and

17.9.3.20.Which tier each medication is on.

17.9.4. The MCO's NH Medicaid Care Management website shall be compliant with the Federal Department of Justice "Accessibility of State and Local Government Websites to people with disabilities".

18. Culturally and Linguistically Competent Services

18.1. Cultural Competency Plan

18.1.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how the MCO shall ensure that services are provided in a culturally and linguistically competent manner to all Medicaid members, including those with Limited English Proficiency (LEP). The Cultural Competency Plan shall describe how the providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. The MCO shall work with DHHS Office of Minority Heath & Refugee Affairs and the New Hampshire Medical Society to address cultural and linguistic considerations as defined in the section.

18.2. General Provisions

18.2.1. The MCO shall participate in efforts to promote the delivery of services in a culturally and linguistically competent manner to all members and their families, including those with LEP and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)].

18.2.2. The MCO shall develop appropriate methods of communicating and working with its members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

18.2.3. The MCO shall develop appropriate methods for identifying and tracking members' needs for communication assistance for health encounters including preferred spoken language for health encounters, need for interpreter, and preferred language for written health information.

18.2.4. The MCO shall collect data regarding member's race, ethnicity, and spoken language in accordance with the current best practice standards from the Office of Management and Budget and/or the 2011 final standards for data collection as required by Section 4302 of the Affordable Care Act from the federal Department of Health and Human Services.

18.2.5. The MCO shall not use children or minors to provide interpretation services.

18.2.6. If the member declines offered free interpretation services, there must be a process in place for informing the member of the potential consequences of declination with the assistance of a competent interpreter to assure the member's understanding, as well as a process to document the member's declination. Interpreter services must be re-offered at every new contact. Every declination requires new documentation of the offer and decline.

18.2.7. The MCO shall respect members whose lifestyle or customs may differ from those of the majority of members.

18.2.8. The MCO shall ensure interpreter services are available to any member who requests them, regardless of the prevalence of the member's language within the overall program for all health plan and MCO services exclusive of inpatient services. The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e., will provide meaningful access) for all members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and will be based upon the unique needs and circumstances of each individual. Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the provider of the encounter service.

18.2.9. The MCO shall bear the cost of interpretive services, including American Sign Language (ASL) interpreters and translation into Braille materials available to hearing- and vision-impaired members.

18.2.10. The Member Handbook shall include information on the availability of oral and interpretive services.

18.2.11. The MCO shall communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care.

18.2.12. As a condition of receipt of Federal financial assistance, the MCO acknowledges and agrees that it must comply with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin (42 U.S.C. 2000d et seq.).

18.2.13.As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of Limited English Proficiency (LEP). To ensure compliance with Title VI, the MCO must take reasonable steps to ensure that LEP persons have meaningful access to the MCO's programs. The MCO shall provide the following assistance, including, but not limited to:

18.2.13.1.Offer language assistance to individuals who have LEP and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

18.2.13.2.Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

18.2.13.3.Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

18.2.13.4.Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

18.2.14.Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. MCOs are encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. For assistance and information regarding MCO LEP obligations, go to **http://www.lep.gov**.

19. Grievances and Appeals

19.1. General Requirements

19.1.1. The MCO shall develop, implement and maintain a Grievance System under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance and which includes a grievance process, an appeal process, and access to the State's fair hearing system. The MCO shall ensure that the Grievance System is in compliance with 42 CFR 438 Subpart F, and N.H. Code of Administrative Rules, Chapter He-C 200-Rules of Practice and Procedure.

19.1.2. The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS' review and approval prior to the first readiness review. Any proposed changes to the Grievance System must be approved by DHHS prior to implementation.

19.1.3. The Grievance System shall be responsive to any grievance or appeal of dual- eligible members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accord with this Agreement. In the event the MCO, after review, determines that the dual-eligible member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the member to the State's SHIP program, which is currently administered by Service Link Aging and Disability Resource Center.

19.1.4. The MCO shall be responsible for ensuring that the Grievance System (grievance process, appeal process, and access to the State's fair hearing system) complies with the following general requirements. The MCO must:

19.1.4.1. Give members any reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the member in providing written consent for appeals;

19.1.4.2. Acknowledge receipt of each grievance and appeal (including oral appeals), unless the enrollee or authorized provider requests expedited resolution;

19.1.4.3. Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making;

19.1.4.4. Ensure that decision makers take into account all comments, documents, records, and other information submitted by the enrollee of their

representative without regard to whether such information was submitted or considered in the initial adverse benefit determination; and

19.1.4.4.1. If deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the member's condition or disease:

a. An appeal of a denial based on lack of medical necessity;

b. A grievance regarding denial of expedited resolutions of an appeal; or

c. A grievance or appeal that involves clinical issues.

19.1.5. The MCO shall send written notice to members and providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

19.1.6. The MCO shall provide information as specified in 42 CFR § 438.10(g) about the Grievance System to providers and subcontractors at the time they enter into a contact or subcontract. The information shall include, but is not limited to:

19.1.6.1. The member's right (or provider acting on their behalf) to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

19.1.6.2. The member's right to file grievances and appeals and their requirements and timeframes for filing;

19.1.6.3. The availability of assistance with filing;

19.1.6.4. The toll-free numbers to file oral grievances and appeals;

19.1.6.5. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

19.1.6.6. Any State-determined provider appeal rights to challenge the failure of the MCO to cover a service.

19.1.7. The MCO shall make available training to providers in supporting and assisting members in the Grievance System.

19.1.8. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the member, the dates received, the dates of each review, the dates of the grievance or appeal, and the date of resolution.

19.1.9. The MCO shall provide a report of all actions, grievances, and appeals, including all matters handled by delegated entities, to DHHS on a monthly basis.

19.1.10. The MCO shall review Grievance System information as part of the State quality strategy and in accord with this Agreement and 42 CFR 438.402. The MCO shall make such information accessible to the State and available upon request to CMS.

19.1.11. The MCO shall provide any and all provider complaint and appeal logs to DHHS.

19.2. Grievance Process

19.2.1. The MCO shall develop, implement, and maintain a grievance process that establishes the procedure for addressing member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.2.2. The grievance process shall address member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. An enrollee or the enrollee's authorized representative with written consent may file a grievance at any time.

19.2.3. Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated, may file a complaint with the MCO in accordance with He-M 204.

19.2.4. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR part 438, subpart K may file a grievance.

19.2.5. The MCO shall have policies and procedures addressing the grievance process, which comply with the requirements of this Agreement. The MCO shall submit in advance to DHHS for its review and approval, all grievance process policies and procedures and related notices to members regarding the grievance process. Any proposed changes to the grievance process must be approved by DHHS prior to implementation.

19.2.6. The MCO shall allow a member, or the member's authorized representative with the member's written consent to file a grievance with the MCO either orally or in writing [42 CFR 438.402(c)].

19.2.7. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance for one hundred percent (100%) of members filing a grievance. If the enrollee requests disenrollment, then the MCO shall resolve the grievance in time to permit

the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment.

19.2.8. The MCO shall notify members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues must be in writing.

19.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

19.3. Appeal Process

19.3.1. The MCO shall develop, implement, and maintain an appeal process that establishes the procedure for addressing member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.3.2. The MCO shall allow a member, or the member's authorized representative, or a provider acting on behalf of the member and with the member's written consent, to request an appeal orally or in writing of any MCO action [42 CFR 438.402(c)].

19.3.3. The MCO shall include as parties to the appeal, the member and the member's authorized representative, or the legal representative of the deceased member's estate.

19.3.4. For appeals of standard service authorization decisions, the MCO shall allow a member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. This shall also apply to a member's request for an expedited appeal. An oral appeal must be followed by a written, signed appeal.

19.3.5. The MCO shall ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the member or the authorized provider requests expedited resolution. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution.

19.3.6. If DHHS receives a request to appeal an action of the MCO, DHHS will forward relevant information to the MCO and the MCO will contact the member and acknowledge receipt of the appeal.

19.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

19.3.8. The MCO shall allow the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO shall inform the member of the limited time available for this in the case of expedited resolution.

19.3.9. The MCO shall provide the member and the member's representative opportunity, to receive the member's case file, including medical records, and any other documents and records considered during the appeal process free of charge prior to the hearing.

19.3.10. The MCO shall resolve one hundred percent (100%) of standard member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. The date of filing shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest. Or, in the case of a provider filing an appeal on behalf of the member, the date of filing shall be considered the date upon which the MCO receives authorization from the member for the provider to file an appeal on the member's behalf.

19.3.11. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the enrollee is deemed to have exhausted the MCO's appeals process, and the enrollee may initiate a state fair hearing.

19.3.12. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR 42 CFR part 438, subpart K may file an appeal.

19.4. Actions

19.4.1. The MCO shall allow for the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

19.4.1.1. Denial or limited authorization of a requested service, including the type or level of service;

19.4.1.2. Reduction, suspension, or termination of a previously authorized service;

19.4.1.3. Denial, in whole or in part, of payment for a service;

19.4.1.4. Failure to provide services in a timely manner, as defined by the State;

19.4.1.5. Untimely service authorizations;

19.4.1.6. Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

19.4.1.7. At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one MCO, the denial of a member's

request to obtain services outside the network, in accord with 42 CFR 438.52(b)(2)(ii).

19.5. Expedited Appeal

19.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the member, or a provider request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

19.5.1.1. The MCO must inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals.

19.5.1.2. The MCO shall make a decision on the member's request for expedited appeal and provide notice, as expeditiously as the member's health condition requires, within 72 hours after the MCO receives the appeal. The MCO may extend the 72 hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest. The MCO shall also make reasonable efforts to provide oral notice. The first date shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest.

19.5.1.3. If the MCO extends the timeframes not at the request of the enrollee, it must:

19.5.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.5.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision;

19.5.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.5.1.4. The MCO shall meet the timeframes in 19.5.1.2 for one hundred percent (100%) of requests for expedited appeals.

19.5.1.5. The MCO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

19.5.1.6. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

19.5.1.7. The member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the member of his/her right and the procedures to file a grievance in the notice of denial.

19.6. Content of Notices

19.6.1. The MCO shall notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing.

19.6.2. Each notice of adverse action shall conform with 42 CFR 431.210, contain and explain:

19.6.2.1. The action the MCO or its subcontractor has taken or intends to take;

19.6.2.2. The reasons for the action;

19.6.2.3. The member's or the provider's right to file an appeal;

19.6.2.4. Procedures for exercising member's rights to appeal or grieve;

19.6.2.5. Circumstances under which expedited resolution is available and how to request it; and

19.6.2.6. The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits.

19.6.3. The MCO shall ensure that all notices of adverse action be in writing and must meet the following language and format requirements:

19.6.3.1. Written notice must be translated for the individuals who speak one of the commonly encountered languages spoken in New Hampshire (as defined by the State per 42 CFR 438.10(d));

19.6.3.2. Notice must include language clarifying that oral interpretation is available for all languages and how to access it; and

19.6.3.3. Notices must use easily understood language and format, and must be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All members and potential members must be informed that information is available in alternative formats and how to access those formats.

19.6.4. The MCO shall mail the notice of adverse benefit determination by the date of the action when any of the following occur:

19.6.4.1. The enrollee has died;

19.6.4.2. The enrollee submits a signed written statement requesting service termination;

19.6.4.3. The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction will result;

19.6.4.4. The enrollee has been admitted to an institution where he or she is ineligible under the state plan for further services;

19.6.4.5. The enrollee's address is determined unknown based on returned mail with no forwarding address;

19.6.4.6. The enrollee is accepted for Medicaid services by another state, territory, or commonwealth;

19.6.4.7. A change in the level of medical care is prescribed by the enrollee's physician;

19.6.4.8. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act;

19.6.4.9. The transfer or discharge from a facility will occur in an expedited fashion.

19.7. Timing of Notices

19.7.1. Termination, suspension or reduction of services - The MCO shall provide members written notice at least ten (10) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services, except the period of advance notice shall be five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the member.

19.7.2. Denial of payment - The MCO shall provide members written notice on the date of action when the action is a denial of payment or reimbursement.

19.7.3. Standard service authorization denial or partial denial- The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

19.7.3.1. The member or the provider requests the extension; or

19.7.3.2. The MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.3.3. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

19.7.4. Expedited process - For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

19.7.4.1. The MCO may extend the three (3) business days' time period by up to seven (7) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.5. Untimely service authorizations - The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations.

19.8. Continuation of Benefits

19.8.1. The MCO shall continue the member's benefits if:

19.8.1.1. The appeal is filed timely, meaning on or before the later of the following:

19.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action; or

19.8.1.1.2. The intended effective date of the MCO's proposed action.

19.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

19.8.1.3.The services was ordered by an authorized provider;

19.8.1.4.The authorization period has not expired; and

19.8.1.5.The member requests extension of benefits, orally or in writing.

19.8.2. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

19.8.2.1.The member withdraws the appeal, in writing;

19.8.2.2.The member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision;

19.8.2.3.A State fair hearing decision adverse to the member is made; or

19.8.2.4.The authorization expires or authorization service limits are met.

19.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the member the amount paid for the services provided to the member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

19.9. Resolution of Appeals

19.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within the following timeframes:

19.9.1.1.For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within thirty (30) calendar days after receipt of the appeal, unless the MCO notifies the member that an extension is necessary to complete the appeal.

19.9.1.2.The MCO may extend the timeframes up to fourteen (14) calendar days if:

19.9.1.2.1. The member requests an extension, orally or in writing; or

19.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the member's best interest.

19.9.1.3.If the MCO extends the timeframes not at the request of the enrollee then it must:

19.9.1.3.1.Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.9.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

19.9.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.9.1.4. Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request.

19.9.2. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

19.9.3. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting provider or member may obtain the Utilization Management clinical review or decision-making criteria.

19.9.4. For notice of an expedited resolution, the MCO shall make reasonable efforts to provide oral notice.

19.9.5. For appeals not resolved wholly in favor of the member, the notice shall:

19.9.5.1. Include information on the member's right to request a State fair hearing;

19.9.5.2. How to request a State fair hearing;

19.9.5.3. Include information on the member's right to receive services while the hearing is pending and how to make the request; and

19.9.5.4. Inform the member that the member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action.

19.10. State Fair Hearing

19.10.1. The MCO shall inform members and providers regarding the State fair hearing process, including but not limited to, members right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F. The Parties to the State fair hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

19.10.2.The MCO shall ensure that members are informed, at a minimum, of the following:

19.10.2.1.That members must exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

19.10.2.2.That if a member does not agree with the MCO's resolution of the appeal, the member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date on the MCO's notice of the resolution of the appeal.

19.10.3.If the member requests a fair hearing, the MCO shall provide to DHHS and the member, upon request, and within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

19.10.4.The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit. The MCO shall consult with DHHS regarding the State fair hearing process In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate and at no additional cost. In the event the State fair hearing decision is appealed by the member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost. The Office of the Attorney General or designee shall represent the State on an appeal from a fair hearing decision by a member.

19.10.5.DHHS shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

19.11.Effect of Adverse Decisions of Appeals and Hearings

19.11.1.If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

19.11.2.If the MCO or DHHS reverses a decision to deny authorization of services, and the member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services.

19.12.Survival

19.12.1. The obligations of the MCO pursuant to Section 19 to fully resolve all grievances and appeals including, but not limited to, providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

20. Access

20.1. Network

20.1.1. The MCO shall provide documentation to DHHS showing that it is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 20 and 21.

20.1.2. The MCO's network shall have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the geographic standards in Section 20.2, the timely provision of services requirements in Section 20.4, Equal Access, and reasonable choice by members to meet their needs.

20.1.3. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the readiness review for the enrollment of NHHPP members.

20.1.4. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the first readiness review for each phase of Step 2.

20.1.5. The MCO shall submit documentation to DHHS to demonstrate that it offers an appropriate range of preventive, primary care, and specialty services and maintains an adequate network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)]:

20.1.5.1. At the second readiness review prior to the Program start date;

20.1.5.2. Forty-five (45) calendar days following the end of the semi-annual period; and

20.1.5.3. At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to:

20.1.5.3.1. Changes in services, benefits, geographic service area, or payments

20.1.5.3.2. Enrollment of a new population in the MCO [42 CFR 438.207(c)]

20.1.6. The MCO shall submit documentation quarterly to DHHS to demonstrate Equal Access to services for Step 1, 2 and NHHPP populations.

20.1.7. The MCO shall be subject to annual, external independent reviews of the timeliness of, and access to the services covered under this Agreement [42 CFR 438.204].

20.1.8. For Step 1 Implementation, the anticipated number of members in Sections 20.1.1 and 20.1.2 shall be based on the "NH Medicaid Care Management Fifty Percent Population Estimate by Zip code" report provided by DHHS.

20.2. Geographic Distance

20.2.1. The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and Equal Access to its members.

Provider/Service	Statewide
PCPs (adult & pediatric)	Two (2) within forty (40) minutes or fifteen (15) miles
Adult Specialists	One (1) within sixty (60) minutes or forty-five (45) miles
Pediatric Specialists	One within one hundred twenty (120) minutes or eighty (80) miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) miles
Mental Health Providers (adult & pediatric)	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
SUD Councilors (MLDAC) (adult & pediatric)	One (1) within forty-five (45) minutes or fifteen (15) miles
SUD Programs (Comprehensive, Outpatient, Methadone Clinics) (adult & pediatric)	One (1) within sixty (60) minutes or forty-five (45) miles.

20.3. Network Adequacy Exception Process

20.3.1. The MCO may request exceptions from the network adequacy standards [42 CFR 438.68] after demonstrating its efforts to create a sufficient network of providers to meet these standards. DHHS shall grant the MCO an exception where:

20.3.1.1. The MCO demonstrates that an insufficient number of qualified providers or facilities willing to contract with the MCO are available to meet the network adequacy standards in 20.2 and 20.4;

20.3.1.2. The MCO demonstrates to the Department's satisfaction that the MCO's failure to develop a provider network that meets the requirements of 20.2 and 20.4 is due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

20.3.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from an in-network physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist licensed by the NH Board of Medicine. RSA 167:4-d.

20.3.2. At any time the provisions of this section may apply, the MCO will work with DHHS to ensure that members have access to needed services.

20.3.3. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the provider network to ensure that necessary admissions can be made.

20.4. Timely Access to Service Delivery

20.4.1. The MCO shall make services available for members twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR 438.206(c)(1)(iii)].

20.4.2. The MCO shall require that all network providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial, and FFS patients. [42 CFR 438.206(c)(1)(ii)].

20.4.3. The MCO shall encourage its PCPs to offer after-hours office care in the evenings and on weekends.

20.4.4. The MCO's network shall meet the following minimum timely access to service delivery standards [42 CFR 438.206(c)(1)(i)]

20.4.4.1. Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

20.4.4.2. The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

20.4.4.2.1. Transitional healthcare by a provider shall be available from a primary or specialty provider for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

20.4.4.2.2. Transitional home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the member's primary care or specialty care provider or as part of the discharge plan.

20.4.4.2.3. Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

20.4.4.2.4. Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

20.4.4.2.5. Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and don't meet the definition of Emergency Medical Condition.

20.4.4.2.6. Emergency medical, SUD and psychiatric care shall be available twenty-four (24) hours per day, seven (7) days per week.

20.4.4.2.7. Behavioral health care shall be available as follows:

a. care within six (6) hours for a non-life threatening emergency;

b. care within forty-eight (48) hours for urgent care; or

c. an appointment within ten (10) business days for a routine office visit.

20.4.4.2.8. For members receiving Step 2 covered services, transitional care shall be readily available and delivered, after discharge from a nursing facility, inpatient or institutional care, in accordance with the member's discharge plan or as ordered by the member's primary care or specialty care provider. Transfers and discharges shall be done in accordance with RSA 151:21 and RSA 151:26.

20.4.5. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide a semi-annual report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v).

20.4.6. The MCO shall develop a Corrective Action Plan if there is a failure to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

20.4.7. The MCO shall monitor waiting times for appointments at approved community mental health providers and report case details on a semi-annual basis.

20.5. Women's Health

20.5.1. The MCO shall provide female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

20.5.2. The MCO shall provide access to family planning services to members without the need for a referral or prior-authorization. Additionally, members shall be able to access these services by providers whether they are in or out of the MCO's network.

20.5.2.1.Family Planning Services shall include, but not be limited to, the following:

20.5.2.1.1. Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

20.5.2.1.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

20.5.2.1.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

20.5.2.1.4. Referral of members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

20.5.2.1.5. Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and HPV vaccine

20.5.2.2. Enrollment in the MCO shall not restrict the choice of the provider from whom the member may receive family planning services and supplies [42 CFR 431.51(b)(2)].

20.5.2.3. The MCO shall only provide for abortions in the following situations:

20.5.2.3.1. If the pregnancy is the result of an act of rape or incest; or

20.5.2.3.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed [42 CFR 441.202].

20.5.3. The MCO shall not provide abortions as a benefit, regardless or funding, for any reasons other than those identified in this Agreement [42 CFR 441.202].

20.6. Indian Health

20.6.1. The term Indian for purposes of this section shall include those individuals defined in 42 CFR 438.14(a).

20.6.2. The MCO shall allow all members that are an Indian to receive covered services from an out-of-state IHCP regardless of whether it is an out-of-network provider. The MCO shall pay for covered services provided at such IHCPs as if it was an approved out-of-network service pursuant to Section 20.8.

20.6.3. Any out-of-state IHCP that serves an Indian member of the MCO may refer the member to a network provider.

20.6.4. The MCO shall pay any out-of-state IHCP who provides covered services to an Indian pursuant to this section the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's fee for service methodology.

20.6.5. The MCO shall pay any out-of-state IHCP that is also a FQHC the encounter rate as if it was an in-network FQHC. If the encounter rate is less than the published encounter rate in the Federal Register than the State will make a supplemental payment to make up the difference between the amount the MCO entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

20.6.6. The MCO shall make payment to any such IHCP in a timely manner as required under 42 CFR 447.45 and 42 CFR 447.46.

20.7. Access to Special Services

20.7.1. The MCO shall ensure members have access to DHHS-designated Level I and Level II trauma centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.

20.7.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, hospice programs, and licensed long term care facilities with Medicare-certified skilled nursing beds. To the extent that the above specialty services are available within New Hampshire, the plan shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable.

20.7.3. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude New Hampshire providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

20.8. Out-of-Network Providers

20.8.1. If the MCO's network is unable to provide necessary medical, behavioral, and SUD services covered under the Agreement to a particular member, the MCO shall adequately and in a timely manner cover these services for the member through out-of-network sources [42 CFR 438.206(b)(4)]. The MCO shall inform the out-of-network provider that the member cannot be balance billed.

20.8.2. The MCO shall coordinate with out-of-network providers regarding payment. For payment to out-of-network, or non-participating providers, the following requirements apply:

20.8.2.1. If the MCO offers the service through an in-network provider(s), and the member chooses to access non-emergent services from an out-of-network provider, the MCO is not responsible for payment.

20.8.2.2. If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the MCO and the out-of-network provider.

20.8.3. The MCO shall ensure that cost to the member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

20.9. Second Opinion

20.9.1. The MCO shall provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no greater cost to the member than allowed by DHHS [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a second opinion in its Member Handbook.

20.10. Provider Choice

20.10.1. The MCO shall allow each member to choose his or her health professional to the extent possible and appropriate [42 CFR 438.3(l)].

21. Network Management

21.1. Provider Network

21.1.1. The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered medical, behavioral health, SUD, and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

21.1.1.1. Current and anticipated New Hampshire Medicaid enrollment;

21.1.1.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the covered New Hampshire population;

21.1.1.3. The number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services;

21.1.1.4. The number of network providers not accepting new or any New Hampshire Medicaid patients;

21.1.1.5. The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by New Hampshire members;

21.1.1.6. Accessibility of provider practices for members with disabilities [42 CFR 438.206(b)(1)];

21.1.1.7. Adequacy of the primary care network to offer each member a choice of at least two appropriate primary care providers that are accepting new Medicaid patients; and

21.1.1.8. Required access standards identified in this Agreement

21.1.2. In developing its network, the MCO's provider selection policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

21.1.3. The MCO shall not employ or contract with providers excluded from participation in federal health care programs.

21.1.4. The MCO shall not employ or contract with providers who fail to provide Equal Access to services.

21.1.5. The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of all members including those with LEP and those with unique cultural needs.

21.1.6. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory, as specified in Section 17.9 of this Agreement.

21.2. Network Requirements

21.2.1. The MCO shall ensure its providers and subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement.

21.2.2. All providers shall be licensed and or certified in accordance with the laws of the state in which they provide the covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program. All provider types that may obtain a National Provider Identifier (NPI) shall have an NPI in accordance with 45 CFR Part 162, Subpart D.

21.2.3. All providers in the MCO's network are required to be enrolled as New Hampshire Medicaid providers. DHHS may waive this requirement for good cause on a case-by-case basis.

21.2.4. In all contracts with health care professionals, the MCO shall comply with requirements in 42 CFR 438.214, NCQA standards, and RSA 420-J:4, which includes selection and retention of providers, credentialing and re-credentialing requirements, and non-discrimination (42 CFR 438.12(a)(2); 42 CFR 438.214].

21.2.5. The MCO shall not require a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

21.2.6. The MCO's Agreement with health care providers shall be in writing, shall be in compliance with applicable federal and state laws and regulations, and shall include the requirements in this Agreement.

21.2.7. The MCO shall submit all model provider contracts to DHHS for review during the Readiness Review process. The MCO shall resubmit the model provider contracts any time it makes substantive modifications to such Agreements. DHHS retains the right to reject or require changes to any provider Agreement.

21.2.8. The MCO shall negotiate rates with providers in accordance with Section 9 of this Agreement, unless otherwise specified in this Agreement.

21.2.9. The MCO shall reimburse private duty nursing agencies for private duty nursing services provided on or after April 1, 2016 at the fee-for-for service rate established by DHHS. The MCO shall provide the following information to determine if access to private duty nursing services is increasing:

21.2.10. The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

21.2.11. The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

21.2.12. The MCO shall submit model provider contracts related to the implementation of NHHPP to DHHS prior to the beginning of enrollment in NHHPP. The contract will provide for:

21.2.12.1. An in-state provider of services included in Step 1 must provide services to both the MCO's Step 1 and NHHPP members, except for SUD providers and chiropractors; provided, however, that exceptions to this requirement may be made upon a request by the MCO and approved by DHHS for providers that only want to provide coverage for Step 1 Services.

21.2.12.2. The provider shall provide equal availability of services and access to both Step 1 and NHHPP members unless an exception to the requirement in section 21.2.10.1 was approved for the provider and the provider is not required to provide coverage for NHHPP Services.

21.2.12.3. The MCO shall pay the provider for services at a rate not more than nor less than the amounts established according to Section 21.2.10.4.

21.2.12.4. The MCO shall reimburse providers for NHHPP services according to the NHHPP Provider Fee Schedule posted at **https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms** as of August 15, 2017 and incorporated herein. DHHS shall provide the MCO sixty (60) days notice prior to any change to the Schedule. Services falling outside the published NHHPP Provider Fee Schedule shall be paid at a rate determined by the Department and enforced in the sixty (60) calendar day notification period.

21.2.12.5. The MCO shall allow a participating provider thirty (30) days to review contract modifications to an existing contract relating to the implementation of the NHHPP.

21.2.13.The MCO provider Agreement shall require providers in the MCO network to accept the member's Medicaid ID Card as proof of enrollment in the MCO until the member receives his/her MCO ID Card.

21.2.14.The MCO shall maintain a provider relations presence in New Hampshire as approved by DHHS.

21.2.15.The MCO shall prepare and issue Provider Manual(s) upon request to all Network Providers, including any necessary specialty manuals (e.g., behavioral health). For newly contracted and credentialed providers, the MCO shall issue copies of the Provider Manual(s) no later than seven (7) calendar days after inclusion in the network. The provider manual shall be available on the web and updated no less than annually.

21.2.16.The MCO shall provide training to all providers and their staff regarding the requirements of this Agreement including the grievance and appeal system. The MCO's provider training shall be completed within thirty (30) calendar days of entering into a contract with a provider. The MCO shall provide ongoing training to new and existing providers as required by the MCO, or as required by DHHS.

21.2.17.Provider materials shall comply with state and federal laws and DHHS and NHID requirements. The MCO shall submit any Provider Manual(s) and provider training materials to DHHS for review and approval sixty (60) calendar days prior to any substantive revisions. Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

21.2.18.The MCO shall operate a toll-free telephone line for provider inquiries from 8 a.m. to 5 p.m. EST, Monday through Friday, except for State-approved holidays. The provider toll free line shall be staffed with personnel who are knowledgeable about the MCO's plan in New Hampshire. The provider call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

21.2.18.1.Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

21.2.18.2.Average Speed of Answer: Eighty percent (80%) of calls will be answered with live voice within thirty (30) seconds; and

21.2.18.3.Ninety percent (90%) of voicemail messages shall be responded to no later than the next business day.

21.2.19.The MCO shall maintain a Transition Plan providing for continuity of care in the event of Agreement termination, or modification limiting service to members, between the MCO and any of its contracted providers, or in the event of site closing(s) involving a primary care provider with more than one location of service.

The Transition Plan shall describe how members will be identified by the MCO and how continuity of care will be provided.

21.2.20. The MCO shall ensure that after regular business hours the provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a member. The MCO shall have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent medical, behavioral health or LTSS related condition or an emergency medical or behavioral health condition.

21.2.21. The MCO shall notify DHHS and affected current members in writing of a provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. Within three (3) calendar days following the effective date of the termination the MCO shall have a Transition Plan in place for all affected members.

21.2.22. If a member is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the MCO shall notify the member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a Transition Plan for the affected members.

21.2.23. The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the provider network. As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued member access to needed service and how the MCO will maintain compliance with its contractual obligations for member access to needed services. A significant change is defined as:

21.2.23.1. A decrease in the total number of PCPs by more than five percent (5%);

21.2.23.2. A loss of all providers in a specific specialty where another provider in that specialty is not available within sixty (60) minutes or forty-five (45) miles;

21.2.23.3. A loss of a hospital in an area where another contracted hospital of equal service ability is not available within forty-five (45) miles or sixty (60) minutes; or

21.2.23.4. Other adverse changes to the composition of the network, which impair or deny the members' adequate access to in-network providers.

21.2.24.The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its network, the MCO shall give the affected providers written notice of the reason for its decision. [42 CFR 438.12(a)(1) ; 42 CFR 438.214(c); SMD letter 02/20/98)].

21.2.25.The requirements in 42 CFR 438.12 (a) may not be construed to:

21.2.25.1.Require the MCO to contract with providers beyond the number necessary to meet the needs of its member;

21.2.25.2.Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

21.2.25.3.Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)].

21.3. Screening and Enrollment

21.3.1. No later than January 1, 2018, the MCO shall ensure that all of its network providers are enrolled with DHHS Medicaid.

21.3.2. No later than November 1, 2017, the MCO shall provide to DHHS all identifying information for its enrolled network providers including:

21.3.2.1.Name;

21.3.2.2.Specialty;

21.3.2.3.Date of Birth;

21.3.2.4.Social Security number;

21.3.2.5.National Provider identifier;

21.3.2.6.Federal taxpayer identification number; and

21.3.2.7.State license or certification number of the provider.

21.4. Provider Credentialing and Re-Credentialing

21.4.1. The MCO shall demonstrate to DHHS that its providers are credentialed according to the requirements of 42 CFR 438.206(b)(6), current NCQA standards, Code of Administrative Rules He-M 403, and RSA 420-J:4.

21.4.2. The MCO shall submit to DHHS its credentialing standards relating to the implementation of Choices for Independence waiver services.

21.4.3. The MCO shall have written policies and procedures to review, approve and at least every three (3) years recertify the credentials of all participating physician and all other licensed providers who participate in the MCO's network [42 CFR 438.214(a); 42 CFR 438.214(b) (1&2); RSA 420-J:4]. At a minimum, the scope and structure of a MCO's credentialing and re-credentialing processes shall be consistent NCQA standards and NHID, and relevant state and federal regulations relating to provider credentialing and notice. The MCO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with NCQA delegated credentialing requirements and any comparable requirements defined by DHHS.

21.4.4. The MCO shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: within thirty (30) calendar days for primary care providers; within forty-five (45) calendar days for specialists, SUD providers, chiropractors, Nursing Facilities and CFI service providers. [RSA 420-J:4). The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying the provider of the MCO's decision.

21.4.5. The re-credentialing process shall occur in accordance with NCQA guidelines. The re-credentialing process shall take into consideration provider performance data including, but not be limited to: member complaints and appeals, quality of care, and appropriate utilization of services.

21.4.6. The MCO shall maintain a policy that mandates board certification levels that, at a minimum, meets the ninety (90) percentile rates indicated in NCQA standards (HEDIS Medicaid All Lines of Business National Board Certification Measures as published by NCQA in Quality Compass) for PCPs and specialty physicians in the provider network. The MCO shall make information on the percentage of board-certified PCPs in the provider network and the percentage of board-certified specialty physicians, by specialty, available to DHHS upon request.

21.4.7. The MCO shall provide that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number [42 CFR 493.1 and 42 CFR 493.3].

21.4.8. The MCO shall not employ or contract with providers, business managers, owners or others excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or 42 CFR 1000.

21.4.9. The MCO shall ensure that providers whose Medicare certification is a precondition of participation in the Medicaid program obtain certification within one year of enrollment in MCO's provider network.

21.4.10. The MCO shall notify DHHS when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

21.5. Provider Engagement

21.5.1. The MCO shall, at a minimum, develop and facilitate an active provider advisory board that is composed of a broad spectrum of provider types. Representation on the provider advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. This advisory board shall include representation from CFI service providers. This advisory board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the meetings shall be provided to DHHS within thirty (30) calendar days of the meeting.

21.5.2. The MCO shall conduct a provider satisfaction survey, approved by DHHS and administered by a third party, on a statistically valid sample of each major provider type; PCP, specialists, hospitals, pharmacies, DME and Home Health providers, Nursing Facilities and CFI service providers. DHHS shall have input to the development of the survey. The survey shall be conducted semi-annually the first year after the program start date and at least once an Agreement year thereafter to gain a broader perspective of provider opinions. The results of these surveys shall be made available to DHHS and published on the DHHS website.

21.5.3. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

21.6. Anti-Gag Clause for Providers

21.6.1. The MCO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

21.6.1.1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

21.6.1.2.For any information the member needs in order to decide among all relevant treatment options;

21.6.1.3.For the risks, benefits, and consequences of treatment or non-treatment; or

21.6.1.4.For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [§1923(b)(3)(D) of the SSA; 42 CFR 438.102(a)(1)(i), (ii), (iii), and (iv); SMD letter 2/20/98].

21.7. Reporting

21.7.1. Provider Participation Report: Provide provider participation reports on an annual basis by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of member access to health care.

21.7.2. Provider Quality Report Card: Ability to provide dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc.

22. Quality Management

22.1. General Provisions

22.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO shall work in collaboration with members and providers to actively improve the quality of care provided to members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate into the MCO's quality improvement activities.

22.1.2. The MCO shall support and comply with the most current version of the Quality Strategy for the New Hampshire Medicaid Care Management Program.

22.1.3. The MCO shall have an ongoing quality assessment and performance improvement program for the operations and the services it furnishes for members [42 CFR 438.330(b); and SMM 2091.7].

22.1.4. The MCO shall approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and shall:

22.1.4.1. Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

22.1.4.2. Foster data-driven decision-making;

22.1.4.3. Solicit member and provider input on the prioritization and strategies for QAPI activities;

22.1.4.4. Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and member and provider satisfaction;

22.1.4.5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements;

22.1.4.6. Support re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions as appropriate; and

22.1.4.7. The MCO shall undertake a member experience of care survey;

22.1.4.7.1. The MCO shall deploy the CMS Home and Community Based Care Service Experience of Care Survey, Testing Experience and Functional Tools (TEFT) as early as 6 months but not later than 9 months from Step 2 Phase 2 start date, if ready for deployment.

22.1.4.7.2. The MCO shall deploy an in-person patient experience survey (PES) if the CMS Home and Community Based Care Service Experience of Care Survey is not ready for deployment with this same timeframe.

22.1.4.7.3. The MCO shall use a DHHS approved, external vendor and statistically sound methodology to conduct the member experience of care survey.

22.1.5. The MCO shall have mechanisms that detect both underutilization and overutilization of services.

The MCO shall develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the requirements of this Agreement. The MCOs shall also meet the requirements of for the QAPI Program [42 CFR 438.330; SMM 2091.7].

22.1.6. The MCO shall submit a QAPI Program Annual Summary in a format and timeframe specified by DHHS or its designee for its approval. The MCO shall keep participating physicians and other Network Providers informed and engaged in the QAPI Program and related activities. The MCO shall include in provider contracts a requirement securing cooperation with the QAPI.

22.1.7. The MCO shall maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO shall designate a senior executive responsible for the QAPI Program and the Medical Director shall have substantial involvement in QAPI Program activities. At a minimum, the MCO shall ensure that the QAPI Program structure:

22.1.7.1. Is organization-wide, with clear lines of accountability within the organization;

22.1.7.2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;

22.1.7.3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

22.1.7.4. Evaluates the effectiveness of clinical and non-clinical initiatives.

22.1.8. If the MCO sub-contracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO shall maintain detailed files documenting work performed by the sub-contractor. The file shall be available for review by DHHS or its designee upon request.

22.1.9.

22.1.10. The MCO shall integrate behavioral health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services provided to members. The MCO shall collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, and psycho-social outcomes, resulting from the integration and coordination of physical and behavioral health services. The MCO shall conduct any performance improvement projects required by CMS and a minimum of four (4) performance improvement projects, subject to DHHS approval, per year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one (1) of these projects shall have a behavioral health focus. At least one (1) of these projects shall have a home and community based waiver focus. The MCO shall report the status and results of each project to DHHS as requested and shall report on the status results of the CMS performance improvement projects described in 42 CFR 438.330.

22.1.11. The performance improvement projects shall involve the following:

22.1.11.1. Measurement of performance using statistically valid, national recognized objective quality indicators;

22.1.11.2. Implementation of system interventions to achieve improvement in the access to and quality of care;

22.1.11.3. Evaluation of the effectiveness of the interventions based on any performance measures required by CMS as outlined in 42 CFR 438.330(c); and

22.1.11.4. Planning and initiation of activities for increasing or sustaining improvement; and

22.1.11.5. Reporting on the status and results to DHHS on an annual basis.

22.1.12. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

22.1.13. The MCO shall have a plan to assess and report the quality and appropriateness of care furnished to members with special needs in order to identify any ongoing special conditions of a member that require a course of treatment or regular care monitoring. The plan must be submitted to DHHS for review and approval. The assessment mechanisms must use appropriate health care professionals.[42 CFR 438.208(c)(2); 42 CFR 438.330].

22.1.14. The MCO's Medical Director and Quality Improvement Director will participate in quarterly Quality Improvement meetings with DHHS and the other MCOs contracted with DHHS to discuss quality related initiatives and how those initiatives could be coordinated across the MCOs.

22.1.15. The MCOs shall be required to be accredited by NCQA, including all applicable Medicaid Standards and Guidelines and the MCOs must authorize NCQA to provide DHHS a copy of its most recent accreditation review, including:

22.1.15.1. Accreditation status, survey type, and level (as applicable);

22.1.15.2. Accreditation results, including recommended actions or improvements, corrective actions plans, and summaries of findings; and

22.1.15.3. Expiration date of the accreditation.

22.2. Practice Guidelines and Standards

22.2.1. The MCO shall adopt evidence-based clinical practice guidelines built upon high quality data and strong evidence. Such practice guidelines shall consider the needs of the MCO's members, be adopted in consultation with Network Providers, and be reviewed and updated periodically, as appropriate.

22.2.2. The MCO shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

22.2.3. The MCO shall make practice guidelines available, including, but not limited to, the web, to all affected providers and, upon request, to members and potential members.

22.2.4. The MCO's decisions regarding utilization management, member education, and coverage of services shall be consistent with the MCO's clinical practice guidelines [42 CFR 438.236(d)].

22.3. External Quality Review Organization

22.3.1. The MCO shall collaborate with DHHS's External Quality Review Organization (EQRO) as outlined in 42 CFR 438.358 to assess the quality of care and services provided to members and to identify opportunities for MCO improvement. To

facilitate this process, the MCO shall supply data, including but not limited to claims data and medical records, to the EQRO.

22.4. Evaluation

22.4.1. The MCO shall prepare a written report within ninety (90) calendar days at the end of each Agreement year on the QAPI that describes:

22.4.1.1. Completed and ongoing Quality management activities, including all delegated functions;

22.4.1.2. Performance trends on QAPI measures to assess performance in quality of care and quality of service;

22.4.1.3. An analysis of whether there have been any demonstrated improvements in the quality of care or service; and

22.4.1.4. An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement

22.4.2. The annual evaluation report shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

22.4.3. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, members, and appropriate MCO staff, as well as posted on the web. The MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

22.5. Quality Measures

22.5.1. MCO shall report annually, according to the then current industry/regulatory standard definitions, the following quality measure sets:

22.5.1.1. CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP;

22.5.1.2. CMS Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid;

22.5.1.3. NCQA Medicaid Accreditation HEDIS/CAHPS Measures, which shall be validated by submission to NCQA; and

22.5.1.4. All available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment; and

22.5.1.5. Any CMS mandated measures outlined in 42 CFR 438.330(c)(1)(i).

22.5.2. If additional measures are added to the NCQA or CMS measure sets, MCO shall include those new measures. For measures that are no longer part of the measures sets, DHHS may at its option continue to require those measures.

22.5.3. In addition MCO shall submit other quality measures as specified by DHHS in Exhibit O in a format to be specified by DHHS.

22.5.4. DHHS shall provide the MCO with ninety (90) calendar days notice of any additions or modifications to the quality measures as specified by DHHS in Exhibit O.

22.5.5. Each Data Year as defined by NCQA HEDIS specifications, or other twelve (12) month period determined by DHHS, at DHHS discretion, DHHS may select four (4) measures to be included in the Quality Incentive Program (QIP). DHHS shall notify the MCO of the four (4) measures to be included in the QIP no later than three (3) months prior to the start of the period for which data will be collected to evaluate the program.

22.5.6. For each measure selected by DHHS for the QIP, DHHS will monitor MCO performance to determine baseline measures and levels of improvement.

22.5.7. Should DHHS choose QIPs and implement withholds for QIP performance, in the event of changes to the Medicaid Care Management program or material circumstances beyond DHHS or the MCOs' control, which DHHS determines would unduly limit all MCOs' ability to reasonably perform and achieve the withhold return threshold, DHHS will evaluate the impact of the circumstances and make such changes as required, at the discretion of DHHS.

22.5.8. At such time DHHS provides access to Medicare data sets to the MCOs, the MCO shall integrate expanded Medicare data sets into its Care Coordination and Quality Programs and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual members. The MCO shall:

22.5.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from care coordination of the dual members;

22.5.8.2. Include Medicare data in DHHS quality reporting; and

22.5.8.3.Sign data use agreements and submit data management plans as required by CMS.

23. Utilization Management

23.1. Policies & Procedures

23.1.1. The MCO's policies and procedures related to the authorization of services shall be in compliance with 42 CFR 438.210 and NH RSA Chapter 420-E:2.

23.1.2. The MCO shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services [42 CFR 438.210(b)(1)].

23.1.3. The MCO shall submit its written utilization management policies, procedures, and criteria to DHHS for approval as part of the first readiness review. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.4. The MCO shall submit its written utilization management policies, procedures, and criteria specific to each phase of Step 2 Phase I to DHHS for approval as part of the first readiness review. Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs and a subsequent person-centered planning process. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.5. The MCO's written utilization management policies, procedures, and criteria shall, at a minimum, conform to the standards of NCQA.

23.1.6. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)].

23.1.7. The MCO's written utilization management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Further such policies, procedures and criteria shall address, at a minimum, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information.

23.1.8. The MCO's written utilization management policies, procedures, and criteria shall be:

23.1.8.1.Developed with input from appropriate actively practicing practitioners in the MCO's service area;

23.1.8.2.Updated at least biennially and as new treatments, applications, and technologies emerge;

23.1.8.3.Developed in accordance with the standards of national accreditation entities;

23.1.8.4.Based on current, nationally accepted standards of medical practice;

23.1.8.5.If practicable, evidence-based; and

23.1.8.6.Be made available upon request to DHHS, providers and members.

23.1.9. The MCOs shall work in good faith with DHHS develop prior authorization forms with consistent information and documentation requirements from providers wherever feasible. Providers shall be able to submit the prior authorizations forms electronically, by mail, or fax. The MCOs shall submit a proposed plan for the development of common prior authorization processes within ninety (90) calendar days of the NHHPP Program Start Date.

23.1.10.The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including, but not limited to, interrater reliability monitoring, and consult with the requesting provider when appropriate and at the request of the provider submitting the authorization [42 CFR 438.210(b)(2)].

23.1.11.The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)(3)].

23.1.12.Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member [42 CFR 438.210(e)].

23.1.13.Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

23.1.14. The MCOs shall follow the transition of care policy developed by DHHS, which is consistent with 42 CFR 438.62.

23.1.15. When a member receiving State Plan Home Health Services and Step 1 services chooses to change to another MCO, the new MCO shall be responsible for the member's claims as of the effective date of the member's enrollment in the new MCO except as specified in Section 31.2.17. Upon receipt of prior authorization information from DHHS, the new MCO shall honor prior authorizations in place by the former MCO for fifteen (15) calendar days or until the expiration of previously issued prior authorizations, whichever comes first. The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 23.4.2.1.

23.1.16. Prior authorizations in place for long term services and supports at the time a member transitions to an MCO will be honored until the earliest of (a) the authorization's expiration date, (b) the member's needs changes, (c) the provider loses its Medicaid status or (d) otherwise approved by DHHS. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO. In the event that the prior authorization specifies a specific provider, that MCO will continue to utilize that provider regardless of whether the provider is participating in the MCO network until such time as services are available in the MCO's network. The MCO will ensure that the member's needs are met continuously and will continue to cover services under the previously issued prior authorization until the MCO issues new authorizations that address the member's needs.

23.1.17. Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire.

23.2. Medical Necessity Determination

23.2.1. The MCO shall specify what constitutes "medically necessary services" in a manner that:

23.2.1.1. Is no more restrictive than the State Medicaid program; and

23.2.1.2. Addresses the extent to which the MCO is responsible for covering services related to the following [42 CFR 438.210(a)]:

23.2.1.2.1. The prevention, diagnosis, and treatment of health impairments;

23.2.1.2.2. The ability to achieve age-appropriate growth and development; and

23.2.1.2.3. The ability to attain, maintain, or regain functional capacity.

23.2.2. For members twenty-one (21) years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are [He-W 530.01(f)]:

23.2.2.1. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

23.2.2.2. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

23.2.2.3. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

23.2.2.4. Not experimental, investigative, cosmetic, or duplicative in nature.

23.2.3. For EPSDT services the following definition of medical necessity shall be used: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service He-W546.01(f).

23.2.4. The MCO must provide the criteria for medical necessity determinations for mental health or substance use disorder benefits to any enrollee, potential enrollee, or contracting provider upon request.

23.3. Necessity Determination

23.3.1. For long term services and supports the following definition of necessity shall be used: "Necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term services and supports within the limits of current waivers, statutes, administrative rules, and/or Medicaid State Plan amendments.

23.4. Notices of Coverage Determinations

23.4.1. The MCO shall provide the requesting provider and the member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

23.4.2. The MCO shall make utilization management decisions in a timely manner. The following minimum standards shall apply:

23.4.2.1. Urgent determinations: The determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for ninety-eight percent (98%) of requests, unless the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the MCO shall notify the member or member's representative within twenty-four (24) hours of receipt of the request and shall advise the member or member's representative of the specific information necessary to make a determination. The member or member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information.

23.4.2.2. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

23.4.2.3. Routine determinations: The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but in no event exceed the following timeframes for ninety-five percent (95%) of requests:

23.4.2.3.1. Fourteen (14) calendar days after the receipt of a request:

a. An extension of up to fourteen (14) calendar days is permissible if:

i. the member or the provider requests the extension; or

ii. the MCO justifies a need for additional information and that the extension is in the member's interest;

23.4.2.3.2. Two (2) calendar days for diagnostic radiology.

23.4.2.4. The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

23.4.2.5. The member or the provider requests the extension; or

23.4.2.6. The MCO justifies a need for additional information and how the extension is in the member's interest.

23.4.2.7. If such an extension is necessary due to a failure of the member or member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the member or member's representative shall be given at least forty- five (45) calendar days from receipt of the notice within which to provide the specified information. Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

23.4.2.8. Determination for Services that have been delivered: The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the member fails to provide sufficient information to determine the request, the MCO shall notify the member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the member shall be given at least forty-five (45) calendar days to provide the required information. The thirty (30) calendar day period for determination shall be tolled until such time as the member submits the required information.

23.4.3. Whenever there is an adverse determination, the MCO shall notify the ordering provider and the member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

23.5. Advance Directives

23.5.1. The MCO shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489.

23.5.2. The MCO shall adhere to the definition of advance directives as defined in 42 CFR 489.100.

23.5.3. The MCO shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCO [42 CFR 422.128].

23.5.4. The MCO shall not condition the provision of care or otherwise discriminate against an enrollee or potential enrollee based on whether or not the individual has executed an advance directive.

23.5.5. The MCO shall provide information in the member handbook with respect to the following:

23.5.5.1. The member's rights under the state law. The information provided by the MCO shall reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change [42 CFR 438.3(j)(3) and (4)].

23.5.5.2. The MCO's policies respecting the implementation of those rights including a statement of any limitation regarding the implementation of advance directives as a matter of conscience

23.5.5.3. That complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State Agency [42 CFR 438.3(;)(1); 42 CFR 438.10(g)(2); 42 CFR 422.128; 42 CFR 489 (subpart I); 42 CFR 489.100].

24. MCIS

24.1. System Functionality

24.1.1. The MCO Managed Care Information System (MCIS) shall include, but not be limited to:

24.1.1.1. Management of Recipient Demographic Eligibility and Enrollment and History

24.1.1.2. Management of Provider Enrollment and Credentialing

24.1.1.3. Benefit Plan Coverage Management, History and Reporting

24.1.1.4. Eligibility Verification

24.1.1.5. Encounter Data

24.1.1.6. Weekly Reference File Updates

24.1.1.7. Service Authorization Tracking, Support and Management

24.1.1.8. Third Party Coverage and Cost Avoidance Management

24.1.1.9. Financial Transactions Management and Reporting

24.1.1.10. Payment Management (Checks, EFT, Remittance Advices, Banking)

24.1.1.11. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)

24.1.1.12. Call Center Management

24.1.1.13. Claims Adjudication

24.1.1.14. Claims Payments

24.1.1.15. Quality of Services (QOS) metrics

24.2. Information System Data Transfer

24.2.1. Effective communication between the MCO and DHHS will require secure, accurate, complete and auditable transfer of data to/from the MCO and DHHS management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

24.2.1.1.DHHS read access to all NH Medicaid Care Management data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

24.2.1.2.Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

24.2.1.3.Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state.

24.2.1.4.Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

24.2.1.5.MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

24.2.1.6.Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and provide for source to target or source to specification mappings;

24.2.1.7.Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

24.2.1.8.A given day's data transmissions, as specified in 24.5.9, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions will be included in the next batch transmission.

24.2.2. The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

24.2.3. The State shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.

24.3. Ownership and Access to Systems and Data

24.3.1. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data will be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

24.4. Records Retention

24.4.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than seven (7) years from the date of termination of this Agreement. Records involving matters that are the subject of litigation shall be retained for a period of not less than seven (7) years following the termination of litigation. Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

24.4.2. Upon expiration of the seven (7) year retention period and upon request, the subject records must be transferred to DHHS' possession. No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

24.5. MCIS Requirements

24.5.1. The MCO shall have a comprehensive, automated, and integrated Managed Care Information System (MCIS) that is capable of meeting the requirements listed below and throughout this Agreement and for providing all of the data and information necessary for DHHS to meet federal Medicaid reporting and information regulations.

24.5.2. All subcontractors shall meet the same standards, as described in this Section 24, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a subcontractor with respect to its provided functions.

24.5.3. Specific functionality related to the above shall include, but is not limited to, the following :

24.5.3.1.The MCIS membership management system must have the capability to receive, update, and maintain New Hampshire's membership files consistent with information provided by DHHS.

24.5.3.2.The MCIS shall have the capability to provide daily updates of membership information to sub-contractors or providers with responsibility for processing claims or authorizing services based on membership information.

24.5.3.3.The MCIS' provider file must be maintained with detailed information on each provider sufficient to support provider enrollment and payment and also meet DHHS' reporting and encounter data requirements.

24.5.3.4.The MCIS' claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system.

24.5.3.5.The MCIS' Services Authorization system shall be integrated with the claims processing system.

24.5.3.6.The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements.

24.5.3.7.The MCIS' credentialing system shall have the capability to store and report on provider specific data sufficient to meet the provider credentialing requirements, Quality Management, and Utilization Management Program Requirements.

24.5.3.8.The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in member, provider, claims and authorization files, and in order to enable encounter data to be utilized for member profiling, provider profiling, claims validation, fraud, waste and abuse monitoring activities, and any other research and reporting purposes defined by DHHS.

24.5.3.9.The encounter data system shall have a mechanism in place to receive, process, and store the required data.

24.5.3.10.The MCO system shall be compliant with the requirements of HIPAA, including privacy, security, National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format. This also includes IRS Pub 1075 where applicable.

24.5.4. MCIS capability shall include, but not be limited to the following:

24.5.4.1.Provider network connectivity to Electronic Data Interchange (EDI) and provider portal systems;

24.5.4.2.Documented scheduled down time and maintenance windows as agreed upon with DHHS for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

24.5.4.3.DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes, and procedures (approved by the State) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

24.5.4.4.DHHS access to user acceptance test environment for externally accessible systems including websites and secure portals;

24.5.4.5.Documented instructions and user manuals for each component; and

24.5.4.6.Secure access.

24.5.5. MCIS Up-time

24.5.5.1.Externally accessible systems, including telephony, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours per day, seven (7) days per week, three-hundred-sixty-five (365) days per year, except for scheduled maintenance upon notification of and pre-approval by DHHS. Maintenance period cannot exceed four (4) consecutive hours without prior DHHS approval.

24.5.5.2.MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions will result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

24.5.6. Systems operations and support shall include, but not be limited to the following:

24.5.6.1.On-call procedures and contacts

24.5.6.2.Job scheduling and failure notification documentation

24.5.6.3.Secure (encrypted) data transmission and storage methodology

24.5.6.4.Interface acknowledgements and error reporting

24.5.6.5.Technical issue escalation procedures

24.5.6.6.Business and member notification

24.5.6.7.Change control management

24.5.6.8.Assistance with User Acceptance Testing (UAT) and implementation coordination

24.5.6.9.Documented data interface specifications – data imported and extracts exported including database mapping specifications.

24.5.6.10.Disaster Recovery and Business Continuity Plan

24.5.6.11.Journaling and internal backup procedures. Facility for storage MUST be class 3 compliant.

24.5.6.12.Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

24.5.7. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

24.5.7.1.Network diagram that fully defines the topology of the MCO's network.

24.5.7.2.State/MCO connectivity

24.5.7.3.Any MCO/subcontractor locations requiring MCIS access/support

24.5.7.4.Web access for DHHS staff, providers and recipients

24.5.8. Data transmissions from DHHS to the MCO will include, but not be limited to the following:

24.5.8.1.Provider Extract (Daily)

24.5.8.2.Recipient Eligibility Extract (Daily)

24.5.8.3.Recipient Eligibility Audit/Roster (Monthly)

24.5.8.4.Medical and Pharmacy Service Authorizations (Daily)

24.5.8.5.Commercial and Medical Third Party Coverage (Daily)

24.5.8.6.Claims History (Bi-Weekly)

24.5.8.7.Capitation payment data

24.5.9. Data transmissions from the MCO to DHHS shall include but not be limited to:

24.5.9.1.Member Demographic changes (Daily)

24.5.9.2.MCO Provider Network Data (Daily)

24.5.9.3.Medical and Pharmacy Service Authorizations (Daily)

24.5.9.4.Beneficiary Encounter Data including paid, denied, adjustment transactions by pay period (Weekly)

24.5.9.5.Financial Transaction Data

24.5.9.6.Updates to Third Party Coverage Data (Weekly)

24.5.9.7.Behavioral Health Certification Data (Monthly)

24.5.10.The MCO shall provide DHHS staff with access to timely and complete data:

24.5.10.1.All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS.

24.5.10.2.The MCO shall work collaboratively with DHHS, DHHS' MMIS fiscal agent, the New Hampshire Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement.

24.5.10.3.The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/subcontractor locations supporting the New Hampshire program.

24.5.10.4.The MCO shall utilize data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

24.5.10.5.The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including encounter data

24.5.10.6.The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this document (24.2.1.8).

24.5.10.7.Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable state and federal law.

24.5.10.8.Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

24.5.11.The MCIS shall include web access for use by and support to enrolled providers and members. The services shall be provided at no cost to the provider or members. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

24.5.11.1.The MCO shall create secure web access for Medicaid providers and members and authorized DHHS staff to access case-specific information.

24.5.11.2.The MCO shall manage provider and member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist providers and members with gaining access and utilizing the web portal.

24.5.11.3.Providers will have the ability to electronically submit service authorization requests and access and utilize other utilization management tools.

24.5.11.4.Providers and members shall have the ability to download and print any needed Medicaid MCO program forms and other information.

24.5.11.5.Providers shall have an option to e-prescribe as an option without electronic medical records or hand held devices.

24.5.11.6.MCO shall support provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es).

24.5.11.7.Providers shall have access to drug information.

24.5.11.8.The website shall provide an e-mail link to the MCO to allow providers and members or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website.

24.5.11.9.The website shall be secure and HIPAA compliant in order to ensure the protection of Protected Health Information and Medicaid recipient confidentiality. Access shall be limited to verified users via passwords and any other available industry standards. Audit logs must be maintained reflecting access to the system and random audits will be conducted.

24.5.11.10.The MCO shall have this system available no later than the Program Start Date.

24.5.11.11.Support Performance Standards shall include:

24.5.11.11.1.Email inquiries – one (1) business day response

24.5.11.11.2.New information posted within one (1) business day of receipt

24.5.11.11.3.Routine maintenance

24.5.11.11.4.Standard reports regarding portal usage such as hits per month by providers/members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports.

24.5.11.11.5.Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO must redirect user to site to install appropriate browser.

24.5.12.Critical systems within the MCIS support the delivery of critical medical services to members and reimbursement to providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

24.5.12.1.The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to New Hampshire within twenty-four (24) hours of incident onset.

24.5.12.2.The MCO shall ensure that the New Hampshire PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements as defined in Section 24.5.13.

24.5.12.3.The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction. Archiving processes shall not modify the data composition of DHHS' records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

24.5.12.4.The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between providers, provider billing agents/clearing houses, or DHHS and the MCO. Audit logs of activities will be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

24.5.12.5.Thirty (30) calendar days prior to the beginning of each State Fiscal Year, the MCO shall submit the following documents and corresponding checklists for DHHS' review and approval:

24.5.12.5.1.Disaster Recovery Plan

24.5.12.5.2.Business Continuity Plan

24.5.12.5.3.Security Plan

24.5.12.5.4.The MCO shall provide the following documents. If after the original documents are submitted the MCO modifies any of them, the revised documents and corresponding checklists shall be submitted to DHHS for review and approval:

a. Risk Management Plan

b. Systems Quality Assurance Plan

c. Confirmation of 5010 compliance and Companion Guides

d. Confirmation of compliance with IRS Publication 1075

e. Approach to implementation of ICD-10 and ultimate compliance

24.5.13.Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements shall be part of the change management process:

24.5.13.1.The complete system shall have proper configuration management/change management in place (to be reviewed and approved by DHHS). The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

24.5.13.2.The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent. DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

24.5.13.3.The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day. The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

24.5.13.4.A New Hampshire program centralized electronic repository shall be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

24.5.13.5.The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any member.

24.5.13.6.The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

24.5.14.DHHS, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

24.5.14.1.The System Readiness Review may include a desk review and/or an onsite review.

24.5.14.2.If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

24.5.14.3.If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency.

24.5.15.Systems enhancements developed specifically, and data accumulated, as part of the New Hampshire Care Management program remain the property of the State of New Hampshire.

24.5.15.1.Source code developed for this program shall remain the property of the vendor but will be held in escrow.

24.5.15.2.All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

24.5.15.3.The MCO shall not destroy or purge DHHS' data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be

retrievable for review and or reporting by DHHS in the timeframe set forth by DHHS.

24.5.16. The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute ad-hoc queries to support DHHS data and information needs. DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

24.5.17. Quality of Service (QOS) Metrics:

24.5.17.1. System Integrity: The system shall ensure that both user and provider portal design, and implementation is in accordance with Federal, standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

24.5.17.2. The security of the care management processing system must minimally provide the following three types of controls to maintain data integrity that directly impacts QOS . These controls shall be in place at all appropriate points of processing:

24.5.17.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

24.5.17.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

24.5.17.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

24.5.17.2.4. System Administration: Ability to comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with Agreement terms and conditions. Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions at no additional cost.

25. Data Reporting

25.1. General Provisions

25.1.1. The MCO shall make all collected data available to DHHS upon request and upon the request of CMS [42 CFR 438.242(b)(4)].

25.1.2. The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility [42 CFR 438.242(a)].

25.1.3. The MCO shall collect data on member and provider characteristics as specified by DHHS and on services furnished to members through a MCIS system or other methods as may be specified by DHHS [42 CFR 438.242(b)(2)].

25.1.4. The MCO shall ensure that data received from providers are accurate and complete by:

25.1.4.1. Verifying the accuracy and timeliness of reported data;

25.1.4.2. Screening the data for completeness, logic, and consistency; and

25.1.4.3. Collecting service information in standardized formats to the extent feasible and appropriate [42 CFR 438.242(b)(3)].

25.2. Encounter Data

25.2.1. The MCO shall submit encounter data in the format and content, timeliness, completeness, and accuracy as specified by the DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS.

25.2.2. All encounter data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

25.2.2.1. The MCO shall provide support to DHHS to substantiate the validity, integrity and reconciliation of DHHS reports that utilize the MCO encounter data.

25.2.3. Submission of encounter data to DHHS does not eliminate the MCO's responsibility under state statute to submit member and claims data to the Comprehensive Healthcare Information System [NH RSA 420-G:1,1 II. (a)]

25.2.4. The MCO shall ensure that encounter records are consistent with the DHHS requirements and all applicable state and federal laws.

25.2.5. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

25.2.6. The MCO shall use appropriate member identifiers as defined by DHHS.

25.2.7. The MCO shall maintain a record of both servicing and billing information in its encounter records.

25.2.8. The MCO shall also use appropriate provider identifiers for encounter records as directed by DHHS.

25.2.9. The MCO shall have a computer and data processing system sufficient to accurately produce the data, reports, and encounter record set in formats and timelines prescribed by DHHS as defined in this Agreement.

25.2.10. The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

25.2.11. The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS. The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

25.2.12. The MCO's systems that are required to use or otherwise contain the applicable data type shall conform with current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards:

25.2.12.1. Health Care Common Procedure Coding System (HCPCS)

25.2.12.2. CPT codes

25.2.12.3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the U.S. Department of Health and Human Services (HHS).

25.2.12.4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

25.2.12.5.International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.

25.2.12.6.National Drug Codes (NDC): The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

25.2.12.7.Code on Dental Procedures and Nomenclature (CDT): The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

25.2.12.8.Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains point of service (POS) codes used throughout the health care industry.

25.2.12.9.Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

25.2.12.10.Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the Medicaid Management Information System (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

25.2.13.All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format.

25.2.14.All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and as applicable the Medicare paid amount, other insurance paid amount and expected member co-payment amount.

25.2.15.The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

25.2.16.The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

25.2.17.The MCO shall collect, and submit to the State's fiscal agent, member service level encounter data for all covered services. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

25.2.18.The MCO shall conform to all current and future HIPAA-compliant standards for information exchange. Batch and Online Transaction Types are as follows:

25.2.18.1.Batch transaction types

25.2.18.1.1.ASC X12N 820 Premium Payment Transaction

25.2.18.1.2.ASC X12N 834 Enrollment and Audit Transaction

25.2.18.1.3.ASC X12N 835 Claims Payment Remittance Advice Transaction

25.2.18.1.4.ASC X12N 837I Institutional Claim/Encounter Transaction

25.2.18.1.5.ASC X12N 837P Professional Claim/Encounter Transaction

25.2.18.1.6.ASC X12N 837D Dental Claim/Encounter Transaction

25.2.18.1.7.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.18.2.Online transaction types

25.2.18.2.1.ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

25.2.18.2.2.ASC X12N 276 Claims Status Inquiry

25.2.18.2.3.ASC X12N 277 Claims Status Response

25.2.18.2.4.ASC X12N 278/279 Utilization Review Inquiry/Response

25.2.18.2.5.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.19.Submitted encounter data shall include all elements specified by DHHS including, but not limited to, those specified in Exhibit N and detailed in the Medicaid Encounter Submission Guidelines.

25.2.20.The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims. Any exceptions will be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception. The MCO shall also use the provider identifiers as directed by DHHS for both Encounter and fee-for-service claims submissions, as applicable.

25.2.21.The MCO shall provide as a supplement to the encounter data submission a member file, which shall contain appropriate member identification numbers, the primary care provider assignment of each member, and the group affiliation of the primary care provider.

25.2.22.The MCO shall submit complete encounter data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

25.2.23.The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

25.2.24.The MCO shall provide complete and accurate encounters to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards:

25.2.24.1.Completeness

25.2.24.1.1.The MCO shall submit encounters that represent at least ninety-nine percent (99%) of the covered services provided by the MCO's network and non-network providers. All data submitted by the providers to the MCO shall be included in the encounter submissions.

25.2.24.2.Accuracy

25.2.24.2.1.Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits.

25.2.24.2.2.Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

25.2.24.2.3.One-hundred percent (100%) of member identification numbers shall be accurate and valid.

25.2.24.2.4.Ninety-eight percent (98%) of servicing provider information will be accurate and valid.

25.2.24.2.5.Ninety-eight percent (98%) of member address information shall be accurate and valid.

25.2.24.3.Timeliness

25.2.24.3.1.Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment. All encounters shall be submitted, both paid and denied claims. The paid claims shall include the MCO paid amount.

25.2.24.3.2.The MCO shall be subject to remedies as specified in Section 34 for failure to timely submit encounter data, in accordance with the accuracy standards established in this Agreement.

25.2.24.4.Error Resolution

25.2.24.4.1.For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice. For all ongoing claim encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fifteen (15) calendar days after such notice. If the MCO fails to do so, DHHS will require a Corrective Action Plan and assess liquidated damages as described in Section 34. MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

25.2.24.4.2.All sub-contracts with providers or other vendors of service shall have provisions requiring that encounter records are reported or submitted in an accurate and timely fashion.

25.2.24.5.Survival

25.2.24.5.1.All encounter data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

25.3. Data Certification

25.3.1. All data submitted to DHHS by the MCO shall be certified by one of the following:

25.3.1.1.The MCO's Chief Executive Officer;

25.3.1.2.The MCO's Chief Financial Officer; or

25.3.1.3.An individual who has delegated authority to sign for, and who reports directly to, the MCO's Chief Executive Officer or Chief Financial Officer.

25.3.2. The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, encounter data, and other information contained in contracts, proposals. The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data. The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

25.4. Data System Support for QAPI

25.4.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI requirements described in Section 21. The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of MCO providers, member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

26. Fraud Waste and Abuse

26.1. Program Integrity Plan

26.1.1. The MCO shall have a Program Integrity Plan in place that has been approved by DHHS and that shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse. The MCO is expected to be familiar with, comply with, and require compliance with, all state and federal regulations related to Medicaid Program Integrity, whether or not those regulations are listed herein, and as required in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008, and Section 1902(a)(68) of the Social Security Act.

26.1.1.1. The MCO shall retain all data, information, and documentation described in 42 CFR 438.604, 438.606, 438.608, and 438.610 for period no less than ten (10) years.

26.1.1.2. Fraud, waste and abuse investigations are targeted reviews of a provider or member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services. Cases which would be considered investigations are as follows, but not limited to:

26.1.1.2.1. review of instances which may range from outliers identified through data mining;

26.1.1.2.2. pervasive or persistent findings of routine audits to specific allegations that involve or appear to involve intentional misrepresentation in an effort to receive an improper payment;

26.1.1.2.3. notification of potential fraud, waste, and abuse through member verification of services, or complaint filed; and.

26.1.1.2.4. any reviews as defined by CMS as fraud, waste, and abuse investigation.

26.1.1.3. Routine claims audits are random reviews conducted for the purpose of verifying provider compliance with contractual requirements including, but not limited to, quality standards, reimbursement guidelines, and/or medical policies.

26.2. Fraud, Waste and Abuse Prevention Procedures

26.2.1. The MCO shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud, waste and abuse. The MCO procedures shall include, at a minimum, the following:

26.2.1.1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;

26.2.1.2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

26.2.1.3. Effective training and education for the compliance officer and the MCO's employees;

26.2.1.4. Effective lines of communication between the compliance officer and the MCO's employees;

26.2.1.5. Enforcement of standards through well-publicized disciplinary guidelines;

26.2.1.6. Provisions for internal monitoring and auditing;

26.2.1.7. Provisions for the MCO's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23; and

26.2.1.8. Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's Agreement [42 CFR 438.608(a) and (b)]

26.2.2. The MCO shall establish a Program Integrity Unit within the MCO comprised of:

26.2.2.1. Experienced Fraud, Waste and Abuse reviewers who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein; and

26.2.2.2. An experienced Fraud, Waste, and Abuse Coordinator who is qualified by having appropriate background, training, education, and experience in health care provider fraud, waste and abuse.

26.2.3. .This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud, Waste and Abuse that may be committed by providers that are paid by the MCO and/or their subcontractors. The MCO Program Integrity Plan shall also include the prevention, detection, investigation and reporting of suspected fraud by the MCO, the MCO's employees, subcontractors, subcontractor's employees, or any other third parties with whom the MCO contracts. The MCO shall refer all suspected provider fraud to the DHHS Program Integrity Unit upon discovery. The MCO shall refer all suspected member fraud to DHHS Special Investigations Unit.

26.3. Reporting

26.3.1. The MCO shall promptly report provider fraud, waste and abuse information to DHHS' Program Integrity Unit, which is responsible for such reporting to federal oversight agencies pursuant to [42 CFR 455.1(a)(1) and 42 CFR438.608].

26.3.1.1. The MCO shall perform a preliminary investigation of all incidents of suspected fraud, waste and abuse internally. The MCO shall not take any of the following actions as they specifically relate to claims involved with the investigation unless prior written approval is obtained from DHHS' Program Integrity Unit, utilizing the MCO Request to Open Investigation form:

26.3.1.1.1. Contact the subject of the investigation about any matters related to the investigation, either in person, verbally or in writing, hardcopy, or electronic;

26.3.1.1.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

26.3.1.1.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

26.3.2. The MCO shall promptly report to DHHS' Division of Client Services all information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including but not limited to:

26.3.2.1. Changes in the enrollee's residence; and

26.3.2.2. Death of an enrollee.

26.3.3. The MCO shall promptly report to DHHS' Office of Medicaid Services and the Program Integrity Unit all changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

26.3.4. The MCO shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (five (5) percent or greater) in the MCO, or any sub-contractor in which the MCO has a five percent (5%) or greater ownership interest [42 CFR 438.608(c)(2)].

26.3.5. [Intentionally left blank.]

26.3.6. The MCO shall provide written disclosure of any prohibited affiliation under §438.610 and as described in subparagraph 4.3.2 of this Agreement [42 CFR 438.608(c)(1)].The MCO shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State.

26.3.7. As an integral part of the Program Integrity function, and in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438, the MCO shall provide DHHS or its designee real time access to all of the MCO electronic encounter and claims data from the MCO's current claims reporting system. The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in section 24.5.16.

26.3.7.1. MCOs shall provide any additional data access upon written request from DHHS for any potential fraud, waste, or abuse investigation or for MCO oversight review. The additional access shall be provider within 3 business days of the request.

26.3.8. The MCO shall make claims and encounter data available to DHHS (and other State staff) using a reporting system that is compatible with DHHS' system(s).

26.3.9. The MCO, their subcontractors, their contracted providers, their subcontractor's providers, and any subcontractor's subcontractor's providers shall cooperate fully with Federal and State agencies and contractors in any program integrity related investigations and subsequent legal actions. The MCO, their subcontractors and their contracted providers, subcontractor's providers, and any subcontractor's subcontractor's providers shall, upon written request and as required by this Agreement or state and/or federal law, make available any and all administrative, financial and medical records relating to the delivery of items or services for which MCO monies are expended. In addition, and as required by this Agreement or state and/or federal law, such agencies shall, also be allowed access to the place of business and to all MCO records of any contractor, their subcontractor or their contracted provider, subcontractor's providers, and any subcontractor's subcontractor's providers.

26.3.9.1. The MCO is responsible for program integrity oversight of its subcontractors. In accordance with federal regulations, CMS requires MCO contracts to contain provisions giving states' Program Integrity Units audit and access authority over MCOs and their subcontractors to include direct on site access to ordinal policies and procedures, claims processing, and provider credentialing for validation purposes at the expense of the MCO.

26.3.10. The MCO shall have a written process approved by DHHS for Recipient Explanation of Medicaid Benefits, which shall include tracking of actions taken on responses, as a means of determining and verifying that services billed by providers were actually provided to members. The MCO shall provide DHHS with a quarterly EOB activity report, including, but not limited to, tracking of all responses received, action taken by the MCO, and the outcome of the activity. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the MCO.

26.3.11. The MCO shall maintain an effective fraud, waste and abuse-related provider overpayment identification, recovery and tracking process. This process shall include

a methodology for a means of estimating overpayment, a formal process for documenting communication with providers, and a system for managing and tracking of investigation findings, recoveries, and underpayments related to fraud, waste and abuse investigations. DHHS and the AG Medicaid Fraud Unit shall have unrestricted access to information and documentation related to the NH Medicaid program for use during annual MCO Program Integrity audits and on other occasions as needed as a means of verifying and validating MCO compliance with the established policies, procedures, methodologies, and investigational activity regarding provider fraud, waste and abuse.

26.3.12.The MCO shall provide DHHS with a monthly report of all Program Integrity, in process and completed during the month, including fraud, waste and abuse by the MCO, the MCO's employees, subcontractors, subcontractor's employees, and contracted providers. [42 CFR 455.17]. The MCO will supply at a minimum:

26.3.12.1.provider name/ID number,

26.3.12.2.source of complaint,

26.3.12.3.type of provider,

26.3.12.4.nature of complaint,

26.3.12.5.review activity, and

26.3.12.6.approximate dollars involved,

26.3.12.7.Provider Enrollment Safeguards related to Program Integrity;

26.3.12.8.Overpayments, Recoveries, and Claim Adjustments;

26.3.12.9.Audits/Investigations Activity;

26.3.12.10.MFCU Referrals;

26.3.12.11.Involuntary Provider Terminations; and

26.3.12.12.Provider Appeal/Hearings Activity resulting from, or related to, Program Integrity.

26.3.13.All fraud, waste and abuse reports submitted to DHHS shall be mutually developed and agreed upon between DHHS and the MCO. The reports will be submitted to DHHS in a format and mode of delivery, mutually agreed upon between DHHS and the MCO.

26.3.14. In the event DHHS is unable to produce a desired Ad Hoc report through its access to the MCO's data as provided herein, DHHS shall request in writing such Ad hoc report from the MCO and, within three (3) business days of receipt of such request, the MCO shall notify DHHS of the time required by the MCO to produce and deliver the Ad hoc report to DHHS, at no additional cost to DHHS.

26.3.15. The MCO shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the MCO discovers wasteful and or abusive incorrect billing trends with a particular provider/provider type, specific billing issue trends, or quality trends, it is the MCO's responsibility, as part of the provider audit/investigative process, to recover any inappropriately paid funds, and as part of the resolution and outcome, for the MCO to determine the appropriate remediation, such as reaching out to the provider to provide individualized or group training/education regarding the issues at hand. Within sixty (60) days of discovery, the MCO shall report overpayments identified during investigations to DHHS Program Integrity and shall include them on the monthly investigation activity report. The MCO shall still notify Program Integrity unit to request approval to proceed with a suspected fraud or abuse investigation.

26.3.16. [Intentionally left blank.]

26.3.17. Annually, the MCO shall submit to DHHS a report of the overpayments it recovered and certify by its Chief Financial Officer that this information is accurate to the best of his or her information, knowledge, and belief [42 CFR 438.606]. DHHS reserves the right to conduct peer reviews of final program integrity investigations completed by the MCO.

26.3.18. DHHS will perform an annual program integrity audit, conducted on-site at the MCO (at the expense of the MCO) to verify and validate the MCO's compliance. The review will include, but not limited to, the plan's established policies and methodologies, credentialing, provider and staff education/training, provider contracts, and case record reviews to ensure that the MCO is making proper payments to providers for services under their agreements, and pursuant to 42 CFR 438 6(g). The review will include direct access to MCO system while on site and hard copy of documentation while on site as requested. Any documentation request at the end of the on site shall be delivered to Program Integrity within 3 business days of request. The MCO shall provide DHHS staff with access to appropriate on-site private work space to conduct DHHS's program integrity contract management reviews.

26.3.19. The MCO shall meet with DHHS monthly, or as determined by DHHS, to discuss audit and investigation results and make recommendations for program improvements. DHHS shall meet with both MCOs together quarterly, or as determined by DHHS, to discuss areas of interest for past, current and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities, and to discuss and share provider audit information and results.

26.3.20.The MCO shall provide DHHS with an annual report of all investigations in process and completed during the Agreement year within thirty (30) calendar days of the end of the Agreement year. The report shall consist of, at a minimum, an aggregate of the monthly reports, as well as any recommendations by the MCO for future reviews, changes in the review process and reporting process, and any other findings related to the review of claims for fraud, waste and abuse.

26.3.21.The MCO shall provide DHHS with a final report within thirty (30) calendar days following the termination of this Agreement. The final report format shall be developed jointly by DHHS and the MCO, and shall consist of an aggregate compilation of the data received in the monthly reports.

26.3.22.The MCO shall refer all suspected provider Medicaid fraud cases to DHHS upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.

26.3.23.The MCO shall institute a Pharmacy Lock-In Program for members which has been reviewed and approved by DHHS.

26.3.23.1.If the MCO determines that a member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to members regarding the Pharmacy Lock-In determination.

26.3.24.MCOs may, with prior approval from DHHS, implement Lock-In Programs for other medical services.

26.3.25.The MCO shall provide DHHS with a monthly report regarding the Pharmacy Lock-In Program. Report format, content, design, and mode of transmission shall be mutually agreed upon between DHHS and the MCO.

26.3.26.DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit or DHHS Special Investigations Unit.

26.3.27.Subject to applicable state and federal confidentiality/privacy laws, upon written request, the MCO will allow access to all NH Medicaid medical records and claims information to State and Federal agencies or contractors such as, but not limited to Medicaid Fraud Control Unit, Recovery Audit Contractors (RAC) the Medicaid Integrity Contractors (MIC), or DHHS Special Investigations Unit.

26.3.27.1.The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency (State and Federal) or their contractors, whether administrative, civil, or criminal. Such cooperation shall include providing, upon written request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in

medical or pharmaceutical questions or in any matter related to an investigation.

26.3.28. The MCO's MCIS system shall have specific processes and internal controls relating to fraud, waste and abuse in place, including, but not limited to the following areas:

26.3.28.1. Prospective claims editing;

26.3.28.2. NCCI edits;

26.3.28.3. Post-processing review of claims; and

26.3.28.4. Ability to pend any provider's claims for pre-payment review if the provider has shown evidence of credible fraud [42 CFR 455.21] in the Medicaid Program.

26.3.29. The MCO and their subcontractors shall post and maintain DHHS approved information related to Fraud, Waste and Abuse on its website, including but not limited to provider notices, updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

26.3.30. The MCO and their subcontractors shall be subject to on-site reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests as a result of an annual or targeted on-site review (at the expense of the MCO).

26.3.31. DHHS shall conduct investigations related to suspected provider fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for any and all types of claims older than six months for which the MCO does not have an active investigation.

26.3.32. DHHS shall validate the MCO and their subcontractors' performance on the program integrity scope of services to ensure the MCO and their subcontractors are taking appropriate actions to identify, prevent, and discourage improper payments made to providers, as set forth in 42 CFR 455 – Program Integrity.

26.3.33. DHHS shall establish performance measures to monitor the MCO compliance with the Program Integrity requirements set forth in this Agreement.

26.3.34. DHHS shall notify the MCO of any policy changes that impact the function and responsibilities required under this section of the Agreement.

26.3.35. DHHS shall notify the MCO of any changes within its agreement with its fiscal agent that may impact this section of this Agreement as soon as reasonably possible.

26.3.36.The MCO(s) shall report to DHHS all identified providers prior to being investigated, to avoid duplication of on-going reviews with the RAC, MIC, MFCU and, using the MCO Request to Open Investigation Form. DHHS will either approve the MCO to proceed with the investigation, or deny the request due to potential interference with an existing investigation.

26.3.37.The MCO(s) shall maintain appropriate record systems for services to members pursuant to 42 CFR 434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff, or its designee, to MCO(s) NH Medicaid related data files. Such information shall include, but not be limited to:

26.3.37.1.Recipient – First Name, Last Name, DOB, gender, and identifying number;

26.3.37.2.Provider Name and number (rendering, billing and Referring);

26.3.37.3.Date of Service(s) Begin/End;

26.3.37.4.Place Of Service;

26.3.37.5.Billed amount/Paid amount;

26.3.37.6.Paid date;

26.3.37.7.Standard diagnosis codes (ICD-9-CM and ICD-10-CM), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim);

26.3.37.8.Paid, denied, and adjusted claims;

26.3.37.9.Recouped claims and reason for recoupment;

26.3.37.10.Discharge status;

26.3.37.11.Present on Admission (POA);

26.3.37.12.Length of Stay;

26.3.37.13.Claim Type;

26.3.37.14.Prior Authorization Information;

26.3.37.15.Detail claim information;

26.3.37.16.Provider type;

26.3.37.17.Category of Service;

26.3.37.18.Admit time and discharge date;

26.3.37.19.Admit code;

26.3.37.20.Admit source;

26.3.37.21.Covered days;

26.3.37.22.TPL information;

26.3.37.23.Units of service;

26.3.37.24.EOB;

26.3.37.25.MCO ID#;

26.3.37.26.Member MCO enrollment date;

26.3.37.27.If available, provider time in and time out for the specific service(s) provided;

26.3.37.28.Data shall be clean, not scrubbed; and

26.3.37.29.And any other data deemed necessary by DHHS

26.3.38.The MCO shall provide DHHS with the following monthly reports as required by CMS:

26.3.38.1.Date of Death.

26.3.39.The MCO shall provide DHHS with any new reports as identified and required by state and federal regulation. The timing, format, content and mode of transmission will be mutually agreed upon between DHHS and the MCO.

27. Third Party Liability

DHHS and the MCO will cooperate in implementing cost avoidance and cost recovery activities. The rights and responsibilities of the parties relating to members and Third Party Payors are as follows:

27.1. MCO Cost Avoidance Activities

27.1.1. The MCO shall have primary responsibility for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans, and workers compensation. The MCO must attempt to avoid initial payment of claims, whenever possible, when federal or private health insurance resources are available. To support that responsibility, the MCO must implement a file transfer protocol between the DHHS MMIS and the MCO's MCIS to receive Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138. MCO shall require its subcontractors to promptly and consistently report COB daily information to the MCO.

27.1.2. The MCO shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

27.1.3. The number of claims cost avoided by the MCO's claims system, including the amount of funds, the amounts billed, the amounts not collected, and the amounts denied, must be reported weekly to DHHS in delimited text format.

27.1.4. The MCO shall maintain records of all COB collection efforts and results and report such information either through monthly electronic data transfers or access rights for DHHS to the MCO's data files. The data extract shall be in the delimited text format. Data elements may be subject to change during the course of the Agreement. The MCO shall accommodate changes required by DHHS and DHHS shall have access to all billing histories and other COB related data.

27.1.5. The MCO shall provide DHHS with a detailed claim history of all claims for a member, including adjusted claims, on a monthly basis based on a specific service date parameter requested for accident and trauma cases. This shall be a full replacement file each month for those members requested. These data shall be in the delimited text format. The claim history shall have, at a minimum, the following data elements:

27.1.5.1.Member name;

27.1.5.2.Member ID;

27.1.5.3.Dates of service;

27.1.5.4.Claim unique identifier (transaction code number);

27.1.5.5.Claim line number;

27.1.5.6.National Diagnosis Code;

27.1.5.7.Diagnosis code description;

27.1.5.8.National Drug Code;

27.1.5.9.Drug code description;

27.1.5.10.Amount billed by the provider;

27.1.5.11.Amount paid by the MCO;

27.1.5.12.Amount of other insurance recovery, name or Carrier ID;

27.1.5.13.Date claim paid;

27.1.5.14.Billing provider name; and

27.1.5.15.Billing provider NPI.

27.1.6. The MCO shall provide DHHS with a monthly file of COB collection effort and results. These data shall be in a delimited text format. The file should contain the following data elements:

27.1.6.1.Medicaid member name;

27.1.6.2.Medicaid member ID;

27.1.6.3.Insurance Carrier, other public payer, PBM, or benefit administrator ID;

27.1.6.4.Insurance Carrier, other public payer, PBM, or benefit administrator name;

27.1.6.5.Date of Service;

27.1.6.6.Claim unique identifier (transaction code number);

27.1.6.7.Date billed to the insurance carrier, other public payer, PBM, or benefit administrator;

27.1.6.8.Amount billed;

27.1.6.9.Amount recovered;

27.1.6.10.Denial reason code;

27.1.6.11.Denial reason description; and

27.1.6.12.Performing provider.

27.1.7. The MCO and its subcontractors shall not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations nor bill or pursue collection from a member for services. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third Party Liability is established at the time the claim is adjudicated.

27.2. DHHS Cost Avoidance and Recovery Activities

27.2.1. DHHS shall be responsible for:

27.2.1.1.Medicare and newly eligible members' initial insurance verification and submitting this information to the MCO;

27.2.1.2.Cost avoidance and pay and chase of those services that are excluded from the MCO;

27.2.1.3.Accident and trauma recoveries;

27.2.1.4.Lien, Adjustments and Recoveries and Transfer of Assets pursuant to § 1917 of the SSA;

27.2.1.5.Mail order co-pay deductible pharmacy program for Fee for Service and HIPP (Health Insurance Premium Payment) program;

27.2.1.6.Veterans Administration benefit determination;

27.2.1.7.Health Insurance Premium Payment Program; and

27.2.1.8.Audits of MCO collection efforts and recovery.

27.3. Post-Payment Recovery Activities

27.3.1. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources.

27.3.2. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts.

27.3.3. Other resources with regard to Third Party Liability include but are not limited to: recoveries from personal injury claims, liability insurance, first party automobile medical insurance, and accident indemnity insurance.

27.4. MCO Post Payment Activities

27.4.1. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources, including a claim involving Workers' Compensation or where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible or collection through either legal action or traditional subrogation and collection procedures.

27.4.2. The MCO shall be responsible for Reviewing claims for accident and trauma codes as required under 42 C.F.R. §433.138 (e). The MCO shall specify the guideline used in determining accident and trauma claims and establish a procedure to send the DHHS Accident Questionnaire to Medicaid members, postage pre-paid, when such potential claim is identified. The MCO shall instruct members to return the Accident Questionnaire to DHHS. The MCO shall provide the guidelines and procedures to DHHS for review and approval. Any changes to procedures must be submitted to DHHS at least thirty days for approval prior to implementation.

27.4.3. Due to potential time constraints involving accident and trauma cases and due to the large dollar value of many claims which are potentially recoverable by DHHS, the MCO must identify these cases before a settlement has been negotiated. Should DHHS fail to identify and establish a claim prior to settlement due to the MCO's untimely submission of notice of legal involvement where the MCO has received such notice, the amount of the actual loss of recovery shall be assessed against the MCO. The actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by DHHS.

27.4.4. The MCO has the latter of eighteen (18) months from the date of service or twelve (12) months from the date of payment of health-related insurance resources to initiate recovery and may keep any funds that it collects. The MCO must indicate its intent to recover on health-related insurance by providing to DHHS an electronic file of those cases that will be pursued. The cases must be identified and a file provided to DHHS by the MCO within thirty (30) days of the date of discovery of the resource.

27.4.5. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a Medically Necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

27.5. DHHS Post Payment Recovery Activity

27.5.1. DHHS retains the sole and exclusive right to investigate, pursue, collect and retain all Other Resources, including accident and trauma. DHHS is assigned the MCO's subrogation rights to collect the "Other Resources" covered by this provision. Any correspondence or Inquiry forwarded to the MCO (by an attorney, provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forward to DHHS.

27.5.2. The MCO may neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by DHHS under the scope of these "Other Resources" shall be retained by DHHS.

27.5.3. DHHS may pursue, collect and retain recoveries of all health-related insurance cases; provided, however, that if the MCO has not notified DHHS of its intent to pursue a case identified for recovery before the latter of eighteen (18) months after the date of service or twelve (12) months after the date of payment, such cases not identified for recovery by the MCO will become the sole and exclusive right of DHHS to pursue, collect and retain. The MCO must notify DHHS through the prescribed electronic file process of all outcomes for those cases identified for pursuit by the MCO.

27.5.4. Should DHHS lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in billing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable Claim shall be assessed against the MCO.

28. Compliance with State and Federal Laws

28.1. General

28.1.1. The MCO, its subcontractors, and the providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

28.1.2. The MCO 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].

28.1.3. The MCO shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

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

28.1.3.2.Related rules: Title 42 Chapter IV;

28.1.3.3.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);

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

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

28.1.3.6.Regulations promulgated thereunder: 42 CFR 457;

28.1.3.7.Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

28.1.3.8.Patient Protection and Affordable Care Act of 2010;

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

28.1.3.10.State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

28.1.3.11.American Recovery and Reinvestment Act; and

28.1.3.12. Any waivers approved by the Centers for Medicare & Medicaid Services.

28.1.4. The MCO will not release and make public statements or press releases concerning the program without the prior consent of DHHS.

28.1.5. The MCO shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and the MCO, 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.

28.2. Non-Discrimination

28.2.1. The MCO shall require its providers and 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 or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

28.2.2. ADA Compliance

28.2.2.1.The MCO shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA.

28.2.2.1.1. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

28.2.2.2.The MCO shall submit to DHHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the MCO's knowledge. The MCO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by the MCO and shall be available for inspection by the DHHS. The MCO warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA. Where applicable, the MCO shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

28.2.2.3.The MCO shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all members who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

28.2.2.4.The MCO shall forward to DHHS copies of all grievances alleging discrimination against members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability for review and appropriate action within three (3) business days of receipt by the MCO.

28.2.3. Non-Discrimination in employment:

28.2.3.1.The MCO shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. The MCO 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. The MCO 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.

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

28.2.3.3.The MCO 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 the MCO'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.

28.2.3.4.The MCO 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.

28.2.3.5.The MCO 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.

28.2.3.6.In the event of the MCO'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 the MCO 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.

28.2.3.7.The MCO 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. The MCO 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 the MCO

becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

28.2.4. Non-Discrimination in Enrollment

28.2.4.1. The MCO shall and shall require its providers and subcontractors to accept assignment of an member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

28.2.4.2. The MCO shall and shall require its providers and subcontractors to not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

28.2.5. Non-Discrimination with Respect to Providers

28.2.5.1. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's members, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the MCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

28.3. Changes in Law

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

29. Administrative Quality Assurance Standards

29.1. Claims Payment Standards

29.1.1. The MCO shall pay or deny ninety-five percent (95%) of clean claims within thirty (30) days of receipt, or receipt of additional information [42 CFR 447.46; 42 CFR 447.45(d)(2), (d)(3), (d)(5), and (d)(6)].

29.1.2. The MCO shall pay interest on any clean claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

29.1.3. The MCO shall pay or deny all claims within sixty (60) calendar days of receipt.

29.1.4. Additional information necessary to process incomplete claims shall be requested from the provider within thirty (30) days from the date of original claim receipt.

29.1.5. For purposes of this requirement, New Hampshire DHHS has adopted the claims definitions established by CMS under the Medicare program, which are as follows:

29.1.5.1. "clean" claim: a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and

29.1.5.2. "incomplete" claim: a claim that is denied for the purpose of obtaining additional information from the provider.

29.1.6. Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or electronic funds transfer is issued to the service provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

29.2. Quality Assurance Program

29.2.1. The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS on a monthly basis.

29.2.2. Monthly reporting shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

29.2.3. The MCO shall implement Corrective Action Plans to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

29.3. Claims Financial Accuracy

29.3.1. Claims financial accuracy measures the accuracy of dollars paid to providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

29.4. Claims Payment Accuracy

29.4.1. Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay ninety-seven percent (97%) of claims accurately.

29.5. Claims Processing Accuracy

29.5.1. Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process ninety-five percent (95%) of all claims correctly.

30. Privacy and Security of Members

30.1. General Provisions

30.1.1. The MCO shall be in compliance with privacy policies established by governmental agencies or by State or federal law.

30.1.2. The MCO shall provide sufficient security to protect the State and DHHS data in network, transit, storage, and cache.

30.1.3. In addition to adhering to privacy and security requirements contained in other applicable laws and statutes, the MCO shall execute as part of this Agreement a Business Associates Agreement governing the permitted uses and disclosure and security of Protected Health Information.

30.1.4. The MCO shall ensure that it uses and discloses individually identifiable health information in accordance with HIPAA privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable [42 CFR 438.224]; complies with federal statutes and regulations governing the privacy of drug and alcohol abuse patient records (42 CFR, Part 2.33), and all applicable state statutes and regulations, including but not limited to: R.S.A. 167:30: protects the confidentiality of all DHHS records with identifying medical information in them.

30.1.5. With the exception of submission to the Comprehensive Healthcare Information System or other requirements of State or federal law, claims and member data on New Hampshire Medicaid members may not be released to any party without the express written consent of DHHS.

30.1.6. The MCO shall ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information [42 CFR 438.208(b)].

31. Finance

31.1. Financial Standards

31.1.1. In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with New Hampshire Insurance Department regulations, and any other relevant laws and regulations.

31.1.2. The MCO shall maintain a risk-based capital (RBC) ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

31.1.3. With the exception of payment of a claim for a medical product or service that was provided to a member, and that is in accordance with a written Agreement with the provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

31.1.3.1. RBC ratio was less than 2.0 for the most recent year filing, per R.S.A. 404-F:14 (III); and

31.1.3.2. MCO was not in compliance with the NHID solvency requirement.

31.1.4. The MCO shall notify DHHS within ten (10) calendar days when its Agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

31.1.5. The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

31.1.6. The MCO shall not be responsible for DSH/GME (IME/DME) payments to hospitals. DSH and GME amounts are not included in capitation payments.

31.1.7. The MCO shall submit data on the basis of which DHHS determines that the MCO has made adequate provision against the risk of insolvency.

31.2. Capitation Payments

31.2.1. Preliminary capitation rates for non NHHPP members for the agreement period through June 30, 2019 are shown in Exhibit B. For each of the subsequent years of the Agreement actuarially sound per member, per month capitated rates will be calculated and certified by the DHHS's actuary.

31.2.2. Capitation rates for NHHPP members are shown in Exhibit B and were determined as part of Agreement negotiations, any best and final offer process, and the DHHS actuary's soundness certification.

31.2.3. Capitation rate cell is determined as of the first day of the capitation month and does not change during the entire month regardless of member changes (e.g., age).

31.2.4. DHHS will make a monthly payment to the MCO for each member enrolled in the MCO's plan. Capitation payments shall only be made for Medicaid-eligible enrollees and be retained by the MCOs for those enrollees. The capitation rates, as set forth in Exhibit B, will be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis as follows:

31.2.4.1. The Chronic Illness and Disability Payment System and/or Medicaid Rx risk adjuster (CDPS + Rx, Medicaid Rx) will be used to risk adjust MCO capitation payments;

31.2.4.2. A risk score will be developed for members with six (6) months or more months of Medicaid eligibility (either FFS or managed care) inclusive of three (3) months of claims run out in the base experience period. For members with less than six (6) months of eligibility, a score equal to the average of those scored beneficiaries in each cohort will be used; and

31.2.4.3. The MCO risk score for a particular rate cell will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population enrolled in the Care Management program. For rate cells with an opt-out provision, the MCO risk score will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population that is eligible to enroll in the Care Management program (FFS eligibles + MCO members).

31.2.4.4. [Intentionally left blank.]

31.2.5. DHHS reserves the right to terminate or implement the use of a risk adjustment process for specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates.

31.2.6. The capitation payment for Medicaid Managed Care members will be made retrospectively with a two (2) month delay. For example, a payment will be made within five (5) business days of the first day in October 2012 for services provided in July 2012.

31.2.7. Section 31.2.6 notwithstanding, capitation payments for NHHPP members will be paid in the month of service.

31.2.8. Capitation payment settlements will be made at three (3) month intervals. DHHS will recover capitation payments made for deceased members, or members who were later determined to be ineligible for Medicaid and/or for Medicaid managed care or need rate cell or kick payment corrections. DHHS will pay MCO for retroactive member assignments, corrections to kick payments, behavioral health certification level correction or other rate assignment corrections.

31.2.9. Capitation payments for members who became ineligible for services in the middle of the month will be prorated based on the number of days eligible in the month.

31.2.10. The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement [42 CFR 438.608(c)(3)].

31.2.11. For each live birth, DHHS will make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all maternity expenses, including all delivery and postpartum care. In the event of a multiple birth DHHS will only make only one maternity kick payment. A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

31.2.12. For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2012 and August 2012 for a baby born any time in July 2012. Enrolled babies will be covered under the MCO capitated rates thereafter. For each live birth, for Fiscal Year 2019, the newborn kick payment will be made for both newborns with and without Neonatal Abstinence Syndrome. Each type of payment is distinct and only one payment is made per newborn.

31.2.13. The MCO shall submit information on maternity and newborn events to DHHS. The MCO shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

31.2.14.

31.2.15. DHHS will inform the MCO of any required program revisions or additions in a timely manner. DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

31.2.16. When requested by DHHS, the MCO shall submit base data to DHHS to ensure actuarial soundness in development of the capitated rates.

31.2.17. The MCO's Chief Financial Officer shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate [42 CFR 438.606].

31.2.18. In the event an enrolled Medicaid member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive full capitation payment for that member. The entity responsible for coverage of the member at the time of admission as an inpatient, i.e. either DHHS or another MCO, shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

31.2.19. Payment for behavioral health rate cells shall be determined based on a member's CMHC behavioral certification level and a member having had an encounter at a CMHC in the last 6 months. Changes in the certification level for a member shall be reflected as of the first of each month and does not change during the month.

31.2.20. The SFY 2019 MCM Capitation rates include directed payments of $5 million to the CMHCs across all programs and populations, pending approval by CMS, to ensure timely access to high-quality care. MCOs are required to pay these amounts directly to the Community Mental Health Centers (CMHCs) according to criteria defined by the Department and approved by CMS. The directed payments will be based on the utilization and delivery of services for Medicaid beneficiaries that receive Community Mental Health Program services delivered at CMHCs, regardless of the basis of their eligibility for Medicaid (i.e., services delivered to members identified as SPMI, SMI, low utilizer and SED children). These amounts are to be paid directly to the providers by the MCOs and do not include additional allowance for administrative expense or risk margin. The Department reserves the right to modify the Exhibit O to support any CMS required reporting related to directed payment.

31.2.21. Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the New Hampshire Insurance Administrative Fund (Fund) pursuant to R.S.A. 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NH Insurance Department.

31.2.22. For any member with claims exceeding five hundred thousand dollars ($500,000) for the fiscal year, after applying any third party insurance off set, DHHS will reimburse fifty percent (50%) of the amount over five hundred thousand dollars ($500,000) after all claims have been recalculated based on the DHHS fee schedule for the services. For a member whose services may be projected to exceed five hundred thousand dollars ($500,000) in MCO claims, the MCO shall advise DHHS. Prior approval from the Medicaid Director is required for subsequent services provided to the member.

31.3. Medicaid Loss Ratio

31.3.1. The MCO shall determine the Medicaid Loss Ratio ("MLR") experienced in accordance with 42 CFR 438.8.

31.3.2. The MCO shall submit MLR summary reports quarterly to DHHS, which shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year. Specifically, the MCO shall provide separate summary reports for NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program. The MCO must attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. Such summary reports shall be based on a template provided and developed by DHHS within sixty (60) days of the effective date of this Agreement.

31.3.3. The MCO and its subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

31.4. NHHPP Risk Protection Structure

31.4.1. DHHS will implement risk adjustment and risk corridors for the NHHPP Medically Frail and NHHPP Transitional populations.

31.4.1.1. Risk adjustment – (MCO Revenue Reallocation) – Similar to the risk adjustment process for the current Medicaid Step 1 population under the MCM program, risk adjustment will shift revenue from MCOs with lower acuity populations to MCOs with higher acuity populations. The risk adjustment component will only apply to the NHHPP Medically Frail population. The risk adjustment process is revenue neutral. The NHHPP Transitional population is expected to have very short enrollment duration and therefore will not be risk adjusted.

31.4.2. Risk adjustment – Methodology – Acuity will be measured using the CDPS+Rx, a diagnosis and pharmacy based risk adjuster that will also be used for the current Medicaid population. Key differences in the risk adjustment process for the NHHPP Medically Frail population include:

31.4.2.1. DHHS will use concurrent risk adjustment for the NHHPP Medically Frail population. DHHS will use SFY 2019 claims and the standard CDPS+Rx concurrent risk weights to estimate SFY 2019 acuity (as opposed to prospective models that use a prior year's claims to estimate current acuity).

31.4.2.2. Risk adjustment transfer payments will be made as part of the contract period settlement, not as prospective payments.

31.4.3. Risk corridors – DHHS will establish a target medical loss ratio (MLR) of 89.3% based on NHHPP pricing assumptions and perform a separate calculation for the NHHPP Medically Frail and NHHPP Transitional populations:

31.4.3.1. Administrative and margin allowance of 8.9% of the capitation rate prior to state premium tax.

31.4.3.2. New Hampshire state premium tax of 2%.

31.4.3.3. DHHS and each MCO will share the financial risk of actual results that are above or below the MLR target as shown in the table below:

New Hampshire Department of Health and Human Services New Hampshire Health Protection Program Population Risk Corridor Program		
Actual MLR Compared to Target MLR	**MCO Share**	**DHHS Share**
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

31.4.3.4. The NHHPP Medically Frail risk corridor calculation will be applied after the risk adjustment calculation.

31.4.4. For SFY 2019, risk protection settlement will occur after the SFY 2019 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.4.1. June 30, 2019: End of NHHPP contract period

31.4.4.2. December 31, 2019: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.4.3. January 31, 2020: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.4.4. April 30, 2020: DHHS releases settlement payment report to MCOs

31.4.4.5. May 31, 2020: DHHS makes / receives final settlement payments to / from MCOs

31.4.5. For SFY 2018, risk protection settlement will occur after the SFY 2018 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.5.1. June 30, 2018: End of NHHPP contract period

31.4.5.2. December 31, 2018: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.5.3. January 31, 2019: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.5.4. April 30, 2019: DHHS releases settlement payment report to MCOs

31.4.5.5. May 31, 2019: DHHS makes / receives final settlement payments to / from MCOs

31.4.6. For SFY 2017, risk protection settlement will occur after the SFY 2017 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.6.1. June 30, 2017: End of NHHPP contract period

31.4.6.2. December 31, 2017: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2017 dates of service paid through December 31, 2017)

31.4.6.3. January 31, 2018: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.6.4. April 30, 2018: DHHS releases settlement payment report to MCOs

31.4.6.5. May 31, 2018 DHHS makes / receives final settlement payments to / from MCOs

31.4.7. For SFY 2016, risk protection settlement will occur after the SFY 2016 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.7.1. June 30, 2016: End of NHHPP contract period

31.4.7.2. December 31, 2016: Cutoff date for encounter data to be used in the risk protection settlement calculations (January 2016 – June 2016 dates of service paid through December 31, 2016)

31.4.7.3. January 31, 2017: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.7.4. April 30, 2017: DHHS releases settlement payment report to MCOs

31.4.7.5. May 31, 2017: DHHS makes / receives final settlement payments to / from MCOs

31.4.8. For September 2014 – December 2015 risk protection settlement:

31.4.8.1. August 31, 2016: DHHS intends to release settlement payment report to MCOs

31.4.8.2. September 30, 2017: DHHS intends to make / receive final settlement payments to / from MCOs.

31.5. Financial Responsibility for Dual-Eligibles

31.5.1. The MCO shall pay any Medicare coinsurance and deductible amount up to what New Hampshire Medicaid would have paid for that service, whether or not the Medicare provider is included in the MCO's provider network. These payments are included in the calculated capitation payment.

31.6. Premium Payments

31.6.1. DHHS is responsible for collection of any premium payments from members. If the MCO inadvertently receives premium payments from members, it shall inform the member and forward the payment to DHHS.

31.7. Sanctions

31.7.1. If the MCO fails to comply with the financial requirements in Section 31, DHHS may take any or all of the following actions:

31.7.1.1. Require the MCO to submit and implement a Corrective Action Plan

31.7.1.2. Suspend enrollment of members to the MCO after the effective date of sanction

31.7.1.3. Terminate the Agreement upon forty-five (45) calendar days written notice

31.7.1.4. Apply liquidated damages according to Section 34

31.8. Medical Cost Accruals

31.8.1. The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims.

31.9. Audits

31.9.1. The MCO shall allow DHHS and/or the NHID to inspect and audit any of the financial records of the MCO and its subcontractors. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)].

31.9.2. The MCO shall file annual and interim financial statements in accordance with the standards set forth below. This Section 31.9.2 will supersede any conflicting requirements in Exhibit C of this Agreement.

31.9.3. Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners ("NAIC"), annual audited financial statements that have been audited by an independent Certified Public Accountant. Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

31.9.4. The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the Insurance Department.

31.9.5. The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

31.10.Member Liability

31.10.1.The MCO shall not hold its Medicaid members liable for:

31.10.1.1. The MCO's debts, in the event of the MCO's insolvency [42 CFR 438.116(a); SMM 2086.6];

31.10.1.2. The covered services provided to the member, for which the State does not pay the MCO;

31.10.1.3. The covered services provided to the member, for which the State, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or

31.10.1.4. Payments for covered services furnished under an Agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided those services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(a), (b) and (c); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.2. Subcontractors and referral providers may not bill members any amount greater than would be owed if the entity provided the services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.3. The MCO shall cover continuation of services to members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency [SMM 2086.6B].

31.11. Denial of Payment

31.11.1. Payments provided for under the Agreement will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in [§1903(m)(5)(B)(ii) of the SSA; 42 CFR 438.726(b); 42 CFR 438.730(e)].

31.12. Federal Matching Funds

31.12.1. Federal matching funds are not available for amounts expended for providers excluded by Medicare, Medicaid, or Children's Health Insurance Program (CHIP), except for emergency services [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and §1903(i)(2) of the SSA; SMD letter 12/30/97]. Payments made to such providers are subject to recoupment from the MCO by DHHS.

31.13. Health Insurance Providers Fee

31.13.1. Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposed an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

31.13.1.1.To the extent such fees exist:

31.13.1.1.1.The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement no later than 120 days following its review and acceptance of the Contractor's Adjusted Fee.

31.13.1.1.2. To claim reimbursement for the Contractor's Adjusted Fee, the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:

Attn: Medicaid Finance Director

New Hampshire Medicaid Managed Care Program

129 Pleasant Street

Concord, NH 03304

32. Termination

32.1. Transition Assistance

32.1.1. Upon receipt of notice of termination of this Agreement by DHHS, the MCO 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 vendor or to perform the work itself.

32.1.1.1. Transition Plan

32.1.1.1.1. MCO must prepare a Transition Plan which is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date.

32.1.1.2. Data

32.1.1.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, 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.

32.1.1.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO shall transmit the information and records required 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.

32.2. Service Authorization

32.2.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received. Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS.

32.2.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

32.3. Claims Responsibilities

32.3.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

32.3.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

32.4. Termination for Cause

32.4.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if the MCO [42 CFR 438.610(c)(3); 42 CFR 434.6(a)(6)]:

32.4.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any member, including significant marketing abuses;

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

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

32.4.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS' notice and written request for compliance;

32.4.1.5. Violates state or federal law or regulation;

32.4.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

32.4.1.7. Becomes insolvent;

32.4.1.8. Fails to meet applicable requirements in sections §1932, §1903 (m) and §1905(t) of the SSA [42 CFR 438.708]. In the event of a termination by DHHS pursuant to 42 CFR 438.708, DHHS shall provide the MCO with a pre-termination hearing in accordance with 42 CFR 438.710;

32.4.1.9. 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

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

32.4.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance.

32.4.2. If DHHS terminates this Agreement for cause, the MCO 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 MCO. 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 reasonable attributable to the MCO's failure to perform any service in accordance with the terms of this Agreement.

32.5. Termination for Other Reasons

32.5.1. Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for sixty (60) calendar days after written notice thereof by the other party.

32.5.2. In the event the MCO gives written notice that it does not accept the actuarially sound capitation rates established by DHHS for Year 2 or later of the program, the MCO and DHHS will have thirty (30) days from the date of such notice or thirty (30) calendar days from the expiration of the rates indicated in Exhibit B, whichever comes later, to attempt to resolve the matter without terminating the agreement. If no resolution is reached in the above thirty (30) calendar days period, then the contract will terminate ninety (90) calendar days thereafter, or at the time that all members have been disenrolled from the MCO's plan, whichever date is earlier. In the event of such termination, the MCO shall accept the lesser of the most recently agreed to capitation rates or the new annual capitation rate for each rating category as payment in full for Covered Services and all other services required under this Agreement delivered to Members until all Members have been disenrolled from the MCO's plan consistent with any mutually agreed upon transition plans to protect Members.

32.6. Final Obligations

32.6.1. DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Amounts due to MCO for unpaid premiums, risk settlement, ABA therapies, High Dollar Stop Loss, shall be paid to MCO within one year of date of termination.

32.7. Survival of Terms

32.7.1. 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:

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

32.7.1.2. 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.

32.8. Notice of Hearing

32.8.1. Except because of change in circumstances or in the event DHHS terminates this Agreement pursuant to subsections (1), (2), (3) or (10 of Section 32.3.1, DHHS shall give the MCO ninety (90) days advance, written notice of termination of this Agreement and shall provide the MCO with an opportunity to protest said termination and/or request an informal hearing in accordance with 42 CFR 438.710. This notice shall specify the applicable provisions of this Agreement and the effective date of termination, which shall not be less than will permit an orderly disenrollment of members to the Medicaid FFS program or transfer to another MCO.

33. Agreement Closeout

33.1. Period

33.1.1. A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day the MCO is responsible for coverage of specific beneficiary groups or operating under this Agreement. During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS. Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

33.2. Data

33.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new MCO and/or DHHS shall define the information required during this period and the time frames for submission.

33.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO 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.

33.2.3. The MCO shall be responsible for continued submission of data to the Comprehensive Healthcare Information System during and after the transition in accordance with NHID regulations.

33.3. Service Authorizations

33.3.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with the new MCO to process service authorization requests received. Disputes between the MCO and the new MCO regarding service authorizations shall be resolved by DHHS.

33.3.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

33.4. Claims Responsibilities

33.4.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

33.4.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

34. Remedies

34.1. Reservation of Rights and Remedies

34.1.1. 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 MCO 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.

34.2. Liquidated Damages

34.2.1. DHHS and the MCO agree that it will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards indicated below throughout the life of this Agreement. Any breach by the MCO will delay and disrupt DHHS's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable.

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

34.2.3. DHHS shall make all assessments of liquidated damages. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify the MCO as specified in Section 34.10 of this Agreement.

34.2.4. The MCO shall submit a written Corrective Action Plan to DHHS, within five business days of notification, for review and approval prior to implementation of corrective action.

34.2.5. The MCO agrees that as determined by DHHS, failure to provide services meeting the performance standards below will result in liquidated damages as specified. The MCO agrees to abide by the Performance Standards and Liquidated Damages specified, provided that DHHS has given the MCO data required to meet performance standards in a timely manner. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

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

34.2.7. Liquidated damages may be assessed for each day, incidence or occurrence, as applicable, of a violation or failure.

34.2.8. The amount of liquidated damages assessed by DHHS to the MCO shall not exceed three percent (3%) of total expected yearly capitated payments, based on average annual membership from start date, for the MCO.

34.2.9. Liquidated damages related to timely processing of membership, claims and or/encounters shall be waived until such time as DHHS's file transfer systems and processes are operational.

34.3. Category 1

34.3.1. Liquidated damages up to $100,000 per violation or failure may be imposed for Category 1 events. Category 1 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.3.1.1. Acts that discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll an enrollee, except as permitted under law or under this Agreement, or any practice that would reasonably be expected to discourage enrollment by an enrollee whose medical condition or history indicates probable need for substantial future medical services. [42 CFR 700(b)(3) and 42 CFR 704(b)(2)].

34.3.1.2. A determination by DHHS that a recipient was not enrolled because of a discriminatory practice; $15,000 for each recipient subject to the $100,000 overall limit in 42 CFR 704(b)(2).

34.3.1.3. A determination by DHHS that a member found eligible for CFI services was relocated to a Nursing Facility due to MCO's failure to arrange for adequate in-home services in compliance with this Agreement and He-E801.09.

34.3.1.4. Misrepresentations of actions or falsifications of information furnished to CMS or the State.

34.3.1.5. Failure to comply with material requirements in this Agreement.

34.3.1.6. [Intentionally left blank.]

34.3.1.7. Failure to meet the Administrative Quality Assurance Standards specified in Section 29 of this Agreement.

34.3.1.8. Failure of the MCO to assume full operation of its duties under this Agreement in accordance with the implementation and transition timeframes specified herein.

34.4. Category 2

34.4.1. Liquidated damages up to $25,000 per violation or failure may be imposed for Category 2 events. Category 2 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.4.1.1. Misrepresentation or falsification of information furnished to a member, potential member, or health care provider.

34.4.1.2. Distribution, directly, or indirectly, through any agent or independent MCO, marketing materials that have not been approved by the State or that contain false or materially misleading information.

34.4.1.3. Violation of any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

34.4.1.4. Imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program; a maximum of $25,000 or double the amount of the charges, whichever is greater. The State will deduct the amount of the overcharge and return it to the affected member.

34.4.1.5. Failure to resolve member Appeals and Grievances within the timeframes specified in Section 19 of this Agreement.

34.4.1.6. Failure to ensure client confidentiality in accordance with 42 CFR 166 and 45 CFR 164; an incident of non-compliance shall be assessed as per member and/or per HIPAA regulatory violation.

34.4.1.7. Violation of a subcontracting requirement in this Agreement.

34.4.1.8. Failure to provide medically necessary services that the MCO is required to provide under law, or under this Agreement, to a member covered under this Agreement.

34.5. Category 3

34.5.1. Liquidated damages up to $10,000 per violation or failure may be imposed for Category 3 events. Category 3 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.5.1.1. Late, inaccurate, or incomplete turnover or termination deliverables.

34.6. Category 4

34.6.1. Liquidated damages up to $5,000 per violation or failure may be imposed for Category 4 events. Category 4 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.6.1.1. Failure to meet staffing requirements as specified in Section 6.

34.6.1.2. Failure to submit reports not otherwise addressed in this Section within the required timeframes.

34.7. Category 5

34.7.1. Liquidated damages as specified below may be imposed for Category 5 events. Category 5 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.7.1.1. Failure to provide a sufficient number of providers in order to ensure member access to all covered services and to meet the geographic access standards and timely access to service delivery specified in this Agreement:

34.7.1.1.1. $1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan;

34.7.1.1.2. $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan.

34.7.1.2. Failure to submit readable, valid health care data derived from Claims, Pharmacy or Encounter data in the required form or format, and timeframes required by the terms of this Agreement:

34.7.1.2.1. $5,000 for each day the submission is late;

34.7.1.2.2. for submissions more than thirty (30) calendar days late, DHHS reserves the right to withhold five percent (5%) of the aggregate

capitation payments made to the MCO in that month until such time as the required submission is made.

34.7.1.3. Failure to implement the Disaster Recovery Plan (DRP):

34.7.1.3.1. Implementation of the DRP exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2.

34.7.1.3.2. Implementation of the DRP exceeds the proposed time by more than two (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per day beginning with day 3 and up to day 5.

34.7.1.3.3. Implementation of the DRP exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days: twenty five thousand dollars ($25,000) per day beginning with day 6 and up to day 10.

34.7.1.3.4. Implementation of the DRP exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per day beginning with day 11.

34.7.1.4. Unscheduled system unavailability occurring during a continuous five (5) business day period:

34.7.1.4.1. Greater than or equal to two (2) and less than twelve (12) hours cumulative; up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof.

34.7.1.4.2. Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative; up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof.

34.7.1.4.3. Greater than or equal to twenty-four (24) hours cumulative; up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

34.7.1.5. Failure to correct a system problem not resulting in system unavailability within the allowed timeframe:

34.7.1.5.1. One (1) to fifteen (15) calendar days late; two hundred and fifty dollars ($250) per calendar day for days 1 through 15.

34.7.1.5.2. Sixteen (16) to thirty (30) calendar days late; five hundred dollars ($500) per calendar day for days 16 through 30.

34.7.1.5.3. More than thirty (30) calendar days late; one thousand dollars ($1,000) per calendar day for days 31 and beyond.

34.7.1.6. Failure to meet telephone hotline performance standards:

34.7.1.6.1. One thousand dollars ($1,000) for each percentage point that is below the target answer rate of ninety percent (90%) in thirty (30) seconds.

34.7.1.6.2. One thousand dollars ($1,000) for each percentage point that is above the target of a one percent (1%) blocked call rate.

34.7.1.6.3. One thousand dollars ($1,000) for each percentage point that is above the target of a five percent (5%) abandoned call rate.

34.7.1.7. The MCO shall resolve one hundred percent (100%) of standard member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO

34.8. Suspension of Payment

34.8.1. Payment of capitation payments shall be suspended when:

34.8.1.1. The MCO fails to cure a default under this Agreement within thirty (30) days of notification;

34.8.1.2. Failing to act on identified Corrective Action Plan;

34.8.1.3. Failure to implement approved program management or implementation plans;

34.8.1.4. Failure to submit or act on any transition plan, or corrective action plan, as specified in this Agreement; or

34.8.1.5. Upon correction of the deficiency or omission, capitation payments shall be reinstated.

34.9. Administrative and Other Remedies

34.9.1. In addition to other liquidated damages described in Category 1-5 events, DHHS may impose the following other remedies:

34.9.1.1. Appointment of temporary management of the MCO, as provided in 42 CFR 438.706, if DHHS finds that the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

34.9.1.2. Suspending enrollment of new members and/or changing auto-assignment of new members to the MCO.

34.9.1.3. Granting members the right to terminate enrollment without cause and notifying affected members of their right to disenroll.

34.9.1.4. Suspension of payment to the MCO for members enrolled after the effective date of the remedies and until CMS or DHHS is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur.

34.9.1.5. Termination of the Agreement if the MCO 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.

34.9.1.6. Civil monetary fines in accordance with 42 CFR 438.704.

34.9.1.7. Additional remedies allowed under State statute or regulation that address area of non-compliance specified in 42 CFR 438.700.

34.10.Notice of Remedies

34.10.1.Prior to the imposition of either liquidated damages or any other remedies under this Agreement, including termination for breach, with the exception of requirements related to the Implementation Plan, DHHS will issue written notice of remedies that will include, as applicable, the following:

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

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

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

34.10.1.4.Request for a Corrective Action Plan;

34.10.1.5.The timeframe and procedure for the MCO to dispute DHHS's determination. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

34.10.1.6. If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor.

35. Dispute Resolution Process

35.1. Informal Dispute Process

35.1.1. In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) days following the action or decision, the MCO may protest such action or decision by the delivery of a notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. The MCO 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 of the time, format and location of the presentations. At the conclusion of the presentations, the Director will consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation. The Director may appoint a designee to hear and determine the matter. If the Director or designee affirms the action or decision and the action or decision relates to termination of this Agreement, DHHS shall give enrollees of the MCO notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

35.2. No Waiver

35.2.1. The MCO's exercise of its rights under Section 34.1 shall not limit, be deemed a waiver of, or otherwise impact the parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A or any applicable provisions of the N.H. Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

36. Confidentiality

36.1. Confidentiality of Records

36.1.1. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Agreement shall be confidential and shall not be disclosed by the MCO, provided however, that pursuant to state laws and the regulations and administrative rules 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 Agreement; 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 MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian. In the case of records protected by 42 CFR Part 2.33, the individual must provide consent and notice as specified by 42 CFR Part 2.33.

36.2. MCO Owned or Maintained Data or Information

36.2.1. 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 the MCO. Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. The MCO acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense. If the MCO fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2018 – December 31, 2018

Medicaid Care Management

Base Population	Capitation Rate
Low Income Children and Adults - Age 2-11 Months	$221.27
Low Income Children and Adults - Age 1-18 Years	135.52
Low Income Children and Adults - Age 19+ Years	470.38
Foster Care / Adoption	336.48
Breast and Cervical Cancer Program	1,830.36
Severely Disabled Children	1,048.08
Elderly and Disabled Adults	1,095.12
Dual Eligibles	234.95
Newborn Kick Payment	2,917.40
Maternity Kick Payment	2,832.00
Neonatal Abstinence Syndrome Kick Payment	9,626.54
NF Resident and Waiver Rate Cell	
Nursing Facility Residents – Medicaid Only – Under 65	2,603.77
Nursing Facility Residents – Medicaid Only – 65+	1,335.68
Nursing Facility Residents – Dual Eligibles – Under 65	276.77
Nursing Facility Residents – Dual Eligibles – 65+	96.42
Community Residents – Medicaid Only – Under 65	3,068.24
Community Residents – Medicaid Only – 65+	1,547.31
Community Residents – Dual Eligibles – Under 65	1,245.48
Community Residents – Dual Eligibles – 65+	448.61
Developmentally Disabled Adults – Medicaid Only	828.65
Developmentally Disabled Adults – Dual Eligibles	250.04
Developmentally Disabled and IHS Children	1,243.43
Acquired Brain Disorder – Medicaid Only	1,453.36
Acquired Brain Disorder – Eligibles Dual	340.97
Behavioral Health Population Rate Cells	
Severe / Persistent Mental Illness – Medicaid Only	2,345.98
Severe / Persistent Mental Illness – Dual Eligibles	1,716.98
Severe Mental Illness – Medicaid Only	1,717.87
Severe Mental Illness – Dual Eligibles	1,031.39
Low Utilizer – Medicaid Only	1,427.57
Low Utilizer – Dual Eligibles	686.12
Serious Emotionally Disturbed Child	953.64

NH Health Protection Program, Transitional Population

Eligibility Category	Capitation Rate
Transitional Population	$510.62
Maternity Kick Payment	2,832.00

NH Health Protection Program, Medically Frail

Eligibility Category	Capitation Rate
Medically Frail	$1,007.86

January 1, 2019 – June 30, 2019

Medicaid Care Management

Base Population	Capitation Rate
Low Income Children and Adults - Age 0-11 Months	$221.91
Low Income Children and Adults - Age 1-18 Years	140.00
Low Income Children and Adults - Age 19+ Years	471.71
Foster Care / Adoption	379.36
Breast and Cervical Cancer Program	1,887.58
Severely Disabled Children	1,054.48
Elderly and Disabled Adults	1,099.84
Dual Eligibles	235.91
Newborn Kick Payment	2,931.19
Maternity Kick Payment	2,842.09
Neonatal Abstinence Syndrome Kick Payment	9,591.63
NF Resident and Waiver Rate Cell	
Nursing Facility Residents – Medicaid Only – Under 65	2,549.46
Nursing Facility Residents – Medicaid Only – 65+	1,338.46
Nursing Facility Residents – Dual Eligibles – Under 65	275.73
Nursing Facility Residents – Dual Eligibles – 65+	93.70
Community Residents – Medicaid Only – Under 65	3,190.23
Community Residents – Medicaid Only – 65+	1,585.40
Community Residents – Dual Eligibles – Under 65	1,245.37
Community Residents – Dual Eligibles – 65+	442.63
Developmentally Disabled Adults – Medicaid Only	853.68
Developmentally Disabled Adults – Dual Eligibles	252.14
Developmentally Disabled and IHS Children	1,281.80
Acquired Brain Disorder – Medicaid Only	1,509.30
Acquired Brain Disorder – Eligibles Dual	343.57
Behavioral Health Population Rate Cells	
Severe / Persistent Mental Illness – Medicaid Only	2,375.43
Severe / Persistent Mental Illness – Dual Eligibles	1,724.91
Severe Mental Illness – Medicaid Only	1,724.75
Severe Mental Illness – Dual Eligibles	1,039.57
Low Utilizer – Medicaid Only	1,460.97
Low Utilizer – Dual Eligibles	690.06
Serious Emotionally Disturbed Child	976.57

Granite Advantage Health Care Program

Eligibility Category	Capitation Rate
Medically Frail	$993.36
Non-Medically Frail	$423.21

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for State Fiscal Year 2019, to be served among all contracts is 1,788,648. Accordingly, the price limitation for SFY 2019 among all contracts is $803,103,161 based on the projected members per month.

3. Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement within 30 days following its review and acceptance of the Contractor's Adjusted Fee.

To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify GRANITE STATE HEALTH PLAN, INC. is a New Hampshire corporation registered on March 14, 2012. I further certify that articles of dissolution have not been filed with this office.

INFORMATION REGARDING ANNUAL REPORTS AND/OR FEES MUST BE OBTAINED FROM THE NEW HAMPSHIRE INSURANCE DEPARTMENT.

Business ID: 667495
Certificate Number : 0004101615

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 25th day of May A.D. 2018.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Keith H. Williamson, hereby certify that I am Secretary of the Granite State Health Plan, Inc., a New Hampshire corporation organized and existing under the laws of the State of New Hampshire (the "Corporation").

I further certify that Jennifer Weigand, President & CEO of the Corporation, is authorized to sign on behalf of the Corporation any and all agreements and execute any and all contracts, documents and instruments necessary to bind the Corporation.

I further certify that the authority given to the individual named above shall remain in full force and effect until this Certificate of Authority is amended by the Corporation.

IN WITNESS WHEREOF, I have subscribed my name as Secretary of the Corporation on this 7th day of December, 2018.

Keith H. Williamson, Secretary

State of Missouri

County of St. Louis

On this 7th day of December, 2018, before me, Rosemarie Bayes, the undersigned Notary Public, personally appeared Keith H. Williamson, personally known to me, to be the person whose name is subscribed to within the instrument, and acknowledged to me that he executed the same for the purposes therein stated.

Signature of Notary Public

ROSEMARIE BAYES
Notary Public - Notary Seal
STATE OF MISSOURI
St. Louis County
My Commission Expires: June 3, 2020
Commission # 12567879

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY): 05/24/2018

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 have ADDITIONAL INSURED provisions or 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	CONTACT NAME:	
Aon Risk Services Central, Inc. St. Louis MO Office 8182 Maryland Avenue St Louis MO 63105 USA	PHONE (A/C, No, Ext): (866) 283-7122	FAX (A/C, No): (800) 363-0105
	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	Zurich American Ins Co	16535
INSURER B:	American Zurich Ins Co	40142
INSURER C:	XL Specialty Insurance Co	37885
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
Granite State Health Plan
c/o Centene Corporation
7700 Forsyth Blvd.
Suite 600
St. Louis MO 63105 USA

COVERAGES CERTIFICATE NUMBER: 570071359178 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. Limits shown are as requested

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			GL0014909900	06/01/2018	06/01/2019	EACH OCCURRENCE	$1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$2,000,000
	POLICY PRO-JECT X LOC						PRODUCTS - COMP/OP AGG	$2,000,000
	OTHER:							
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	ANY AUTO						BODILY INJURY (Per person)	
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	
C	X UMBRELLA LIAB X OCCUR			US00068524LI18A SIR applies per policy terms & conditions	06/01/2018	06/01/2019	EACH OCCURRENCE	$5,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$5,000,000
	DED X RETENTION						Retention	$10,000
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			WC647833305	06/01/2018	06/01/2019	X PER STATUTE OTH-ER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? N N/A (Mandatory in NH)						E.L. EACH ACCIDENT	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-EA EMPLOYEE	$1,000,000
							E.L. DISEASE-POLICY LIMIT	$1,000,000

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

CERTIFICATE HOLDER

NH Department of Health and
Human Services
Attn: Jeffrey A. Meyers, Commissioner
Brown Building, 129 Pleasant Street
Concord NH 03301-3857 USA

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

Aon Risk Services Central Inc.

Holder Identifier :

Certificate No : 570071359178

CERTIFICATE OF PROPERTY INSURANCE

DATE (MM/DD/YYYY) 11/01/2017

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.

PRODUCER
Aon Risk Services Central, Inc.
St. Louis MO Office
8182 Maryland Avenue
St Louis MO 63105 USA

CONTACT NAME:
PHONE (A/C, No, Ext): (866) 283-7122 FAX (A/C, No): (800) 363-0105
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #: 10234228

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	National Fire & Marine Ins Co	20079
INSURER B:	Liberty Mutual Fire Ins Co	23035
INSURER C:	American Guarantee & Liability Ins Co	26247
INSURER D:	Lexington Insurance Company	19437
INSURER E:		
INSURER F:		

INSURED
Granite State Health Plan
c/o Centene Corporation
7700 Forsyth Blvd.
Suite 600
St. Louis MO 63105 USA

Holder Identifier :

COVERAGES CERTIFICATE NUMBER: 570069123950 REVISION NUMBER:

LOCATION OF PREMISES / DESCRIPTION OF PROPERTY (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

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	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	COVERED PROPERTY	LIMITS
A	X PROPERTY	42IHAP30442501	11/01/2017	06/01/2019	BUILDING	
C	CAUSES OF LOSS — DEDUCTIBLES	ERP106446500	11/01/2017	06/01/2019	PERSONAL PROPERTY	
O	BASIC — BUILDING	033313492	11/01/2017	06/01/2019	X BUSINESS INCOME	Included
B	BROAD — CONTENTS	MJ2L9L468094017	11/01/2017	06/01/2019	X EXTRA EXPENSE	$125,000,000
	SPECIAL				RENTAL VALUE	
	EARTHQUAKE				BLANKET BUILDING	
	WIND				BLANKET PERS PROP	
	FLOOD				X BLANKET BLDG & PP	$1,000,000
	X ALL RISK-Subject to Exclusions					
	X Blkt BAPP Ded $50,000					
	INLAND MARINE — CAUSES OF LOSS — NAMED PERILS	TYPE OF POLICY / POLICY NUMBER				
	CRIME — TYPE OF POLICY					
	BOILER & MACHINERY / EQUIPMENT BREAKDOWN					

SPECIAL CONDITIONS / OTHER COVERAGES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE NUMBER: 570069123950

CERTIFICATE HOLDER

NH Department of Health and
Human Services,
Attn: Nicholas A. Toumpas, Commissioner
Brown Building, 129 Pleasant Street
Concord NH 03301-3857 USA

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
Aon Risk Services Central Inc

State of New Hampshire
Department of Health and Human Services
Amendment #17 to the
Medicaid Care Management Contract

This 17th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment #17") dated this 3rd day of December, 2018, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Boston Medical Center Health Plan, Inc., (hereinafter referred to as "the Contractor"), a Massachusetts nonprofit corporation with a place of business at Schraffts Business Center, 529 Main Street, Charlestown, MA, 02129.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013 (Item #, 67A), Amendment #2 February 12, 2014 (Item #25), Amendment #3 April 9, 2014 (Item #44), Amendment #4 June 18, 2014 (Item #65A), Amendment #5 July 16, 2014(Late Item A), Amendment #6 December 23, 2014 (Item #11), Amendment #7 June 24, 2015 (Item #30), Amendment #8 August 5, 2015 (Tabled Item A), Amendment #9 December 16, 2015 (Late Item A3), Amendment #10 January 27, 2016 (Item #7B), Amendment #11 March 9, 2016 (Item #10A) Amendment #12 June 29, 2016 (Late Item A2), Amendment #13 October 5, 2016, (Item #12A), Amendment #14 June 21, 2017 (Tabled Item #18), Amendment #15 December 6, 2017 (Item #7B), and Amendment #16 June 6, 2018 (Item #6A), 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to modify the price limitation, modify the scope of services to support continued delivery of these services, and modify the capitation rates, 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 to amend as follows:

1. Form P-37, General Provisions, Block 1.8, Price Limitation to increase the Price Limitation by $147,676,924.60 from $3,557,921,400.41 to read: $3,705,598,325.01 for a cumulative contract value for all Medicaid Care Management contracts.
2. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:

   Nathan D. White, Director.
3. Form P-37, General Provisions, Block 1.10, State Agency Telephone Number, to read:

   603-271-9631.
4. Delete Exhibit A Amendment #14 in its entirety and replace with Exhibit A Amendment #15.
5. Delete Exhibit B Amendment #16 in its entirety and replace with Exhibit B Amendment #17.

SMC 12/5/18

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

12/7/18
Date

Name: Jeffrey A. Meyers
Title: Commissioner

Boston Medical Center Health Plan, Inc.

12.5.18
Date

Name: Susan Coakley
Title: President

Acknowledgement of Contractor's signature:

State of Massachusetts, County of Suffolk on 12-5-18, before the undersigned officer, personally appeared the person identified directly 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

Kim Graham, Mgr. of Corp. Adm.
Name and Title of Notary or Justice of the Peace

My Commission Expires: 3.11.22

SMC 12/5/18

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

OFFICE OF THE ATTORNEY GENERAL

12/19/2019
Date

Name: Nancy J. Smith
Title: Deputy Attorney General

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:

SMC 12/5/19

New Hampshire
Department of Health and Human Services

Medicaid Care Management Contract
Exhibit A - Amendment 15

Table of Contents

1. Introduction

1.1. Purpose

1.1.1. The purpose of this Agreement is to set forth the terms and conditions for the MCO's participation in the NH Medicaid Care Management Program.

1.2. Type of Agreement

1.2.1. This is a comprehensive full risk prepaid capitated contract. The MCO is responsible for the timely provision of all medically necessary services as defined under this Agreement. In the event the MCO incurs costs that exceed the capitation payments, the State of New Hampshire and its agencies are not responsible for those costs and will not provide additional payments to cover such costs.

1.3. Agreement Period

1.3.1. The Department of Health and Human Services (DHHS) and the MCO agree to extend this Agreement by 12 months to June 30, 2019 at which point this Agreement is targeted to end.

2. Glossary of Terms and Acronyms

Abuse

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. 455.2]

Administrative Review Committee

Applies appropriate risk management principles to ensure due diligence and oversight to protect the patient, community and hospital in treating high risk or high profile patients.

Acquired Brain Disorder (HCBC-ABD) Waiver

"Acquired Brain Disorder (HCBC-ABD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of services and supports to individuals age 22 years and older with traumatic brain injuries or neurological disorders who are financially eligible for Medicaid and medically qualify for institutional level of care provided with a need for specialized nursing care or specialized rehabilitation services. Covered services are identified in He-M 522.

Adequate Network of Providers

A network sufficient in numbers, types and geographic location of providers, as defined in the Agreement, to ensure that covered persons will have access to health care services without unreasonable delay.

Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of New Hampshire, relating to the provision of health care when an individual is incapacitated (42 CFR 438.6, 438.10, 422.128, and 489.100).

Agreement

"Agreement" means the entire written Agreement between DHHS and the MCO, including any Exhibits, documents, and materials incorporated by reference.

Agreement Period

Dates indicated in the P-37 of this Agreement.

Agreement Year

NH State Fiscal Year.

Appeal

"Appeal" means a request for review of an action as described in this Agreement (42 CFR 438.400(b)).

Auxiliary aids

"Auxiliary aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of programs or activities conducted by the MCO. Such aids shall include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Behavioral Health Crisis Treatment Center

"Behavioral Health Crisis Treatment Center" (BHCTC) means a treatment service center that provides 24/7 intensive, short term stabilization treatment services for individuals experiencing a mental health crisis, including those with co-occurring substance use disorder. The BHCTC accepts individuals for treatment on a voluntary basis who walk-in, are transported by first responders, or as a stepdown treatment site post emergency department visit or inpatient psychiatric treatment site. The BHCTC delivers an array of services to de-escalate and stabilize individuals at the intensity and for the duration necessary to quickly and successfully discharge, via specific after care plans, the individual back into the community or to a step-down treatment site.

Care coordination

"Care coordination" is the deliberate organization of patient care activities between two or more participants (including the individual) involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial, and long term services and supports. Organizing care involves the marshalling of personnel and other resources needed to carry out all required services and supports, and requires the exchange of information among participants responsible for different aspects of care. (42 CFR 438.208).

Effective care coordination includes the following:

- Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Employs evidence-based clinical practices;
- Coordinates care across health care settings and providers, including tracking referrals;
- Actively assists patients to take personal responsibility for their health care;
- Provides education regarding avoidance of inappropriate emergency room use;

- Emphasizes the importance of participating in health promotion activities; Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- Uses appropriate community resources to support individual patients, families and caregivers in coordinating care.
- Adheres to conflict of interest guidelines set forth by the health plan and contractor (State of NH)
- Ensures the patient is aware of all appeal and grievance processes including how to request a different care coordinator.
- Facilitates ready and consistent access to long term supports and services that are, to the extent possible, integrated with all other aspects of the member's health care.

Centers for Medicare and Medicaid Services (CMS)

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare program.

Children's Health Insurance Program

"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009.

Children with Special Health Care Needs

Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Choices for Independence (HCBC-CFI) Waiver

"Choices for Independence (HCBC-CFI) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities. This term is also known as home and community based care for the elderly and chronically ill (HCBC-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and covered services are identified in He-E 801.

Chronic Condition

"Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence and includes, but is not limited to: a mental health condition; a substance use disorder; asthma; diabetes; heart disease; or obesity, as evidenced by a body mass index over twenty-five.

Cold Call Marketing

"Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential member or a member with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

Communications Plan

"Communications Plan" means a written strategy for timely notification to DHHS regarding expected or unexpected interruptions or changes that impact MCO policy, practice, operations, members or providers. The Communications Plan shall define the purpose of the communication, the paths of communication, the responsible MCO party required to communicate, and the time line and evaluation of effectiveness of MCO messaging to DHHS and to affected parties. The Communications Plan shall also provide for the MCO to communicate with DHHS and respond to correspondence received from DHHS within one (1) business day on emergent issues and five (5) business days on non-emergent issues.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under federal or state law. Confidential Information includes, but is not limited to, Personal Information.

Conflict Free Care Coordination

"Conflict Free Care Coordination" separates clinical or non-financial eligibility determination from direct service provision. Care Coordinators and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual, their paid caregivers or to anyone financially responsible for the individual; robust monitoring and oversight are in place to promote consumer-direction and beneficiaries are clearly informed about their right to appeal or submit a grievance decisions about plans of care, eligibility determination and service delivery. State level oversight is provided to measure the quality of care coordination services and to ensure meaningful stakeholder engagement. In circumstances when one entity is responsible for providing care coordination and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

Conflict Free Care Management

(see Care Coordination)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

"Consumer Assessment of Healthcare Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey used to measure member experience of health care.

Consumer Direction

"Consumer Direction", also known as participant direction or self-direction, means a service arrangement whereby the individual or representative, if applicable, directs the services and makes the decisions about how the funds available for the individual's services are to be spent. It includes assistance and resources available to individuals in order to maintain or improve their skills and experiences in living, working, socializing, and recreating.

Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through member transitions between: facilities and home; facilities; providers; service areas; managed care contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.

Contracted Services

"Contracted Services" means covered services that are to be provided by the MCO under the terms of this Agreement.

Covered Services

"Covered Services" means health care services as defined by DHHS and State and Federal regulation.

Debarment

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Developmental Disabilities (HCBC-DD) waiver

"Developmental Disabilities (HCBC-DD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports in non-institutional settings to individuals of any age with mental retardation and/or developmental disabilities who are financially eligible for Medicaid and medically qualify for institutional level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Division for Children, Youth & Families (DCYF) Services

"Division of Children, Youth & Families (DCYF) Services" means community based services and residential treatment services as indicated in Section 8.2 Covered Services Matrix as DCYF..

Early, Periodic Screening, Diagnostic and Treatment (EPSDT)

"EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of services in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r), 42 CFR 441.50, and DHHS EPSDT program policy and billing instructions. Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The MCO shall be responsible for all services found to be medically necessary services during the EPSDT exam.

Eligible Members

"Eligible Members" means individuals determined eligible by DHHS and eligible to enroll for health care services under the terms of this Agreement.

Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

Emergency Services

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

Equal Access

"Equal Access" means Steps 1 and 2, and NHHPP members having the same access to providers and services for those services common to both populations.

Execution Date

Date Agreement approved by Governor and Executive Council.

External Quality Review (EQR)

"External Quality Review (EQR" means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the MCO or its subcontractors furnish to members (42 CFR 438.320).

External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358.

Fraud

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 C.F.R. 455.2]

Granite Advantage Health Care Program

"Granite Advantage Health Care Program" means the program for coverage of the newly eligible adult population that replaces the New Hampshire Health Protection Program beginning on January 1, 2019 as established in Senate Bill 313, 2018 NH Laws Chap. 342.

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights (42 CFR 438.400(b)).

Grievance Process

"Grievance Process" means the procedure for addressing member grievances (42 CFR 438.400(b)).

Grievance System

"Grievance System" means the overall system that includes grievances and appeals handled by the MCO and access to the State fair hearings (42 CFR 438, Subpart F).

Healthcare Effectiveness Data and Information Set (HEDIS)

"Healthcare Effectiveness Data and Information Set (HEDIS)" means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes a standardized survey of members' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

Health Home

"Health Home" means coordinated health care provided to members with special health care needs. At minimum, health home services include:

- Comprehensive care coordination including, but not limited to, chronic disease management;

- Self-management support for the member, including parents of caregivers or parents of children and youth;
- Care coordination and health promotion;
- Multiple ways for the member to communicate with the team, including electronically and by phone;
- Education of the member and his or her parent or caregiver on self-care, prevention, and health promotion, including the use of patient decision aids;
- Member and family support including authorized representatives;
- The use of information technology to link services, track tests, generate patient registries and provide clinical data;
- Linkages to community and social support services;
- Comprehensive transitional health care including follow-up from inpatient to other settings;
- A single care plan that includes all member's treatment and self-management goals and interventions ; and
- Ongoing performance reporting and quality improvement.

Home and Community Based Care (HCBC)

"Home and Community Based Care (HCBC)", also known as Home and Community Based Services (HCBS), means the waiver of sections 1902 (a) (10) and 1915 (c) of the Social Security Act which allows the federal Medicaid funding of long term services and supports in non-institutional settings for individuals who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility. This includes services provided under the Choices for Independence Waiver (HCBC-CFI) waiver program, Developmental Disabilities (HCBC-DD) waiver program, Acquired Brain Disorders (HCBC-ABD) waiver program, and In Home Supports (HCBC-IHS) waiver program.

Implementation Period

"Implementation Period" means each period of time prior to Program Start Date for the following segments: Step 1, NHHPP, SUD Phases 1, 2 and 3, and Step 2 Phase 1.

Implementation Plan

"Implementation Plan" means a proposed and agreed upon written and detailed listing of all objectives, tasks, activities, time allocation, deliverables, dependencies and responsible parties required to design, develop and implement the steps and phases of the Care Management Program. The Implementation Plan(s) shall include documentation of approvals as well as document change history.

In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver

"In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to families with children diagnosed with autism and other developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization. Covered services are identified in He-M524.

Long Term Services and Supports (LTSS)

"Long Term Services and Supports (LTSS)" means nursing facility services, all four of New Hampshire's Home and Community Based Care Waivers, and services provided to children and families through the Division for Children, Youth & Families.

Managed Care Organization (MCO)

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible DHHS members under the DHHS Care Management Program.

Marketing

"Marketing" means any communication from the MCO to a potential member or member with another DHHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the MCO or to either not enroll or end enrollment with another DHHS contracted MCO (42 CFR 438.104(a)).

Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).

Medically Frail

"Medically frail" means a member who identifies as having a physical, mental, or emotional health condition that causes limitations in activities (e.g. bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Medically Necessary Services

"Medically Necessary Services" means services that are "medically necessary" as is defined in Section 23.2.2.

Member

"Member" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having an Agreement with DHHS (42 CFR 438.10(a)).

Member Handbook

"Member Handbook" means the handbook published by the Managed Care Organization (MCO) which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Member participation in Medicaid Managed Care and which means all informing requirements as set forth in 42 CFR 438.10.

Mental Health Court

A "Mental Health Court" is a specialized court docket for certain defendants with mental illnesses that substitutes a problem solving model for traditional criminal court processing.

National Committee for Quality Assurance (NCQA)

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

Necessary Services

"Necessary Services" means services to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term service and support.

New Hampshire Community Passport (NHCP) Program or Money Follows the Person (MFP) Demonstration

"Money Follows the Person (MFP)" means a federal demonstration that assists individuals residing in nursing institutions who meet CMS eligibility requirements find suitable healthcare programs to support them in the community and then assists them to transition from nursing institution care to community care. The program's intent is to help strengthen and improve community based systems of long term care for low-income seniors and individuals with disabilities. "New Hampshire Community Passport (NHCP) Program" means the MFP program specific to New Hampshire.

New Hampshire Health Protection Program (NHHPP)

Coverage provided through the MCOs for individuals newly eligible for Medicaid based the new income levels established in Senate Bill 413, Chapter 3, Laws of 2014; provided, however, that on and after January 1, 2016, coverage under this program shall be limited to said individuals who are Medically Frail and who choose to participate in the New Hampshire Health Protection Program and those MCO members who transition from an eligibility category other than the New Hampshire Health Protection Program who have not yet begun their coverage in the Premium Assistance Program.

New Member

"New Member" means a member transferring from FFS to an MCO, or transferring from another MCO.

Non-Participating Provider

"Non-Participating Provider" means a person, health care provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with the MCO to participate in a managed care organization's provider network, but provides health care services to members.

Participating Provider

"Participating Provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice and licensure, and who is under a written contract with the MCO to provide services to members under the terms of this Agreement.

Payment Reform Plan

"Payment Reform Plan" means an MCO's plan to engage its provider network in health care delivery and payment reform activities such as pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements, and shall contain information on the anticipated impact on member health outcomes, providers affected.

Physician Group

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Provider Incentive Plan

"Provider Incentive Plan" means any compensation arrangement between the MCO and a provider or provider group that may directly or indirectly improve the delivery of healthcare services as directed by a provider under the terms of this Agreement.

Program Management Plan

"Program Management Plan" means a proposed and agreed upon written detailed plan that includes a framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program as provided for in the Agreement. Includes documentation of approvals as well as document change history.

Program Start Date

Each date when MCO is responsible for coverage of services to its members with respect to the steps and phases of the Medicaid Care Management program.

Post-stabilization Services

"Post-stabilization Services" means contracted services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition (42 CFR 438.114 and 422.113).

Primary Care Provider (PCP)

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Agreement.

Provider

"Provider " means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Referral Provider

"Referral Provider" means a provider, who is not the member's PCP, to whom a member is referred for covered services

Regulation

"Regulation" means any federal, state, or local regulation, rule, or ordinance.

Risk

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a provider incentive plan, as defined herein.

Special Needs

Special Needs include chronic physical, developmental, behavioral or emotional conditions or adverse social circumstances resulting in need for help with related services of a type or amount beyond that required by members generally. Members with Special Needs include both Children and Adults.

Start Date of the Program

Date initial member enrollment begins.

Start of Program

Date initial member enrollment begins.

State

"State" or "state" means the State of New Hampshire

Step 1

Services as indicated in Section 8.2 Covered Services Matrix as Step 1.

Step 2

Services as indicated in Section 8.1 Covered Populations Matrix and Section 8.2 Covered Services Matrix as Step 2.

Subcontract

"Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") which relates directly or indirectly to the performance of all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

Substance Use Disorder

"Substance Use Disorder" is marked by a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. The cluster of symptoms includes tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substance or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol, tobacco and/or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use; craving or strong desire to use. Specific diagnostic criteria are specified in "Substance-Related and Addictive Disorders", in the Diagnostic and Statistical Manual of Disorders, 5th Edition, American Psychiatric Association, 2013.

Willing Provider

"Willing Provider" is a provider credentialed according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's provider agreement, including rates, and policy manual.

2.1. Acronyms

Unless otherwise indicated acronyms used in this Agreement are as follows:

Acronym	Description
ABD	Acquired Brain Disorders Waiver

Acronym	Description
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ANB	Aid to the Needy Blind
ANSA	Adult Needs and Strengths
APTD	Aid to the Permanently and Totally Disabled
ASC	Accredited Standards Committee
ASL	American Sign Language
BCCP	Breast and Cervical Cancer Program
BMH	Bureau of Mental Health
CAD	Coronary Artery Disease
CANS	Child and Adolescent Needs and Strengths Assessment
CDC	Centers for Disease Control and Prevention
CFI	Choices for Independence Waiver
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CLA	Community Living Assessment
CLAS	Cultural and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
DCYF	Division of Children, Youth & Families
DD	Developmental Disabilities Waiver
DHHS	Department of Health and Human Services (New Hampshire)
DOB	Date of Birth

Acronym	Description
DME	Durable Medical Equipment
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospitals
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EST	Eastern Standard Time
ETL	Extract Transformation Load
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HC-CSD	Home Care for Children with Severe Disabilities
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ICF	Intermediate Care Facility
IHS	In Home Supports for Children with Developmental Disabilities Waiver
IME	Indirect Medical Education
LTSS	Long term services and supports
MCO	Managed Care Organization
MCIS	Managed Care Information System
MFP	Money Follows the Person Program
MIC	Medicaid Integrity Contractor
MEAD	Medicaid for Employed Adults with Disabilities
MMIS	Medicaid Management Information System
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NHCP	New Hampshire Community Passport Program

Acronym	Description
NF	Nursing Facility
NHHPP	New Hampshire Health Protection Program
NHID	New Hampshire Insurance Department
NPI	National Provider Identifier
OAA	Old Age Assistance
OBRA	Omnibus Budget Reconciliation Act
PBM	Pharmacy Benefit Management
PCP	Primary Care Provider
PE	Presumptive Eligibility
PIN	Personal Identification Number
POA	Present on Admission
QAPI	Quality Assessment and Performance Improvement
QIP	Quality Incentive Program
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
RAC	Recovery Audit Contractors
RBC	Risk-Based Capital
RFP	Request for Proposal
RHC	Rural Health Center
RIMP	Risk Identification Mitigation Plan
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse and Mental Health Services Administration
SLMB	Special Low-Income Medicare Beneficiaries
SLRC	ServiceLink Resource Center network under the New Hampshire Aging and Disability Resource Center model
SNF	Skilled Nursing Facility
SSA	Social Security Act

Acronym	Description
SSI	Supplemental Security Income
SSAE	Statement on Standards for Attestation Engagements
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TQM	Total Quality Management
USC	United States Code
VA	Veteran's Administration

3. General Terms and Conditions

3.1. Agreement Elements

The Agreement between the parties shall consist of the following:

3.1.1. P-37 Agreement General Provisions.

3.1.2. 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 MCO.

3.1.3. Exhibit B – Capitation Rates.

3.1.4. Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS that must be adhered to in addition to those outlined in the P-37.

3.1.5. Exhibit D – Certification Regarding Drug Free Workplace Requirements – MCO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988.

3.1.6. Exhibit E – Certification Regarding Lobbying – MCO's Agreement to comply with specified lobbying restrictions.

3.1.7. 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.

3.1.8. Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – MCO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act.

3.1.9. Exhibit H – Certification Regarding Environmental Tobacco Smoke – MCO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities.

3.1.10. Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the MCO in reference to the Health Insurance Portability and Accountability Act.

3.1.11. Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.

3.1.12. Exhibit K – MCO's Program Management Plan approved by DHHS in accordance with Section 7.4 of this Agreement.

3.1.13. Exhibit L – MCO's Implementation Plan approved by DHHS in accordance with Sections 7.6-7.8 of this Agreement.

3.1.14. Exhibit M – MCO's RFP (#12-DHHS-CM-01) Technical Proposal, including any addenda, submitted by the MCO.

3.1.15. Exhibit N – Encounter Data.

3.1.16. Exhibit O –Quality and Oversight Reporting.

3.1.17. Exhibit P – Substance Use Disorder (SUD) Services.

3.2. Order of Documents.

In the event of any conflict or contradiction between or among the Agreement documents, the documents shall control in the above order of precedence.

3.3. 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 unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS and NHID.

3.4. Authority of the New Hampshire Insurance Department

Wherever, by any provision of this Agreement or by the laws and rules of the State of New Hampshire the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a Managed Care Organization in the State of New Hampshire.

3.5. Errors & Omissions

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

3.6. Time of the Essence

In consideration of the need to ensure uninterrupted and continuous Medicaid Managed Care services, time is of the essence in the performance of the Scope of Work under the Agreement.

3.7. CMS Approval of Agreement & Any Amendments

3.7.1. This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to the prior approval of the Centers for Medicare and Medicaid Services ("CMS."). Notwithstanding any other provision of this Agreement, DHHS agrees that enrollment for any step or phase will not commence until DHHS has received required CMS approval.

3.7.2. At the time of this Amendment, the application of the State of New Hampshire under section 1115(a)(2) of the Social Security Act to replace the New Hampshire Health Protection Program with the Granite Advantage Health Care Program for the coverage of the newly eligible adult population by the MCO beginning on January 1, 2019 for the six month period ending on June 30, 2019 is currently pending with CMS. Upon the granting of the State's waiver, the special terms and conditions of the Granite Advantage Health Care Program shall replace the existing waiver approval entitled "New Hampshire Health Program Premium Assistance" (Project Number 11-W-00298/1) in all respects and the amended waiver shall apply as any other waiver under Section 28.1.3.12 of this Agreement.

3.8. Cooperation with Other Vendors and Prospective Vendors

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. The MCO 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.

3.9. Renegotiation and Reprocurement Rights

3.9.1. Renegotiation of Agreement Terms

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

3.9.2. Reprocurement of the Services or Procurement of Additional Services

3.9.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO'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 MCO under the Agreement. DHHS shall give the MCO ninety (90) calendar days notice of intent to replace another MCO participating in the Medicaid Managed Care program or to add an additional MCO to the Medicaid Managed Care program.

3.9.3. Termination Rights Upon Reprocurement.

3.9.3.1. 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, the MCO shall have the rights and responsibilities set forth in Section 32 ("Termination"), Section 33 ("Agreement Closeout") and Section 35 ("Dispute Resolution Process").

4. Organization

4.1. Organization Requirements

4.1.1. Registrations and Licenses

The MCO shall be licensed by the New Hampshire Department of Insurance to operate as an Managed Care Organization in the State as required by New Hampshire RSA 420-B, and shall have all necessary registrations and licensures as required by the New Hampshire Insurance Department and any relevant federal and state laws and regulations. An MCO must be in compliance with the requirements of this section in order to participate in any Steps and Phases of the Medicaid Care Management program.

4.2. Articles & Bylaws

4.2.1. The MCO shall provide by the beginning of each Agreement year or at the time of any substantive changes written assurance from MCO's legal counsel that the MCO 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.

4.3. Relationships

4.3.1. Ownership and Control

4.3.1.1. The MCO shall notify DHHS of any person or corporation that has five percent (5%) or more ownership or controlling interest in the MCO, parent organization, subcontractors, and/or affiliates and shall provide

a. financial statements;

b. Date of Birth in the case of an individual;

c. Social Security numbers in the case of an individual; and

d. In the case of corporations primary business address, every business location, P.O. Box address, and tax identification number 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]. The MCO shall certify by its Chief Executive Officer that this information provided to DHHS is accurate to the best of the officer's information, knowledge, and belief [42 CFR 438.606].

4.3.1.2. The MCO shall inform DHHS and the New Hampshire Insurance Department (NHID) of its intent for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of the action.

4.3.1.3. The MCO shall inform key DHHS and NHID staff by phone and by email within one business day of when any key MCO staff learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement with DHHS.

4.3.2. Prohibited

4.3.2.1. The MCO shall not knowingly have a relationship with the following:

4.3.2.1.1. 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

4.3.2.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 4.3.2.1.

4.3.2.1.3. An individual is described as follows:

a. A director, officer, or partner of the MCO;

b. A subcontractor of the MCO;

c. A person with beneficial ownership of five percent (5%) or more of the MCO's equity; or

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

4.3.3. The MCO shall retain any data, information, and documentation regarding the above described relationships for a period no less than 10 years [42 CFR 438.3(u)].

4.3.4. The MCO shall conduct background checks on all employees actively engaged in the Care Management Program. 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.

4.3.5. The MCO shall not and shall certify it does not employ or contract, directly or indirectly, with:

4.3.5.1. 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;

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

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

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

4.3.5.5. 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.

5. Subcontractors

5.1. MCO Obligations

5.1.1. The MCO remains fully responsible for the obligations, services and functions performed by its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by MCO employees, and for the purposes of this Agreement such work will be deemed performed by the MCO. DHHS reserves 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 or use of a subcontractor.

5.1.2. The MCO shall provide written policies for all employees and subcontractors describing in detail the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the SSA including information about rights of employees to be protected as whistleblowers.

5.1.3. The MCO regardless of its written agreements with any subcontractors maintains ultimate responsibility for complying with this Agreement.

5.1.4. The MCO shall inform all subcontractors at the time of entering into an agreement with the MCO about the grievance and appeal system as described in 42 CFR 438.10(g).

5.1.5. The MCO shall have a written agreement between the MCO and each subcontractor in which the subcontractor:

5.1.5.1. Agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and MCO contract provisions;

5.1.5.2. Agrees to hold harmless DHHS and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO;

5.1.5.3. Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors;[

5.1.5.4. Agrees that the State, CMS, the HHS Inspector General, or their designees shall have the right to audit, evaluate, and inspect any premises, physical facilities, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO Managed Care activities;

5.1.5.5. Agrees that it can be audited for ten years from the final date of the contract period or from the date of any completed audit, whichever is later; and

5.1.5.6. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk [42 CFR 438.230].

5.1.4 The MCO shall notify DHHS in writing within 10 business days if a subcontractor is cited for corrective action by any federal or state regulatory authority.

5.2. Notice and Approval

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

5.2.2. The MCO 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.

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

5.2.4. DHHS may grant a written exception to the notice requirements of 5.2.1 and 5.2.2 if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period or deems that the subcontractor is not a material subcontractor.

5.2.5. The MCO shall notify DHHS within twenty four (24) hours after receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

5.2.6. The MCO shall notify DHHS of any material breach of an agreement between the MCO and the subcontractor within twenty four (24) hours of validation that such breach has occurred.

5.3. MCO's Oversight

5.3.1. The MCO shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor in accordance with 42 CFR 438.230 and SMM 2087.4, including:

5.3.1.1.The MCO shall have a written agreement between the MCO and the subcontractor that specifies the activities and responsibilities delegated to the subcontractor and its transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's

performance is inadequate as determined by the MCO or NH DHHS. In such written agreement, the subcontractor shall also agree to perform the delegated activity and related reporting responsibilities as specified in the subcontractor agreement and the applicable responsibilities in this Agreement.

5.3.1.2. All subcontracts related to any aspect of the MCO Managed Care activities shall fulfill the applicable requirements of 42 CFR Part 438 for those responsibilities delegated to the subcontractor.

5.3.1.3. The MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

5.3.1.4. The MCO shall monitor the subcontractor's performance on an ongoing basis consistent with industry standards and State and Federal laws and regulations.

5.3.1.5. The MCO shall audit the subcontractor's care systems at least annually and when there is a substantial change in the scope or terms of the subcontract agreement.

5.3.1.6. The MCO shall identify deficiencies or areas for improvement, if any, with respect to which the MCO and the subcontractor shall take corrective action.

5.3.1.7. The MCO shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the Agreement between the MCO and DHHS.

5.3.1.8. If the MCO identifies deficiencies or areas for improvement are identified, the MCO shall notify DHHS and take corrective action within seven (7) calendar days of identification. The MCO shall provide DHHS with a copy of the Corrective Action Plan, which is subject to DHHS approval.

5.4. Transition Plan

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

6. Staffing

6.1. Key Personnel

6.1.1. The MCO shall commit key personnel to the New Hampshire Care Management program on a full-time basis. Positions considered to be key personnel are listed below, along with any specific requirements for each position:

6.1.1.1. Executive Director: Individual has clear authority over the general administration and day-to-day business activities of this Agreement.

6.1.1.2. Finance Officer: Individual is responsible for accounting and finance operations, including all audit activities.

6.1.1.3. Medical Director: Physician licensed by the NH Board of Medicine shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health). The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

6.1.1.4. The MCO will also have a physician available to the New Hampshire Care Management program with experience in the diagnosis and treatment of SUD.

6.1.1.5. Quality Improvement Director: Individual is responsible for all Quality Assessment and Performance Improvement (QAPI) program activities. This person shall be a licensed clinician with relevant experience in quality management for physical and/or behavioral healthcare.

6.1.1.6. Coordinators for the following five (5) functional areas shall be responsible for overseeing care coordination activities for MCO members with complex medical, behavioral health, developmental disability and long term care needs. They shall also serve as liaisons to DHHS staff for their respective functional areas:

6.1.1.6.1. Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

6.1.1.6.2. Behavioral Health Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within community mental health services.

6.1.1.6.3. Developmental Disabilities Coordinator: The individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

6.1.1.6.4. Substance Use Disorder Coordinator: The individual will have a minimum of a Master's Degree in a SUD related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to substance use disorders.

6.1.1.6.5. Long Term Services and Supports Coordinator: The individual will have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a LTSS related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care.

6.1.1.7. Network Management Director: Individual is responsible for development and maintenance of the MCO's provider network.

6.1.1.8. Member Services Manager: Individual is responsible for provision of all MCO member-services activities. The manager shall have prior experience with Medicaid or Medicare populations.

6.1.1.9.Utilization Management (UM) Director: Individual is responsible for all UM activities. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services and Necessary Services.

6.1.1.10.Systems Director/Manager: Individual is responsible for all MCO information systems supporting this Agreement including, but not limited to, continuity and integrity of operations, continuity flow of records with DHHS' information systems and providing necessary and timely reports to DHHS.

6.1.1.11.Claims/Encounter Manager: Individual is responsible for and is qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

6.1.1.12.Grievance Coordinator: Individual is responsible for overseeing the MCO's Grievance System.

6.1.1.13.Fraud, Waste, and Abuse Coordinator: Individual is responsible for tracking, reviewing, monitoring, and reducing fraud, waste, and abuse.

6.1.1.14.Compliance Officer: Individual is responsible for MCO's compliance with the provisions of this Agreement and all applicable state and federal regulations and statutes.

6.1.2. The MCO shall have an on-site presence in New Hampshire. The following key personnel shall be located in New Hampshire:

6.1.2.1.Executive Director

6.1.2.2.Medical Director

6.1.2.3.Quality Improvement Director

6.1.2.4.Special Needs Coordinator

6.1.2.5.Behavioral Health Coordinator

6.1.2.6.Developmental Disabilities Coordinator

6.1.2.7.Long Term Services and Supports Coordinator

6.1.2.8.Network Management Director

6.1.2.9.Fraud, Waste, and Abuse Coordinator

6.1.2.10.Grievance Coordinator

6.1.2.11.Substance Use Disorder Coordinator

6.1.2.12.Claim Encounter Manager

6.1.2.13.Provider Relations Manager

6.1.3. The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) days prior to start of program.

6.1.4. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.

6.1.5. DHHS may grant a written exception to the notice requirements of this Section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

6.2. General Staffing Provisions

6.2.1. The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 34.

6.2.2. The MCO shall ensure that all staff have appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

6.2.3. All key staff shall be available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

6.2.4. The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in New Hampshire with DHHS.

6.2.5. The MCO shall notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

6.2.6. If a member of the MCO's key staff is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit proposed alternate staff to DHHS for review and approval, which approval shall not be unreasonably withheld.

6.3. Staffing Contingency Plan

6.3.1. The MCO shall, deliver to DHHS a Staffing Contingency Plan within thirty (30) calendar days of signing this Agreement and after any substantive changes to the Staffing Contingency Plan. The Plan shall include but is not limited to:

6.3.1.1. The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the Agreement;

6.3.1.2. Allocation of additional resources to the Agreement in the event of inability to meet any performance standard;

6.3.1.3. Replacement of key personnel with staff with similar qualifications and experience;

6.3.1.4. Discussion of time frames necessary for obtaining replacements;

6.3.1.5. MCO's capabilities to provide, in a timely manner, replacements/additions with comparable experience; and

6.3.1.6. The method of bringing replacements/additions up-to-date regarding this Agreement.

7. Program Management and Planning

7.1. General

7.1.1. The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to members enrolled in the New Hampshire Medicaid Program and provide for all aspects of managing such program, including claims processing and operational reports. The MCO shall establish and demonstrate audit trails for all claims processing and financial reporting carried out by the MCO's staff, system, or designated agents.

7.2. Representation and Warranties

7.2.1. The MCO warrants that all Managed Care 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.

7.2.2. The MCO acknowledges that in entering this Agreement, DHHS has relied upon representations made by the MCO in its RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda, with respect to delivery of Managed Care. In reviewing and approving the program management and planning requirements of this Section, DHHS reserves the right to require the MCO to develop plans that are substantially and materially consistent with the representations made in the MCO's RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda.

7.3. Audit Requirements

7.3.1. No later than forty (40) business days after the end of the State Fiscal Year each June 30, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period. DHHS will share the report with internal and external auditors of the State of New Hampshire and federal oversight agencies. The SSAE 16 Type 2 report shall include:

7.3.1.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period.

7.3.1.2. Written assertion by the MCO's management about whether:

7.3.1.2.1. The aforementioned description fairly presents the system in all material respects;

7.3.1.2.2. The controls were suitably designed to achieve the control objectives stated in that description; and

7.3.1.2.3. The controls operated effectively throughout the specified period to achieve those control objectives.

7.3.1.3. Report of the MCO's auditor, which:

7.3.1.3.1. Expresses an opinion on the matters covered in management's written assertion; and

7.3.1.3.2. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

7.3.2. The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO. If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

7.3.3. The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

7.3.4. DHHS, CMS, the Office of the Inspector General, the Comptroller General, and their designees have the right to inspect and audit any records of the MCO, or its subcontractors and conduct on-site reviews of the MCO's operations at the MCO's expense. These on-site visits may be unannounced. The MCO shall fully cooperate with DHHS' on-site reviews. This right exists for ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

7.3.5. DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing Corrective Action Plans and review MCO compliance with requirements and standards as specified in this Agreement.

7.3.6. The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.

7.4. Program Management and Communications Plans

7.4.1. The MCO shall submit a Program Management Plan (PMP) to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Annually, thereafter, the MCO shall submit an updated PMP to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.4.1.1. The PMP shall elaborate on the general concepts outlined in the MCO's proposal and the section headings of Exhibit A;

7.4.1.2. The PMP shall describe how the MCO will operate in New Hampshire by outlining management processes such as communications, workflow, overall systems as detailed in the section headings of Exhibit A, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to member and provider experiences; and

7.4.1.3. The PMP shall outline the MCO integrated organizational structure including New Hampshire-based resources and its support from corporate, subcontractors, and workgroups or committees.

7.4.1.4. The MCO shall submit a Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the scheduled start date of the program. Thereafter, the MCO shall submit an updated Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5. Emergency Response Plan

7.5.1. The MCO shall submit an Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Thereafter, the MCO shall submit an updated Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5.2. The plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

7.5.2.1. Employee training;

7.5.2.2. Essential business functions and key employees within the organization necessary to carry them out;

7.5.2.3. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; and

7.5.2.4. Communication with staff, members, providers, subcontractors and suppliers when normal systems are unavailable;

7.5.2.5. Plans to ensure continuity of services to providers and members;

7.5.2.6. How the MCO will coordinate with and support DHHS and the other MCOs; and

7.5.2.7.How the plan will be tested, updated and maintained.

7.6. Step 1 Program Implementation Plan

7.6.1. Submission and Contents of the Plan

7.6.1.1.The MCO shall submit a "Step 1 Program Implementation Plan" (Step 1 Implementation Plan) to DHHS for review and approval no later than fourteen (14) calendar days after the signing of this Agreement. The Step 1 Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for implementation of the Plan:

7.6.1.1.1. Provider credentialing/contracting;

7.6.1.1.2. Provider payments;

7.6.1.1.3. Member Services;

7.6.1.1.4. Member Enrollment;

7.6.1.1.5. Pharmacy Management;

7.6.1.1.6. Care Coordination;

7.6.1.1.7. Utilization Management;

7.6.1.1.8. Grievance System;

7.6.1.1.9. Fraud, Waste, and Abuse;

7.6.1.1.10. Third-Party Liability;

7.6.1.1.11. MCIS ;

7.6.1.1.12. Financial management; and

7.6.1.1.13. Provider and member communications.

7.6.1.2.The Step 1 Program Implementation Plan shall become an addendum to this Agreement as Exhibit L.

7.6.2. Implementation

7.6.2.1.Upon approval of the Step 1 Implementation Plan, the MCO shall implement the Plan as approved covering the Step 1 populations and services identified in Sections 8.1 and 8.2 of this Agreement.

7.6.2.2.The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.6.2.3.The MCO must obtain prior written approval from DHHS for any changes or deviations from the submitted and approved Plan.

7.6.2.4. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.6.2.4.1. Progress on Step 1 Implementation Plan;

7.6.2.4.2. Risks/Issues and mitigation strategy;

7.6.2.4.3. Modifications to the Step 1 Implementation Plan;

7.6.2.4.4. Progress on any Corrective Action Plans;

7.6.2.4.5. Program delays; and

7.6.2.4.6. Upcoming activities.

7.6.2.5. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.6.3. Readiness Reviews

7.6.3.1. DHHS intends to conduct two (2) readiness reviews of the MCO during the implementation phase prior to the Program Start Date. The first review shall take place thirty (30) days after contract effective date or scheduled after DHHS has verified that at least two MCOs have satisfied the DHHS Substantial Provider Network reporting requirements, whichever comes later, and will take place ninety(90) calendar days prior to the Program Start Date. The second review shall take place thirty (30) calendar days prior to the Program Start Date. The MCO shall fully cooperate with DHHS during these readiness reviews. During the readiness reviews, DHHS shall assess the MCO's progress towards a successful program implementation through regular reporting activities. The review shall include validation of readiness in multiple areas, including but not limited to:

7.6.3.1.1. MCO's ability to pay a claim;

7.6.3.1.2. MCO's network adequacy;

7.6.3.1.3. MCO's member transition plan;

7.6.3.1.4. MCO's system preparedness;

7.6.3.1.5. MCO's member experience procedures;

7.6.3.1.6. Grievance System; and

7.6.3.1.7. MCO subcontracts.

7.6.3.2. DHHS may adjust the timing, number and requirements of Readiness Reviews at its sole discretion.

7.6.3.3. Should the MCO fail to pass either readiness review, the MCO shall submit a Corrective Action Plan to DHHS sufficient to ensure the MCO passes the readiness review and shall complete implementation on schedule. This Corrective Action Plan shall be integrated into the overall program Step 1 Implementation Plan as a modification subject to review and approval by DHHS. DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified and/or apply liquidated damages as provided in Section 34.

7.6.3.4. During the first one hundred and eighty (180) days following the effective date of this Agreement or within ninety (90) days prior to the Program Start Date, whichever comes later, DHHS may give tentative approval of the MCO's required policies and procedures.

7.6.3.5. DHHS may at its discretion suspend application of the remedies specified in Section 34, except for those required under 42 CFR 700 and Section 1903(m) or Section 1932 of the Social Security Act, provided that the MCO is in compliance with any Corrective Action Plans developed during the readiness period, unless the MCO fails to meet the start date of the NH Medicaid Care Management program.

7.6.3.6. The start date of the Medicaid Care Management program shall be when at least two MCOs have met the readiness requirements 7.6.3.1.

7.7. Step 2 Program Implementation Plans

7.7.1. Implementation of Step 2 will take place as follows:

7.7.1.1. Phase 1. Mandatory Enrollment populations indicated in Section 8.1 – Program Start Date February 1, 2016.

7.8. NHHPP Program Implementation Plan

7.8.1. Submission and Contents of the NHHPP Implementation Plan

7.8.1.1. The MCO shall submit a NHHPP Implementation Plan to DHHS for review and approval no later than fourteen days (14) calendar days after signing the related contract amendment. The Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for the implementation of the Plans:

7.8.1.1.1. Provider credentialing/contracting for SUD and chiropractic providers;

7.8.1.1.2. Provider agreements and or amendments for services provided to NHHPP members;

7.8.1.1.3. Paying NHHPP providers according to the methodology prescribed by DHHS Section 21.2.10.4;

7.8.1.1.4. Sufficient provider capacity to serve NHHPP population without compromising access for Step 1 members;

7.8.1.1.5. Production of new Member handbooks or updates to reflect the differences for the NHHPP plan members;

7.8.1.1.6. Implementation of a process by which to reduce inappropriate emergency room utilization;

7.8.1.1.7. Implementation of new member co-payments and cost sharing as required in Medicaid Care Management; and

7.8.1.1.8. Call center training for NHHPP related inquiries.

7.8.2. NHHPP Implementation

7.8.2.1. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.8.2.2. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.8.2.2.1. Progress on NHHPP Implementation Plan;

7.8.2.2.2. Risks/Issues and mitigation strategy;

7.8.2.2.3. Modifications to the NHHPP Implementation Plan;

7.8.2.2.4. Progress on any Corrective Action Plans;

7.8.2.2.5. Program delays; and

7.8.2.2.6. Upcoming activities.

7.8.2.3. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.8.3. NHHPP Readiness Review

7.8.3.1. DHHS intends to conduct one (1) readiness review no sooner than thirty (30) days prior to the enrollment of NHHPP members. The MCO shall fully cooperate with DHHS during this review.

8. Covered Populations and Services

8.1. Covered Populations Matrix

The MCO shall provide managed care services to population groups deemed by DHHS to be eligible for managed care. The planned phase-in of population groups is depicted in the matrix below.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[1]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Beckett) - With Member Opt Out	X			
HC-CSD (Katie Beckett) - Mandatory Enrollment		X		
Children with special health care needs (enrolled in Special Medical Services / Partners in Health) - Mandatory Enrollment		X		
Children with Supplemental Security Income (SSI) - Mandatory Enrollment		X		
M-CHIP	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			

[1] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
Pregnant Women	X			
Native Americans and Native Alaskans w/ member opt out[2]	X			
Native Americans and Native Alaskans - Mandatory Enrollment (w/CMS waiver)		X		
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
Members with VA Benefits				X
NHHPP Enrollees			X	
Medically Frail			X	
Family Planning Only Benefit				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X
Health Insurance Premium Payment Program (HIPP)				X

8.2. Covered Services Matrix Overview

The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with CMS-approved Medicaid State Plan, to its members, reflecting the planned phase-in.

[2] Per 42 USC §1396u-2(a)(2)(c); however, NH has no recognized tribes.

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Maternity & Newborn Kick Payments	x	x	x	
Inpatient Hospital	x	x	x	
Outpatient Hospital[3]	x	x	x	
Inpatient Psychiatric Facility Services Under Age 21[4]	x	x	x	
Physicians Services	x	x	x	
Advanced Practice Registered Nurse	x	x	x	
Rural Health Clinic & FQHC	x	x	x	
Prescribed Drugs[5]	x	x	x	
Community Mental Health Services	x	x	x	
Psychology	x	x	x	
Ambulatory Surgical Center	x	x	x	
Laboratory (Pathology)	x	x	x	
X-Ray Services	x	x	x	
Family Planning Services	x	x	x	
Medical Services Clinic (mostly methadone clinic)	x	x	x	
Physical Therapy[6]	x	x	x	
Occupational Therapy[7]	x	x	x	

[3] Including facility and ancillary services for dental procedures

[4] Under age 22 if individual admitted prior to age 21

[5] Except as indicated in Section 14.1.15

[6] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Speech Therapy[8]	x	x	x	
Audiology Services	x	x	x	
Podiatrist Services	x	x	x	
Home Health Services	x	x	x	
EPSDT Services[9]	x	x	x	
Private Duty Nursing	x	EPSDT only	x	
Adult Medical Day Care	x	EPSDT only	x	
Personal Care Services	x	EPSDT only	x	
Hospice	x	x	x	
Optometric Services Eyeglasses	x	x	x	
Furnished Medical Supplies & Durable Medical Equipment	x	x	x	
Non-Emergent Medical Transportation [10]	x	x	x	
Ambulance Service	x	x	x	
Wheelchair Van	x	x	x	
Independent Care Management	x	EPSDT only	x	

[7] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[8] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[9] EPSDT includes Applied Behavioral Analysis Services.

[10] Also includes mileage reimbursement for medically necessary travel

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Home Visiting Services	x	x[11]		
Acquired Brain Disorder Waiver Services				
Developmentally Disabled Waiver Services				
Choices for Independence Waiver Services				
In Home Supports Waiver Services				
Skilled Nursing Facility				
Skilled Nursing Facility Atypical Care				
Inpatient Hospital Swing Beds, SNF				
Intermediate Care Facility Nursing Home				
Intermediate Care Facility Atypical Care				
Inpatient Hospital Swing Beds, ICF				
Glencliff Home				
Developmental Services Early Supports and Services				
Home Based Therapy – DCYF				
Child Health Support Service – DCYF				
Intensive Home and Community Services – DCYF				
Placement Services – DCYF				
Private Non-Medical Institutional For Children – DCYF				
Crisis Intervention – DCYF				
Substance use disorder services as per He-W	x	x	x	

[11] Provided within the SUD benefit

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
513				
Chiropractic services (NHHPP population only)		x		
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)[12]				
Medicaid to Schools Services				x
Dental Benefit Services[13]				x
Behavioral Health Crisis Treatment Center	x	x	x	
Services provided in an IMD pursuant to an approved waiver[14]	x	x	x	

8.3. Covered Services Additional Provisions

8.3.1. While the MCO may provide a higher level of service and cover additional services than required by DHHS, the MCO shall, at a minimum, cover the services identified at least up to the limits described in N.H. Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by informing the MCO [42 CFR 438.210(a)(1) and (2)]. Changes to the Medicaid State Plan, state statutes and rules shall be done in accordance with Federal and state requirements.

8.3.2. Pursuant to 42 CFR 438.3, the MCO shall provide enrollees with services or settings that are in lieu of services or settings described in 8.2 that are authorized by DHHS, which include, Medical Nutrition & Diabetes Self Management. The MCO shall not require the enrollee to use these alternate services.

8.3.3. Pursuant to 42 CFR 438.6, the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any enrollee that is receiving treatment in an institution for

[12] e.g. Cedarcrest

[13] except facility and ancillary services for dental procedures

[14] The Department anticipates that the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver will be approved by July of 2018.

mental disease (IMD) for the primary treatment of a psychiatric disorder that is not a state owned or operated facility. The MCO shall not pay for any days in a given month if the enrollee exceeds fifteen (15) days in an IMD for that month. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for in lieu of services at 42 CFR 438.3(e)(2)(i) through (iii).

8.3.4. Effective November 1, 2014, with the exception of HCBC waiver participants and nursing facility residents, the MCO shall require co-payment for services for members deemed by DHHS to have annual incomes at or above 100% of the FPL as follows:

8.3.4.1. Co-payments for drug prescriptions of up to $1 for generic drugs and $2 for brands and compound drugs for Step 1 members with annual incomes higher than 100% of the FPL, and for Step 2 members with annual incomes higher than 100% of the FPL consistent with the beneficiary and service exemptions as found in federal regulations and the approved Medicaid State Plan; and

8.3.4.2. Co-payments for drugs prescriptions of up to $1 for generic drugs and $4 for brands and compound drugs for NHHPP members with annual incomes higher than 100% of the FPL.

8.3.5. Effective 3/1/2016, the MCO Shall require point-of-service copayment for services for members deemed by DHHS to not be exempt from cost-sharing and have incomes above 100 percent of the federal poverty level as follows:

8.3.6. For Medicaid recipients subject to copayments:

8.3.6.1. A copay of $1.00 will be required for each preferred prescription drug and each refill of a preferred prescription drug.

8.3.6.2. A copay of $2.00 will be required for each non-preferred prescription drug and each refill of a nonpreferred prescription drug, unless the prescribing provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the copay for the non-preferred drug will be $1.00.

8.3.6.3. A copay of $1.00 will be required for a prescription drug that is not identified as either a preferred or nonpreferred prescription drug.

8.3.6.4. Copays are not required for family planning products or for Clozaril (Clozapine) prescriptions. All Cost sharing shall be applied consistent with beneficiary and service exemptions as found at 42 USC §§ 1396-o and 1396o-1, 42 C.F.R. §447.50 - 447.90, and New Hampshire's Medicaid State Plan.

8.3.7. Those individuals, who meet the definition of an Indian in 42 CFR 438.14(a), are exempt from any premiums or cost-sharing including copayments.

8.3.8. The MCO may, with DHHS approval, require co-payment for services that do not exceed current Medicaid co-payment amounts established by DHHS.

8.3.9. The MCO shall with no disruption in service delivery to members or providers transition these services into managed care from fee-for-service (FFS).

8.3.10. All services shall be provided in accordance with 42 CFR 438.210.

8.3.11. The MCO shall adopt written policies and procedures to verify that services are actually provided [42 CFR 455.1(a)(2)].

8.3.12. The MCO shall comply with provisions of RSA 167:4-d by providing access to telemedicine services to Medicaid members for specialty care only.

8.3.13. The MCO shall cover services consistent with 45 CFR 92.207(b) including gender reassignment surgery.

8.4. Emergency Services

8.4.1. The MCO shall cover and pay for emergency services at rates that are no less than the equivalent DHHS fee-for-service rates if the provider that furnishes the services has an agreement with the MCO [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98].

8.4.2. If the provider that furnishes the emergency services has no agreement with the MCO, the MCO shall cover and pay for the emergency services in compliance with 1932(b)(2)(D) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98.

8.4.3. In accordance with the Deficit Recovery Act of 2005, the MCOs will cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall pay non-contracted providers of Emergency and Post-Stabilization services an amount no more than the amount that would have been paid under the DHHS Fee-For-Service system in place at the time the service was provided.

8.4.4. The MCO shall not deny treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(ii)(A); SMD letter 2/20/98].

8.4.5. The MCO shall not deny payment for treatment obtained when a representative, such as a network provider, of the MCO instructs the member to seek emergency services [42 CFR 438.114(c)(1)(ii)(B); SMD letter 2/20/98].

8.4.6. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

8.4.7. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or DHHS of the member's screening and treatment within ten (10) calendar days of presentation for emergency services [42 CFR 438.114(d)(1)(ii)].

8.4.8. The MCO may not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient [42 CFR 438.114(d)(2)].

8.4.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment [42 CFR 438.114(d)(3)].

8.5. Post-Stabilization Services

8.5.1. Post-stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for post-stabilization services obtained within or outside the MCO that are pre-approved by a MCO provider or other MCO representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i); SMD letter 8/5/98]

8.5.2. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii); SMD letter 8/5/98.]

8.5.3. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain, improve or resolve the member's stabilized condition if:

8.5.3.1.The MCO does not respond to a request for pre-approval within one (1) hour;

8.5.3.2.The MCO cannot be contacted; or

8.5.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with a MCO physician and the treating physician may continue with care of the patient until a MCO physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)].

8.5.4. The MCO shall limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the MCO. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv); SMD letter 8/5/98]

8.5.5. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

8.5.5.1. A MCO physician with privileges at the treating hospital assumes responsibility for the member's care;

8.5.5.2. A MCO physician assumes responsibility for the member's care through transfer;

8.5.5.3. A MCO representative and the treating physician reach an agreement concerning the member's care; or

8.5.5.4. The member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3); SMD letter 8/5/98]

9. Payment Reform Plan

9.1. Payment Reform Plan Timeline

9.1.1. The MCO shall submit within sixty (60) calendar days from a Program Start Date and sixty (60) calendar days prior to the start of each Agreement year, its Payment Reform Plan to engage its provider network in health care delivery and payment reform activities, subject to review and approval by DHHS. These activities may include, but are not limited to, pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements.

9.1.1.1. DHHS shall respond to the MCO regarding the Payment Reform Plan within thirty (30) calendar days of receipt.

9.1.2. The MCO shall submit a report to DHHS describing its performance against the MCO's healthcare delivery and Payment Reform Plan within ninety (90) calendar days of the end of each year of the Agreement.

9.1.2.1. The report shall indicate, by provider type, the number and percentage participating in each type of payment reform activities.

9.1.2.2. DHHS will evaluate the MCO's performance and make payments to the MCO, if warranted, within ninety (90) calendar days of receipt of the report. DHHS shall provide the MCO with a written explanation of DHHS's evaluation of the MCO's performance within thirty (30) days of the MCO's request.

9.1.2.3. In the event that MCO disputes DHHS's evaluation of MCO's performance, MCO will have thirty (30) calendar days from receipt of DHHS's written explanation to submit a written request for reconsideration along with a description of MCO's reasons for the dispute, after which DHHS shall meet with the MCO within a reasonable time frame to achieve a good faith resolution of the disputed matter.

9.2. Payment Reform Plan Content

9.2.1. The Payment Reform Plan shall contain:

9.2.1.1. Information on the anticipated impact on member health outcomes of each specific activity, providers affected by the specific activity, outcomes anticipated as a result of the implementation of a process by which to reduce inappropriate emergency room use, an implementation plan for each activity and an implementation milestone to be met by the end of each year of the Agreement for each activity;

9.2.1.2. A process to ensure Equal Access to services; and

9.2.1.3. A process for engaging LTSS providers in health care delivery and payment reform activities.

9.3. Payment Reform Plan Compliance Requirements

9.3.1. The MCO's Payment Reform Plan(s) shall be in compliance with the following requirements:

9.3.1.1. FQHCs and RHCs will be paid at minimum the encounter rate paid by DHHS at the time of service.

9.3.1.2. The Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

9.3.1.3. The MCO's provider incentive plan shall comply with requirements set forth in 42 CFR 422.208 and 42 CFR 422.210 [42 CFR 438.6(h)].

9.3.1.4. The MCO's payment reform plan must comply with state and federal laws requiring nonpayment to a Contracted Provider for hospital-acquired conditions and for provider preventable conditions. The MCO shall report to NH DHHS all provider-preventable conditions in a form and frequency as specified by the State [42 CFR 438.3(g)].

9.3.1.5. The MCO may not make payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.6. The MCO shall provide information on its provider incentive program to any New Hampshire recipient upon request (this includes the right to adequate and

timely information on the plan) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.6(h)].

9.3.1.7. The MCO shall report whether services not furnished by physician/group are covered by an incentive plan. No further disclosure is required if the incentive plan does not cover services not furnished by the physician/group [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.7.1. The MCO shall report the type of incentive arrangement (e.g., withhold, bonus, capitation) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.8. The MCO shall report the percent of withhold or bonus (if applicable) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.9. The MCO shall report panel size, and if patients are pooled, the approved method used [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.10. If the physician/group is at substantial financial risk, the MCO shall report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss [§1903(m)(2)(A)(x)of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.11. Primary Care reimbursement to follow DHHS policy and to comply with 42 CFR 438, 42 CFR 441 and 42 CFR 447 II.A.5

9.3.1.11.1. MCO shall pass on the full benefit of the payment increase to eligible providers; and

9.3.1.11.2. MCO shall adhere to the definitions and requirements for eligible providers and services as specified in Section 1902(a)(13)(C), as amended by the Affordable Care Act of 2010 (ACA) and federal regulations; and

9.3.1.11.3. MCO shall submit sufficient documentation, as per DHHS policy, to DHHS to validate that enhanced rates were made to eligible providers.

10. Care Coordination Program

10.1. Minimum Care Coordination Program Components

10.1.1. The MCO shall implement a comprehensive care array of care coordination services that have at a minimum the following components:

10.1.1.1.Care Coordination

10.1.1.2.Support of Patient-Centered Medical Homes and Health Homes

10.1.1.3.Non-Emergent Medical Transportation

10.1.1.4.Wellness and Prevention programs

10.1.1.5.Chronic Care Coordination programs

10.1.1.6.High Risk/ High Cost Member Management programs

10.1.1.7.A Special Needs program

10.1.1.8.Coordination and Integration with Social Services and Community Care

10.1.1.9.A Long Term Services and Supports Program

10.2. Care Coordination: Role of the MCO

10.2.1. The MCO shall develop a strategy for coordinating all care for all members. Care coordination for its members includes coordination of primary care, specialty care, and all other MCO covered services as well as services provided through the fee-for-service program and non-Medicaid community based services. Care coordination shall promote and assure service accessibility, focus attention to individual needs, actively assist members or their caregiver to take personal responsibility for their health care, provide education regarding the use of inappropriate emergency room care, emphasize the importance of participating in health promotion activities, provide for continuity of care, and assure comprehensive coordinated and integrated culturally appropriate delivery of care.

10.2.2. The MCO shall ensure that services provided to children are family driven and based on the needs of the child and the family. The MCO shall support the family in having a primary decision making role in the care of their children utilizing the Substance Abuse and Mental Health Services Administration (SAMHSA) core elements of a children's services system of care. The MCO shall employ the SAMHSA principles in all children's behavioral health services assuring they:

10.2.2.1.Are person centered;

10.2.2.2. Include active family involvement;

10.2.2.3. Deliver behavioral health services that are anchored in the community;

10.2.2.4. Build upon the strengths of the member and the family;

10.2.2.5. Integrate services among multiple providers and organizations working with the child; and

10.2.2.6. Utilize a wraparound model of care within the context of a family driven model of care.

10.2.2.6.1. MCO shall submit a written policy to DHHS describing the integrated model of care including but not limited to the involvement of each member and family in the development of the plan.

10.2.3. The MCO will ensure that its providers are providing services to children, youth members, and their families in accordance with RSA 135-F.

10.2.4. The MCO shall provide a written policy to DHHS for approval that ensures that services to individuals who are homeless are to be prioritized and made available to those individuals.

10.3. Care Coordination: Role of the Primary Care Provider

10.3.1. MCO Cooperation with Primary Care Provider

10.3.1.1. The MCO shall implement procedures that ensure that each member has access to an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with 42 CFR 438.208(b)(1) through (6).

10.3.1.2. The MCO shall submit a written plan that describes the development, implementation and evaluation of programs to assess and support, wherever possible, primary care providers to act as a patient centered medical home. A patient centered medical home shall include all of the five key domains outlined by the Agency for Healthcare Research and Quality (AHRQ):

10.3.1.2.1. Comprehensive care;

10.3.1.2.2. Patient-centered care;

10.3.1.2.3. Coordinated care;

10.3.1.2.4. Accessible services; and

10.3.1.2.5. Quality and safety.

10.3.1.3. DHHS recognizes that there is a variety of ways in which these domains can be addressed in clinical practices. External accreditation is not required by DHHS to qualify as a medical home. The MCO's support to primary care providers acting as patient centered medical homes shall include, but is not limited to, the development of systems, processes and information that promote coordination of the services to the member outside of that provider's primary care practice.

10.4. Care Coordination: Role of Obstetric Providers

10.4.1. If, at the time of entering the MCO as a new member, the member is transferring from another MCO within the state system, is in her first trimester of pregnancy and is receiving, medically necessary covered prenatal care services, as defined within this Agreement as covered services, before enrollment the MCO shall be responsible for the costs of continuation of medically necessary prenatal care services, including prenatal care, delivery, and postpartum care.

10.4.2. If the member is receiving services from an out-of-network provider prior to enrollment in the MCO, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services until such time as the MCO can reasonably transfer the member to a network provider without impeding service delivery that might be harmful to the member's health.

10.4.3. If the member, at the time of enrollment, is receiving services from a network provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider through the postpartum period.

10.4.4. In the event a member entering the MCO, either as a new member or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services at the time of enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider, whether an out-of-network or in network provider, through the postpartum period.

10.4.5. Postpartum care includes the first postpartum visit, any additional visits necessary to manage any complications related to delivery, and completion of the medical record.

10.4.6. The MCO shall develop and maintain policies and procedures, subject to DHHS approval, regarding the transition of any pregnant members.

10.5. Non-Emergent Transportation (NEMT)

10.5.1. The MCO shall be required to arrange for the non-emergent medical transportation of its members to ensure members receive medically necessary services covered by the New Hampshire Medicaid program regardless of whether those medically necessary services are covered by the MCO. The MCO shall ensure that a member's lack of personal transportation is not a barrier to accessing care.

10.5.2. The MCO and/or any subcontractors shall be required to perform background checks on all non-emergent medical transportation providers.

10.5.3. The MCO shall provide quarterly reports to DHHS on its non-emergent medical transportation activities to include but not be limited to:

10.5.3.1.NEMT requests delivered by mode of transportation;

10.5.3.2.NEMT request authorization approval rates by mode of transportation;

10.5.3.3.NEMT scheduled trip results by outcome;

10.5.3.4.NEMT services delivered by type of medical service;

10.5.3.5.NEMT service use by population; and

10.5.3.6.Number of transportation requests that were delivered late and not on time.

10.5.3.6.1. On-time shall be defined as less than or equal to fifteen (15) minutes after the appointed time; and

10.5.3.6.2. Transportation requests for methadone services will be excluded from the calculation of late and not-on-time services.

10.5.3.7.Member cancellations of scheduled trips by reason for member cancellations.

10.6. Wellness and Prevention

10.6.1. The MCO shall develop and implement wellness and prevention programs for its members.

10.6.2. The MCO shall, at a minimum, develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs in consultation with DHHS.

10.6.3. The MCO shall, at minimum, provide primary and secondary preventive care services, rated A or B, in accordance with the recommendations of the U.S.

Preventive Services Task Force, and for children, those preventive services recommended by the American Academy of Pediatrics Bright Futures Program.

10.6.4. The MCO may substitute generally recognized accepted guidelines for the requirements set forth in 10.6.3, provided that such substitution is approved in advance by DHHS. The MCO shall provide members with a description of preventive care benefits to be used by the MCO in the member handbook and on the MCO's website.

10.6.5. The MCO shall provide members with general health information and provide services to help members make informed decisions about their health care needs. The MCO shall encourage patients to take an active role in shared decision making.

10.6.6. The MCO shall also participate in other public health initiatives at the direction of DHHS.

10.7. Member Health Education

10.7.1. The MCO shall develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of empowering patients to actively participate in their healthcare.

10.7.2. The MCO shall conduct a Health Needs Assessment for all new members within the following timeframes from the date of enrollment in the MCO:

10.7.2.1.thirty (30) calendar days for pregnant women, children with special health care needs, adults with special health care needs; and

10.7.2.2.ninety (90) calendar days for all other members, including members residing in a nursing facility longer than 100 days.

10.7.2.3.The MCO shall document at least three attempts to conduct the screen. If unsuccessful, the MCO shall document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.

10.7.3. The MCO will submit their Health Needs Assessment forms to DHHS for review and approval.

10.7.4. The MCO shall report quarterly, with reports due the last day of the month following the reporting quarter, with the first report due January 31, 2015. Reports shall include:

10.7.4.1.the number of members and the percentage of eligible members who completed a Health Needs Assessment in the quarter;

10.7.4.2.the percentage of eligible members who completed the Health Needs Assessment in the prior year; and

10.7.4.3.the percentage of members eligible for chronic care coordination, high cost/high risk care coordination, complex care coordination and/or the MCO's special needs program who completed a Health Needs Assessment in the prior year.

10.7.5. The MCO shall actively engage members in both wellness program development and in program participation and shall provide additional or alternative outreach to members who are difficult to engage or who utilize the emergency room inappropriately.

10.8. Chronic Care Coordination, High Risk/High Cost Member and Other Complex Member Management

10.8.1. The MCO shall develop effective care coordination programs that assist members in the management of chronic and complex health conditions, as well as those clients that demonstrate high utilization of services indicating a need for more intensive management services. The MCO may delegate the chronic and complex care member management to a patient centered medical home or health home provided that all the criteria for qualifying as a patient centered medical home or a health home and the additional conditions of this section have been met. These programs shall incorporate a "whole person" approach to ensure that the member's physical, behavioral, developmental, and psychosocial needs are comprehensively addressed. The MCO or its delegated entity shall ensure that the member, and/or the member's care giver, is actively engaged in the development of the care plan.

10.8.2. The MCO shall submit status reports to DHHS on MCO care coordination activities and any delegated medical home or health home activities as requested or required by DHHS.

10.8.3. The MCO shall at, a minimum, provide chronic care coordination services for members with the following or other chronic disease states who are appropriate for such care coordination services based on MCO's methodologies, which have been approved by DHHS, for identifying such members:

10.8.3.1.Diabetes, in coordination with the forthcoming federal diabetes initiative;

10.8.3.2.Congestive Heart Failure (CHF);

10.8.3.3.Chronic Obstructive Pulmonary Disease (COPD);

10.8.3.4.Asthma;

10.8.3.5.Coronary Artery Disease (CAD), in coordination with the Million Hearts Campaign;

10.8.3.6.Obesity;

10.8.3.7.Mental Illness;

10.8.3.8.Requiring wound care.

10.8.4. The MCO shall report on the number and types of members receiving chronic care coordination services.

10.9. Special Needs Program

10.9.1. The MCO shall create an organizational structure to function as patient navigators to:

10.9.1.1.Reduce any barriers to care encountered by members with special needs

10.9.1.2.Ensure that each member with special needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists as appropriate

10.9.1.3.Support in accessing all covered services appropriate to the condition or circumstance.

10.9.2. The MCO shall identify special needs members based on the member's physical, developmental, behavioral condition, or adverse social circumstances, including but not limited to:

10.9.2.1.A member with at least two chronic conditions;

10.9.2.2.A member with one chronic condition and is at risk for another chronic condition;

10.9.2.3.A member with one serious and persistent mental health condition;

10.9.2.4.A member living with HIV/AIDS;

10.9.2.5.A member who is a child in foster care;

10.9.2.6.A member who is a child and a client of DCYF receiving services through a court order; and

10.9.2.7.A member who is homeless.

10.9.3. The MCO shall assess, pursuant to 42 CFR 438.208(c)(2), and reach out to members identified with special needs and their PCP to inform them of additional services and supports available to them through the MCO's special needs program.

10.9.4. The MCO shall share the results of its identification and assessment of any enrollee with special health care needs as described in this section with the State so that those activities will not be duplicated.

10.9.5. The MCO shall ensure enrollees determined to have special health care needs as described in this section and who need a course of treatment or regular care monitoring, will have direct access to a specialist as appropriate for the enrollee's condition and identified needs.

10.9.6. For enrollees with special health needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.9.7. The MCO shall report on the number and types of members in the special needs program.

10.10.Coordination and Integration with Social Services and Community Care

10.10.1.The MCO shall develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including not limited to:

10.10.1.1.Juvenile Justice and Adult Community Corrections;

10.10.1.2.Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

10.10.1.3.Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

10.10.1.4.Public Health Agencies;

10.10.1.5.Schools;

10.10.1.6.Step 2 Programs and Services;

10.10.1.7.The court system;

10.10.1.8.ServiceLink Resource Network; and

10.10.1.9.Housing

10.10.1.9.1.Veterans Administration Hospital and other programs and agencies serving service members, veterans and their families.

10.10.2.The MCO shall report on the number of referrals for social services and community care provided to members by member type.

10.11.Long Term Services and Supports (LTSS)

10.11.1.Navigators. The MCO shall create an organizational structure to function as navigators for members in need of LTSS to:

10.11.1.1.Reduce any barriers to care encountered by members with long term care needs;

10.11.1.2.Ensure that each member with long term care needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists, as appropriate; and

10.11.1.3.Ensure that each member with long term care needs receives conflict free care coordination that facilitates the integration of physical health, behavioral health, psychosocial needs, and LTSS through person-centered care planning to identify a member's needs and the appropriate services to meet those needs; arranging, coordinating, and providing services; facilitating and advocating to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

10.11.2.Integrated Care. The MCO shall ensure that LTSS are delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation, based on the member's preferences and pursuant with 28 C.F.R. Pt. 35, App. A (2010), the Americans with Disabilities Act (ADA) [42 USC 126.12101] and Olmstead v. L.C., 527 U.S. 581 (1999).

10.11.2.1.The MCO shall support accessing all covered services appropriate to the medical, behavioral, psychosocial, and/or LTSS condition or circumstance.

10.11.2.2.The MCO shall identify members with long term care needs based on the member's physical, developmental, psychosocial, or behavioral conditions including but not limited to:

10.11.2.2.1.Children with DCYF involvement;

10.11.2.2.2.Children with special needs other than DCYF;

10.11.2.2.3.Children with Waiver, NF or CMHC services;

10.11.2.2.4.Adults with Special Needs with Waiver, NF or CMHC services;

10.11.2.2.5.Adults with Waiver, NF or CMHC services;

10.11.2.2.6.Older Adults with Waiver or CMHC services; or

10.11.2.2.7.Older adults with NF services.

10.11.2.3.The MCO shall reach out to members identified with long term care needs and their PCP to:

10.11.2.3.1. Assess them and identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring; and

10.11.2.3.2.Inform them of additional services and supports available to them through the MCO; and

10.11.2.3.3.Identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

10.11.2.4.For enrollees with long term care needs determined through an assessment or through regular care monitoring to need services, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.11.2.5.For enrollees with long term care needs determined through an assessment or regular care monitoring, the MCO must have a mechanism in place to assist enrollees to access medically necessary services.

11. EPSDT

11.1. Compliance

11.1.1. The MCO shall provide Early Periodic Screening Diagnostic Treatment (EPSDT) services to members less than twenty-one (21) years of age in compliance with all requirements found below:

11.1.1.1. The MCO shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the SSA and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The MCO shall comply with all EPSDT requirements pursuant to the New Hampshire Medicaid Rules.

11.1.1.2. The MCO shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through Health Check screens and exams and follow-up on any abnormal screening exams. The EPSDT Plan shall also include procedures for referral, tracking, and follow up for annual dental examinations and visits, upon receipt of dental claims information from DHHS. The EPSDT Plan shall consider and be consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists to the extent that such policy statements relate to the role of the primary care provider in coordinating care for infants, children and adolescents. The MCO shall submit its EPSDT Plan to DHHS for review and approval ninety (90) days prior to program start and annually sixty (60) calendar days prior to the first day of each Agreement year.

11.1.1.3. The MCO shall ensure providers perform a full EPSDT visit according to the periodic schedule approved by DHHS and the American Academy of Pediatrics periodicity schedule. The visit shall include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements §1902(a)(43) of the SSA, §1905(a)(4)(B) of the SSA and 42 CFR 441.50-.62, and health education/anticipatory guidance. All five (5) components shall be performed for the visit to be considered an EPSDT visit.

12. Behavioral Health

12.1. Behavioral Health - General Provisions

12.1.1. This section applies to individuals who have been determined to be eligible for community mental health services based on diagnosis, level of impairment and the requirements outlined in N.H. Code of Administrative Rules, chapter He-M 401.

12.1.2. Community mental health services, as set forth in Section 8.2, shall be provided in accordance with the NH Medicaid State Plan, He-M 426, He-M 408 and all other applicable state and federal regulations.

12.1.3. All clinicians providing community mental health services are subject to the requirements of He-M 426 and any other applicable state and federal regulations.

12.1.4. All individuals approved to provide community mental health services through a waiver granted by NH DHHS shall be recognized as qualified providers under the MCO plan subject to NCQA credentialing requirements.

12.1.5. All other behavioral health services shall be provided to all NH Medicaid-eligible recipients in accordance with the NH Medicaid State Plan.

12.1.6. The MCO shall pay for all NH Medicaid State Plan Services for its members as ordered to be provided by the Mental Health Court.

12.1.7. The MCO shall continue to support and ensure that culturally and linguistically competent community mental health services currently provided for people who are deaf continue to be made available. These services shall be similar to services currently provided through the Deaf Services Team at Greater Nashua Mental Health Center.

12.2. Community Mental Health Services

12.2.1. The MCO shall ensure, through review of individual service plans and quarterly reviews, that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall inform DHHS of their findings on a monthly basis.

12.2.2. The MCO shall employ a trauma informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan, pursuant to He-M 401, that will effectively address the individual's trauma history.

12.2.3. The MCO shall make Community Mental Health Services available to all members who have a severe mental disability. DHHS encourages agreement between the MCO and CMHCs to develop a capitated payment program with the intent to establish payment mechanisms to meet the goals of DHHS to strengthen the State's outpatient community health service system and the requirements of the Community Mental Health Agreement, and to further payment reform. In the event that any CMHC fails to sign a contract with the MCO within thirty (30) days before the current contract end date, the MCO shall notify DHHS of the failure to reach agreement with a CMHC and DHHS shall implement action steps to designate a community mental health program to provide services in the designated community mental health services region.

12.2.3.1. The MCO shall submit to DHHS a plan to assure continuity of care for all members accessing a community mental health agency.

12.2.4. In the event that an alternative community mental health program is approved and designated by DHHS, a transition plan shall be submitted for approval by DHHS including implementation strategy and timeframes. State Administrative Rule He-M 426, Community Mental Health Services, details the services available to adults with a severe mental illness and children with serious emotional disturbance. The MCO shall, at a minimum, make these services available to all members determined eligible for community mental health services under State Administrative Rule He-M 401.

12.2.4.1. The MCO shall be required to continue the implementation of evidence based practices across the entire service delivery system.

12.2.4.2. Behavioral Health Services shall be recovery and resiliency oriented, based on SAMHSA's definition of recovery and resiliency.

12.2.4.3. The MCO shall ensure that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans.

12.2.4.4. The MCO shall ensure that community mental health services to individuals who are homeless continue to be prioritized and made available to those individuals.

12.2.4.5. The MCO shall maintain or increase the ratio of community based to office based services for each region in the State, as specified in He-M 425, to be greater than or equal to the regional current percentage or 50%, whichever is greater.

12.2.4.6. The MCO shall monitor the ratio of community based to office based services for each region in the State, as specified in He-M 425.

12.2.4.7. The Department of Health and Human Services (DHHS) will issue a list of covered office and community based services annually, by procedure code, that are used to determine the ratio outlined in 12.2.4.5.

12.2.4.8. The MCO shall submit a written report to the Department of Health and Human Services DHHS every six (6) months, by region, of the ratio of community based services to office based services.

12.2.5. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

12.2.5.1. Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web-based training and certification system.

12.2.5.1.1. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member eligibility renewal following clinician certification to utilize the CANS and the ANSA and upon eligibility determination for newly evaluated consumers effective July 1, 2015.

12.2.5.1.2. The community mental health long term care eligibility tool, specified in He-M 401, and in effect on January 1, 2012 shall continue to be utilized by a clinician until such time as the Department of Health and Human Services implements web-based access to the CANS and the ANSA, the clinician is certified in the use of the CANS and the ANSA, and the member annual review date has passed.

12.2.6. The MCO shall ensure that community mental health service providers operate in a manner that enables the State to meet its obligations under Title II of the Americans with Disabilities Act, with particular attention to the "integration mandate" contained in 28 CFR 35.130(d).

12.2.7. The MCO shall continue the implementation of New Hampshire's 10-year Olmstead Plan, as updated from time to time, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration."

12.2.7.1. The MCO shall include in its written Program Management Plan:

12.2.7.1.1. Screening criteria for Assertive Community Treatment Teams for all persons with serious mental disabilities.

12.2.7.1.2. A needs assessment, capacity analysis and access plan for Community Residential and Supported Housing.

12.2.7.1.3. New and innovative interventions that will reduce admissions and readmissions to New Hampshire Hospital and increase community tenure for adults with a severe mental illness and children with a serious emotional disturbance.

12.2.8. The MCO shall work collaboratively to support the implementation of the Medicaid-funded services described in the Class Action Settlement Agreement in the case of Amanda D. et al. v. Hassan, et al., US v. State of New Hampshire, Civ. No. 1:12-cv-53-SM in conjunction with DHHS and the Community Mental Health Centers.

12.2.8.1. Adult Assertive Community Treatment Teams (ACT). The MCO shall ensure that ACT teams are available twenty-four (24) hours per day, seven (7) days per week, with on-call availability from midnight to 8:00 am. At a minimum, ACT teams shall deliver comprehensive, individualized, and flexible services, supports, treatment, and rehabilitation in a timely manner as needed, onsite in the individuals homes and in other natural environments and community settings, or alternatively, via telephone where appropriate to meet the needs of the individual. Each ACT team shall be composed of a multi-disciplinary group of between seven (7) and ten (10) professionals, including, at a minimum, a psychiatrist, a nurse, a Masters-level clinician (or functional equivalent therapist); functional support worker and a peer specialist. The team also will have members who have been trained and are competent to provide substance abuse support services, housing assistance and supported employment. Caseloads for ACT teams serve no more than ten (10) to twelve (12) individuals per ACT team member (excluding the psychiatrist who will have no more than seventy (70) people served per 0.5 FTE psychiatrist).

12.2.8.2.Evidence-based Supported Employment (EBSE). The MCO shall ensure that EBSE is provided to eligible consumers in accordance with the Dartmouth model. The MCO shall ensure that the penetration rate of individuals receiving EBSE increases to 18.6 percent by June 30, 2017. The penetration rate is determined by dividing the number of adults with severe mental illness (SMI) receiving EBSE by the number of adults who have SMI being served.

12.2.9. The Department of Health and Human Services will lead regional planning activities in each community mental health region to develop and refine community mental health services in New Hampshire. The MCO shall support and actively participate in these activities.

12.2.9.1.The focus of the regional planning process will be on reducing the need for inpatient care and emergency department utilization, and on increasing community tenure.

12.2.10.The MCO shall develop a Training Plan each year of the Agreement for how it will support the New Hampshire community mental health service system's effort to hire and train qualified staff. The MCO shall submit this Training Plan to DHHS sixty (60) calendar days prior to program start and annually ninety (90) calendar days prior to beginning of each Agreement year.

12.2.10.1.The MCO shall submit a report summarizing what training was provided, a copy of the agenda for each training, a participant registration list for each contracted CMHC and a summary, for each training provided, of the evaluations done by program participants, within ninety (90) calendar days of the conclusion of each Agreement year.

12.2.10.2.As part of that Training Plan, the MCO shall promote provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

12.2.10.3.The MCO Training Plan outlined in 12.2.10.1 shall be designed to sustain and expand the use of the Evidence Based Practices of Illness Management and Recovery (IMR), Evidence Based Supported Employment (EBSE), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Treatment (DBT) and Assertive Community Treatment (ACT), and to improve NH's penetration rates for Illness Management and Recovery (IMR) and Supported Employment, by 2% each year of the Agreement. The baseline measure for penetration rates shall be the NH submission to the SAMHSA Uniform Reporting System for 2011.

12.2.10.4.The MCO shall offer a minimum of 2 hours of training each contract year to all contracted community mental health center staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the State's objective of reducing the number of suicides in New Hampshire.

12.2.10.5.The MCO shall submit an annual report no later than ninety (90) calendar days following the close of each Agreement year with a summary of the trainings provided, a list of attendees from each contracted community mental health program, and the proposed training for the next fiscal year.

12.3. Emergency Services

12.3.1. The MCO shall ensure, through its contracts with local providers, that regionally based crisis lines and Emergency Services as defined in He-M 403 and He-M 426 are in place 24 hours a day/ 7 days a week for individuals in crisis. These crisis lines and Emergency Services Teams shall employ clinicians who are trained in managing crisis intervention calls and who have access to a clinician available to evaluate the member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

12.3.2. The MCO shall submit for review to the DHHS MCM Account Manager and the Director of the Bureau of Mental Health an annual report identifying innovative and cost effective models of providing crisis and emergency response services that will provide the maximum clinical benefit to the consumer while also meeting the State's objectives in reducing admissions and increasing community tenure.

12.4. Care Coordination

12.4.1. The MCO shall develop policies governing the coordination of care with primary care providers and community mental health programs. These policies shall be submitted to DHHS for review and approval ninety (90) calendar days prior to the beginning of each Agreement year, including Year 1.

12.4.2. The MCO shall ensure that there is coordination between the primary care provider and the community mental health program.

12.4.3. The MCO shall ensure that both the primary care provider and community mental health program request written consent from the member to release information to coordinate care regarding mental health services, primary care, and in the case of alcohol and drug abuse services written consent from the member and a notice to the recipient of the records stating 42 CFR Part 2 prohibits unauthorized disclosure of records regarding or substance abuse services.

12.4.4. The MCO shall monitor instances in which consent was not given, and if possible the reason why, and submit this report to DHHS no later than sixty (60) calendar days following the end of the fiscal year.

12.4.5. The MCO shall review with DHHS the approved policy, progress toward goals, barriers and plans to address identified barriers.

12.4.6. The MCO shall ensure integrated care coordination by requiring that providers accept all referrals for its members from the MCO that result from a court order or a request from DHHS.

12.5. New Hampshire Hospital

12.5.1. The MCO shall maintain a collaborative agreement with New Hampshire Hospital, the State of New Hampshire's state operated inpatient psychiatric facility. This collaborative agreement subject to the approval of DHHS shall at a minimum address the Americans with Disabilities Act requirement that individuals be served in the most integrated setting appropriate to their needs, include the responsibilities of the community mental health program in order to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.

12.5.2. It is the policy of the State to decrease discharges from inpatient care at New Hampshire Hospital to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning from New Hampshire Hospital. The MCO shall utilize the collaborative agreement to track any discharges that the MCO, through its provider network, was unable to place into the community and who instead were discharged to a shelter or into homelessness. The MCO shall submit a report to the Department of Health and Human Services DHHS, quarterly, detailing the reasons why members were placed into homelessness and include efforts made by the MCO to arrange appropriate placements.

12.5.3. The MCO shall designate a liaison with privileges, as required by New Hampshire Hospital, to continue members' care coordination activities, and assist in facilitating a coordinated discharge planning process for adults and children admitted to New Hampshire Hospital. Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital treatment team meetings and discharge planning meetings to ensure that individuals receive treatment in the least restrictive environment complying with the Americans with Disabilities Act and other applicable federal and State regulations.

12.5.3.1. The liaison shall actively participate, and assist New Hampshire Hospital staff in the development of a written discharge plan within twenty-four (24) hours of admission.

12.5.3.2. The MCO shall ensure that the final NHH Discharge Instruction Sheet shall be provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of members discharged. The MCO shall ensure that the discharge progress note shall be provided to the aftercare provider within 7 calendar days of member discharge for at least ninety percent (90%) of members discharged.

12.5.3.3.The MCO shall make at least three (3) attempts to contact members for whom the MCO has record of a telephone number within three (3) business days of discharge from New Hampshire Hospital in order to review the discharge plan, support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the member may have. The performance metric shall be that at least ninety-five percent (95%) of members discharged shall have been attempted to be contacted within three (3) business days.

12.5.3.4.The MCO shall ensure an appointment with a community mental health program or other appropriate mental health clinician for the member is scheduled prior to discharge. Such appointment shall occur within seven (7) calendar days after discharge.

12.5.3.4.1. Persons discharged from psychiatric hospitalization and new to a CMHC must have an intake appointment within seven (7) days.

12.5.3.5.The MCO shall work with DHHS to review cases of members that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

12.5.3.6.The MCO shall establish a reduction in readmissions plan, subject to approval by DHHS, to monitor the 30-day and 180-day readmission rates to New Hampshire Hospital, review member specific data with each of the community mental health programs, and implement measurable strategies within 90 days of the execution of this Agreement to reduce 30-day and 180-day readmission. The MCO shall include benchmarks and reduction goals in the Program Management Plan.

12.5.4. The MCO shall perform in-reach activities to New Hampshire Hospital designed to accomplish transitions to the community.

12.6. In Shape Program

12.6.1. The MCOs shall promote community mental health service recipients' whole health goals. Functional support services may be utilized to enable recipients to pursue and achieve whole health goals within an In Shape program or other program designed to improve health.

12.7. Parity

12.7.1. The MCO and its subcontractors must comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which requires the MCOs

to not discriminate based upon an enrollee's health status of having a mental health or substance use disorder.

12.7.1.1.The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.

12.7.1.2.The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

12.7.1.3.The MCO shall not impose Non- Quantitative Treatment Limits for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

12.7.1.4.Annual Certification with Federal Mental Health Parity Law: The MCOs must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the Federal Mental Health Parity Law, regulations and guidance issued by state and federal entities.

12.7.1.4.1. The MCO must submit a certification signed by the chief executive officer and chief medical officer stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.2. If the MCO determines that all administrative, clinical, and utilization practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will affirmatively state, that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.3. If the MCO determines that any administrative, clinical, and utilization practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law or guidance issued by state and federal entities during the calendar year, the certification will state that not all practices were in compliance with Federal Mental Health Parity Law or any guidance issued by state or federal entities and will include a list of the practices not in compliance and the steps the managed care entity has taken to bring these practices into compliance.

12.7.1.5.The MCO shall complete the DHHS Parity Compliance Report annually and shall include:

12.7.1.5.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCOs pursuant to DHHS criteria;

12.7.1.5.2. All member grievances and appeals regarding a parity violation and resolutions;

12.7.1.5.3. The processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification; and

12.7.1.5.4. Any other requirements identified by DHHS.

12.7.1.6.A member enrolled in any MCO may file a complaint with the New Hampshire Insurance Department at **https://www.nh.gov/insurance/consumers/complaints.htm** if services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance.

13. Substance Use Disorder

13.1. Substance Use Disorder - General Provisions

13.1.1. The MCO will offer contracts to Medicaid enrolled SUD providers who meet the MCO's credentialing standards. The MCO will reimburse those SUD providers in accordance with Section 21.2.10.

13.1.2. The MCO will submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of SUD service providers so that services are accessible without reasonable delays.

13.1.2.1. If the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours this provider is required to provide interim substance use disorder counselors services until such a time that the clients starts receiving the identified level of care. If the type of service is not provided by this agency they are then responsible for making an active referral to a provider of that type of service (for the identified level of care) within fourteen (14) days from initial contact and to provider interim substance use disorder counselors services until such a time that the member is accepted and starts receiving services by the receiving agency.

13.1.3. The MCO shall provide data, reports and plans in accordance with Exhibit O.

13.2. Compliance Metrics for Access to SUD Services

13.2.1. Agencies under contract with MCOs to provide SUD services shall respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The SUD provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face to face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but not later than two (2) business days following the date of first contact.

13.2.2. Members who have screened positive for SUD services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation (as identified in the He-W 513 administrative rules) as soon as possible following the ASAM Level of Care Assessment and no later than (3) days after admission.

13.2.3. Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed. Members identified for Partial

Hospitalization (PH) or Rehabilitative Residential (RR) Services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

13.2.3.1. Pregnant women shall be admitted to the identified level of care within 24 hours of the ASAM Level of Care Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor shall:

13.2.3.1.1. Assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance must include actively reaching out to identify providers on the behalf of the client; and

13.2.3.1.2. Provide interim services until the appropriate level of care becomes available at either the contractor agency or an alternative provider. Interim services shall include:

a. At least one 60 minute individual or group outpatient session per week;

b. Recovery support services as needed by the client; and

c. Daily calls to the client to assess and respond to any emergent needs.

13.2.4. If the type of service identified in the ASAM Level of Care Assessment will not be available from the provider that conducted the initial assessment within the fourteen (14) business day period, or if the type of service is not provided by the agency that conducts the ASAM Level of Care Assessment, this agency is responsible for making an active referral to a provider of that type of services (for the identified level of care) within fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

14. Pharmacy Management

14.1. Pharmacy Management – General Provisions

14.1.1. The MCO's, including any pharmacy subcontractors, shall create: formulary and pharmacy prior authorization criteria and other point of service edits (i.e. prospective drug utilization review edits and dosage limits), pharmacy policies and pharmacy programs subject to DHHS approval, and in compliance with §1927 of the SSA [42 CFR 438.3(s)]. The MCO shall not include drugs by manufacturers not enrolled in the OBRA 90 Medicaid rebate program on its formulary without DHHS consent.

14.1.2. The MCO shall adhere to New Hampshire law with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, law 2004, SB 383-FN, Sect. IVa. Specifically, a MCO member shall continue to be treated, or, if newly diagnosed, may be treated with a non-preferred drug based on any one of the following criteria:

14.1.2.1. Allergy to all medications within the same class on the preferred drug list;

14.1.2.2. Contraindication to or drug-to-drug interaction with all medications within the same class on the preferred drug list;

14.1.2.3. History of unacceptable or toxic side effects to all medications within the same class on the preferred drug list;

14.1.2.4. Therapeutic failure of all medications within the same class on the preferred drug list;

14.1.2.5. An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal Food and Drug Administration-approved indication;

14.1.2.6. Age specific indication;

14.1.2.7. Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or

14.1.2.8. Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

14.1.3. The MCO shall submit all of its policies, prior authorizations, point-of-sale and drug utilization review edits and pharmacy services procedures related to its maintenance drug policy, specialty pharmacy programs, and any new pharmacy service program proposed by the MCO to DHHS for its approval at least 60 calendar days prior to implementation.

14.1.4. The MCO shall submit the items described in 14.1.1 and 14.1.3 to DHHS for approval sixty (60) calendar days prior to the program start date of Step 1.

14.1.5. Any modifications to items listed in 14.1.1 and 14.1.3 shall be submitted for approval at least sixty (60) calendar days prior to the proposed effective date of the modification.

14.1.6. The MCO shall notify members and providers of any modifications to items listed in 14.1.1 and 14.1.3 thirty (30) calendar days prior to the modification effective date.

14.1.7. Implementation of a modification shall not commence prior to DHHS approval.

14.1.8. At the time a member with currently prescribed medications transitions to an MCO: upon MCO's receipt of (written or verbal) notification validating such prescribed medications from a treating provider, or a request or verification from a pharmacy that has previously dispensed the medication, or via direct data from DHHS, the MCO shall continue to cover such medications through the earlier of sixty (60) calendar days from the member's enrollment date, or until completion of a medical necessity review. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

14.1.9. The MCO shall adjudicate pharmacy claims for its members utilizing a point of service (POS) system where appropriate. System modifications, including but not limited to systems maintenance, software upgrades, implementation of International Classification of Diseases- 10 (ICD-10) code sets, and NDC code sets or migrations to new versions of National Council for Prescription Drug Programs (NCPDP) transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

14.1.10.In accordance with Section 1927 (d)(5)(A and B) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization and reimburse for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation when prior authorization cannot be obtained.

14.1.11.The MCO shall develop or participate in other State of New Hampshire pharmacy related quality improvement initiatives. At minimum, the MCO shall routinely monitor and address:

14.1.11.1.Polypharmacy (physical health and behavioral health medications);

14.1.11.2.Adherence to the appropriate use of maintenance medications, such as the elimination of gaps in refills;

14.1.11.3.The appropriate use of behavioral health medications in children by encouraging the use of and reimbursing for consultations with child psychiatrists;

14.1.11.4.For those beneficiaries with a diagnosis for substance use disorder (SUD) and all infants with a diagnosis of neonatal abstinence syndrome (NAS), or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall evaluate these patients needs for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment;

14.1.11.5.For those beneficiaries who enter the MCO lock-in program, the MCO shall evaluate the need for SUD treatment.

14.1.11.6.The MCO shall require prior authorization documenting the rationale for the prescription of more than 200 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective April 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescription of more than 120 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective October 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescriptions of more than 100 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries effective upon NH Board Administrative Rule MED 502 Opioid Prescribing;

14.1.12.In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 (CMS) rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process, in accordance with section 1927(b) of the SSA, and the MCO shall submit the encounter data file within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment.

14.1.13.The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for members for medications covered by other payers.

14.1.14.Specialty Drugs. The MCO shall pay for all specialty drugs consistent with the MCO's formulary and pharmacy edits and criteria.

14.1.15. DHHS will be directly responsible for the pharmacy benefit for Carbaglu and Ravicti, and those Hepatitis C and Hemophilia drugs specifically excluded from the actuarial rate calculations.

14.1.16.Other specialty and orphan drugs.

14.1.16.1.Other currently FDA approved specialty and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

14.1.16.2.When medically necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

14.1.17.Polypharmacy medication review. The MCO shall provide an offer for medication review and counseling to address polypharmacy.

14.1.17.1.MCO shall offer a medication review and counseling no less than annually by a pharmacist or other health care professional as follows:

14.1.17.1.1. To the primary care provider and care taker for children less than 19 years dispensed four (4) or more drugs per month (or prescriptions for 90 day supply covering each month); and

14.1.17.1.2.To adult beneficiaries dispensed more than 10 drugs each month (or prescriptions for 90 day supply covering each month).

14.1.18.The MCO shall adhere to federal regulation with respect to providing pharmacy data required to complete the Annual Drug Utilization Review Report to CMS:

14.1.18.1. The MCO must provide a detailed description of its drug utilization review program to DHHS on an annual basis in accordance with the Medicaid Drug Utilization Review Annual Report format and requirements; and

14.1.18.2. The MCO must operate a drug utilization review program in accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, which includes:

14.1.18.2.1. Prospective drug utilization review;

14.1.18.2.2.Retrospective drug utilization review; and

14.1.18.2.3. An educational program for providers including prescribers and dispensers.

14.2. Continuity of Care

14.2.1. The MCO shall provide continuity of care for current beneficiaries after the transition of the PDL to the MCO. For existing beneficiaries, the MCO shall provide coverage for all drugs for each current beneficiary for six months beginning September 1, 2015 for those drugs dispensed to the beneficiary within the six months prior to September 1, 2015.

14.3. Use of Psychotropic Medicines for Children in Foster Care – DCYF's SafeRx Program

14.3.1. The MCO shall assist in the oversight and management of the use of psychotropic medicines for children and youth in DCYF placement in accordance with PL (Public Law 112-34) and in accordance with DCYF policy 1653. Assistance includes:

14.3.1.1.Psychiatry review of Medications when requested by DCYF staff, with Peer To Peer discussion if warranted to include:

14.3.1.1.1. Pharmacy claims;

14.3.1.1.2. Provider progress notes;

14.3.1.1.3. Telephone contact with the providers, if necessary;

14.3.1.1.4. Current Diagnoses, DSM I-III;

14.3.1.1.5. Current Behavioral Functioning; and

14.3.1.1.6. Information from the placement provider, either foster care or residential re: behaviors and medication response.

14.3.1.2.Edits in pharmacy systems for outlying red flag criteria that would require further explanation and authorization including:

14.3.1.2.1. Children 5 and under being prescribed antipsychotics;

14.3.1.2.2. Children 3 and under on any psychotropic medicine; and

14.3.1.2.3. A child or youth being prescribed 4 or more psychotropic medicines, allowing for tapering schedules for ending one medicine and starting a new medicine.

15. Reserved.

16. Member Enrollment and Disenrollment

16.1. Eligibility

16.1.1. The State has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether he/she will be enrolled in the Care Management program. The State shall maintain its current responsibility for determining member eligibility. The MCO shall comply with eligibility decisions made by DHHS.

16.1.2. The MCO shall ensure that ninety-five percent (95%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. Data received Monday-Friday is to be uploaded Tuesday-Saturday between 12 AM EST and 8AM EST. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded by 10 AM EST. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond 10 AM EST.

16.1.3. The ASCX12 834 enrollment file will limit enrollment history to eligibility spans reflective of any assignment of the member with the MCO.

16.1.4. To ensure appropriate continuity of care, DHHS will provide up to two (2) years (as available) of all fee-for-service paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all fee-for-service Medicaid beneficiaries assigned to MCO. For members transitioning from another MCO, DHHS will also provide such claims data as well as available encounter information regarding the member supplied by other MCOs.

16.2. Relationship with Enrollment Services

16.2.1. DHHS or its designee shall be responsible for member enrollment and passing that information along to the MCO for plan enrollment [42 CFR 438.3(d)(2)].

16.2.2. The MCO shall accept individuals into its plan from DHHS or its designee in the order in which they apply without restriction, (unless authorized by the regional administrator), up to the limits set in this Agreement [42 CFR 438.3(d)(1)].

16.2.3. The MCO will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll [42 CFR 438.3(d)(3)].

16.2.4. The MCO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has a discriminatory effect [42 CFR 438.3(d)(4].

16.2.5. The MCO shall furnish information to DHHS or its designee so that it may comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the recipient receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; State Medicaid Manual (SMM) 2090.1; SMM 2101].

16.2.6. The MCO shall provide information, within five (5) business days, to DHHS or its designee that allows for a determination of a possible change in eligibility of members (for example, those who have died, been incarcerated, or moved out-of-state).

16.3. Enrollment

16.3.1. The MCO shall accept members who choose to enroll in the MCO:

16.3.1.1.During the initial enrollment period;

16.3.1.2.During an annual enrollment period;

16.3.1.3.During a renegotiation or reprocurement enrollment period;

16.3.1.4.If the member requests to be assigned to the same plan in which another family member is currently enrolled; or

16.3.1.5.Who have disenrolled with another MCO at the time described in 16.5.3.1.

16.3.2. The MCO shall accept that enrollee enrollment is voluntary, except as described in 42 CFR 438.50.

16.3.3. The MCO shall accept for automatic re-enrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less.

16.3.4. The MCO shall accept members who have been auto-assigned by DHHS to the MCO.

16.3.5. The MCO shall accept members who are auto-assigned to another MCO but have an established relationship with a primary care provider that is not in the network of the auto-assigned MCO. The member can request enrollment any time during the first twelve (12) months of auto-assignment.

16.4. Auto-Assignment

16.4.1. DHHS will use the following auto-assignment methodology:

16.4.1.1.Preference to an MCO with which there is already a family affiliation;

16.4.1.2.Equal assignment among the MCOs.

16.4.2. DHHS reserves the right to change the auto assignment process at its discretion.

16.4.3. DHHS may also revise its auto-assignment methodology during the Contract Period for new Medicaid members who do not select an MCO (Default Members). The new assignment methodology would reward those MCOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. DHHS will also consider other appropriate factors.

16.4.4. DHHS may revise its auto-assignment methodology when exercising renegotiation and reprocurement rights under section 3.9.1 of this Agreement.

16.5. Disenrollment

16.5.1. Disenrollment provisions of 42 CFR 438.56(d)(2) apply to all members, regardless of whether the member is mandatory or voluntary [42 CFR 438.56(a); SMD letter 01/21/98].

16.5.2. A member may request disenrollment with cause at any time when:

16.5.2.1.The member moves out of state;

16.5.2.2.The member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the member to unnecessary risk; or

16.5.2.3.Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to providers experienced in dealing with the member's health care needs [42 CFR 438.56(d)(2)]

16.5.3. A member may request disenrollment without cause, at the following times:

16.5.3.1.During the ninety (90) calendar days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later;

16.5.3.2.For members who are auto-assigned to a MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO, the member can request disenrollment during the first twelve (12) months of enrollment at any time;

16.5.3.3.Any time for members who enroll on a voluntary basis;

16.5.3.4.During open enrollment every twelve (12) months;

16.5.3.5. During open enrollment related to renegotiation and reprocurement under Section 3.9.

16.5.3.6. For sixty (60) calendar days following an automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual enrollment/disenrollment opportunity (This provision applies to re-determinations only and does not apply when a member is completing a new application for Medicaid eligibility); and

16.5.3.7. When DHHS imposes the intermediate sanction on the MCO specified in 42 CFR 438.702(a)(3) [§1932(a)(4)(A) of the SSA; §1932(e)(2)(C) of the SSA; 42 CFR 438.56(c)(1); 438.56(c)(2)(i), (ii), (iii), and (iv); 42 CFR 438.702(a)(3); SMD letter 02/20/98; SMD letter 01/21/98]

16.5.4. The MCO shall provide members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period.

16.5.5. If a member is requesting disenrollment, the member (or his or her representative) shall submit an oral or written request to DHHS or its agent.

16.5.6. The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS' request for information.

16.5.7. The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons [42 CFR 438.56(b)(1); SMM 2090.12]:

16.5.7.1. Member has established out of state residence;

16.5.7.2. Member death;

16.5.7.3. Determination that the member is ineligible for enrollment based on the criteria specified in this Agreement regarding excluded populations; or

16.5.7.4. Fraudulent use of the member ID card.

16.5.8. The MCO shall not request disenrollment of a member for any reason not permitted in this Agreement [42 CFR 438.56(b)(3)].

16.5.9. The MCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular

member or other members) or abuse of substances, prescribed or illicit, and any legal consequences resulting from substance abuse. [42 CFR 438.56(b)(2)].

16.5.10.The MCO may request disenrollment in the event of threatening or abusive behavior that jeopardizes the health or safety of members, staff, or providers.

16.5.11.If an MCO is requesting disenrollment of a member, the MCO shall:

16.5.11.1.Specify the reasons for the requested disenrollment of the member; and

16.5.11.2.Submit a request for involuntary disenrollment to DHHS (or its agent) along with documentation and justification, for review and approval

16.5.12.Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member or the MCO files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); SMM 2090.6; SMM 2090.11].

16.5.13.DHHS (or its agent) shall provide for automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less [42 CFR 438.56(g)].

17. Member Services

17.1. Member Information

17.1.1. The MCO shall maintain a Member Services Department to assist members and their family members, guardians or other authorized individuals in obtaining covered services under the Care Management program.

17.1.2. The MCO shall have a 'No Wrong Door' approach, consistent with the DHHS Balancing Incentive Program, to member calls and inquiries, and shall have one toll-free number for members to contact.

17.1.3. The MCO shall have in place a mechanism to help members and potential members understand the requirement and benefits of the plan [42 CFR 438.10(c)(7)].

17.1.4. The MCO shall make a welcome call to each new member within thirty (30) days of the member's enrollment in the MCO. A minimum of three (3) attempts should be made at various times of the day, on different days, for at least ninety-five percent (95%) of new members. The welcome call shall at a minimum:

17.1.4.1. Assist the member to select a Primary Care Provider (PCP) or confirm selection of a PCP;

17.1.4.2. Include a brief Health Needs Assessment;

17.1.4.3. Screen for special needs and /or services of the member; and

17.1.4.4. Answer any other member questions about the MCO and ensure that members can access information in their preferred language.

17.1.5. Welcome calls shall not be required for members residing in a nursing facility longer than 120 days. The MCO shall:

17.1.5.1. Meet with each nursing facility no less than annually to provide an orientation to the MCM program and instructions regarding completion of the Health Needs Assessment for each member residing in a nursing facility longer than 120 days; and

17.1.5.2. Send letters to members residing in nursing facilities longer than 120 days or their authorized representatives describing welcome calls and how a member or their authorized representative can request a welcome call.

17.1.6. The MCO shall send a letter to a member upon initial enrollment, and anytime the member requests a new Primary Care Provider (PCP), confirming the member's PCP and providing the PCP's name address and telephone number.

17.1.7. The MCO shall issue an Identification Card (ID Card) to all new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. The ID Card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the ID card:

17.1.7.1.The member's name;

17.1.7.2.The member's date of birth;

17.1.7.3.The member's Medicaid ID number assigned by DHHS at the time of eligibility determination;

17.1.7.4.The name of the MCO; and

17.1.7.5.The name of MCO's NHHPP product;

17.1.7.6.The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

17.1.7.7.How to file an appeal or grievance.

17.1.8. The MCO shall reissue a Member ID card if:

17.1.8.1.A member reports a lost card;

17.1.8.2.A member has a name change; or

17.1.8.3.Any other reason that results in a change to the information disclosed on the ID card.

17.1.9. The MCO shall publish member information in the form of a member handbook available at the time of member enrollment in the plan for benefits effective January 1, 2018. The member handbook shall be based upon the model enrollee handbook developed by DHHS.

17.1.9.1. Two weeks in advance of open enrollment, the MCOs shall inform all members by mail of their right to receive at no cost to any member a written copy of the member handbook effective for the new benefit year.

17.1.10.The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives.

17.1.11.The MCO shall submit the member handbook to DHHS for approval at the time it is developed and after any substantive revisions, prior to publication and distribution

17.1.12.Pursuant to the requirements set forth in 42 CFR 438.10, the Member Handbook shall include, in easily understood language, but not be limited to:

17.1.12.1.A table of contents;

17.1.12.2. DHHS developed definitions so that enrollees can understand the following terminology: appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, grievance, habilitation services and devices, home health care, hospice services, hospitalization, hospital, outpatient care, physician services, prescription drug coverage, prescription drugs, primary care physician, PCP, rehabilitation services and devices, skilled nursing care, and specialist.

17.1.12.3.Information about the role of the primary care provider (PCP);

17.1.12.4.Information about choosing and changing a PCP;

17.1.12.5.Appointment procedures;

17.1.12.6.[Intentionally left blank.]

17.1.12.7.Description of all available benefits and services, including information on out-of-network providers;Information on how to access services, including EPSDT services, non-emergency transportation services, and maternity and family planning services. The handbook should also explain that the MCO cannot require a member to receive prior approval prior to choosing a family planning provider;

17.1.12.8.An explanation of any service limitations or exclusions from coverage;

17.1.12.9.A notice stating that the MCO shall be liable only for those services authorized by or required of the health plan;

17.1.12.10.Information on where and how members may access benefits not available from or not covered by the MCO;

17.1.12.11.The Necessity definitions used in determining whether services will be covered;

17.1.12.12.Detailed information regarding the amount, duration, and scope of benefits so that enrollees understand the benefits to which they are entitled.

17.1.12.13.A description of all pre-certification, prior authorization, or other requirements for treatments and services;

17.1.12.14.Information regarding prior authorization in the event the member chooses to transfer to another MCO and the member's right to continue to utilize a provider specified in a prior authorization regardless of whether the provider is participating in the MCO network;

17.1.12.15.The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;

17.1.12.16.Information on how to obtain services when the member is out of the State and for after-hours coverage;

17.1.12.17.Cost-sharing requirements;

17.1.12.18.Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including an inclusion of the MCO's toll-free telephone line and website;

17.1.12.19.A description of Utilization Review policies and procedures used by the MCO;

17.1.12.20.A description of those member rights and responsibilities, described in 17.3 of this Agreement, but also including but not limited to notification that:

17.1.12.20.1.Oral interpretation is available for any language, and information as to how to access those services;

17.1.12.20.2.Written translation is available in prevalent languages, and information as to how to access those services;

17.1.12.20.3.Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and information as to how to access those services;

17.1.12.21.The policies and procedures for disenrollment;

17.1.12.22.Information on Advance Directives;

17.1.12.23.A statement that additional information, including information on the structure and operation of the MCO plan and provider incentive plans, shall be made available upon request;

17.1.12.24.Member rights and protections;

17.1.12.25.Information on the Grievance, Appeal, and Fair Hearing procedures and timeframes in a DHHS-approved description, including:

17.1.12.25.1.The right to file grievances and appeals;

17.1.12.25.2.The requirements and timeframes for filing a grievance or appeal;

17.1.12.25.3.The availability of assistance in the filing process;

17.1.12.25.4.The right to request a State fair hearing after the MCO has made a determination on an enrollee's appeal which is adverse to the enrollee; and

17.1.12.25.5.An enrollee's right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however if the enrollee receives an adverse decision then the enrollee may be required to pay for the cost of service furnished while the appeal or State fair hearing is pending as specified in 42 CFR 438.10(g)(2);

17.1.12.26.Member's right to a second opinion from a qualified health care professional within the network, or one outside the network arranged by the MCO at no cost to the member. [42 CFR 438.206(b)(3)].

17.1.12.27.The extent to which, and how, after hours and emergency coverage are provided including:

17.1.12.27.1.What constitutes an emergency and emergency medical care; and

17.1.12.27.2.The fact that prior authorization is not required for emergency services; and

17.1.12.27.3.The enrollee's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)];

17.1.12.28.Information on how to access the New Hampshire Office of the Long Term Care Ombudsman;

17.1.12.29. Information on how to access auxiliary aids and services, including additional information in alternative formats or languages;

17.1.12.30. Information and guidance as to how the enrollee can effectively use the managed care program as described in 42 CFR 438.10(g)(2);

17.1.12.31.Information on how to report suspected fraud or abuse;

17.1.12.32.Information on how to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center who can provide all enrollees and potential enrollees choice counseling and information on managed care; and

17.1.12.33. Disenrollment information.

17.1.13.The MCO shall produce a revised member handbook, or an insert informing members of changes to covered services, upon DHHS notification of any change in covered services, and at least thirty (30) calendar days prior to the effective date of such change. In addition to changes to documentation, the MCO shall notify all existing members of the covered services changes at least thirty (30) calendar days prior to the effective date of such changes.

17.1.14.The MCO shall mail the handbook to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment [42 CFR 438.10(g)(1)].

17.1.15.The MCO shall notify all enrollees of their disenrollment rights, at a minimum, annually [42 CFR 438.10 (f)].

17.1.16. [Intentionally left blank.]

17.1.17.The MCO shall notify all enrollees, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the plan's website.The member information appearing on the website shall include the following, at a minimum:

17.1.17.1.Information contained in the Member Handbook

17.1.17.2.The following information on the MCO's provider network:

17.1.17.2.1.Names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English languages (including American Sign Language) spoken by current contracted providers, including identification of providers that are not accepting new patients. This shall include, at a minimum: information on PCPs, specialists, Family Planning Providers, pharmacies, Federally

Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals;

17.1.17.2.2. Any restrictions on the member's freedom of choice among network providers; and

17.1.17.2.3. How to file an appeal and/or a grievance.

17.1.18. For any change that affects member rights, filing requirements, time frames for grievances, appeals, and State fair hearing, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each member written notice of the change at least thirty (30) days before the intended effective date of the change.

17.1.19. Should the MCO not cover a covered service because of moral/ethical or religious reasons, the MCO shall provide a list of these services to the Department. This list shall be used by the Department to provide information to members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

17.1.20. Should the MCO contract with providers and/or subcontractors to deliver services to members pursuant to the MCO's obligations under this Contract and the providers or subcontractors cannot provide a covered service because of moral/ethical or religious reasons, the MCO shall provide a list of these services to the Department. This list shall be used by the MCO and Department to provide information to members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

17.1.21.

17.1.22. The MCO shall submit a copy of all information intended for members to DHHS for approval ten (10) business days prior to distribution.

17.2. Language and Format of Member Information

17.2.1. The MCO shall develop all member materials at or below a sixth (6th) grade reading level, as measured by the appropriate score on the Flesch reading ease test.

17.2.2. The MCO shall use the DHHS developed definitions consistently throughout its user manual, notices, and in any other form of client communication.

17.2.3. The MCO shall develop enrollee notices in accordance with the DHHS model notices.

17.2.4. The MCO shall provide all enrollment notices, information materials, and instructional materials relating to members and potential members in a manner and

format that may be easily understood in a font size no smaller than 12 point [42 CFR 438.10(d) / SMD Letter 2/20/98].

17.2.5. The MCO's written materials shall be developed to meet all applicable Cultural Considerations requirements in Section 18 so that they are communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The MCO shall inform members that information is available in alternative formats and how to access those formats [42 CFR 438.10(d)(6)].

17.2.6. The MCO shall make all written member information available in English, Spanish, and the commonly encountered languages of New Hampshire. All written member information shall include at the bottom a tagline explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the MCO's Customer Service Center. The MCO shall also provide all written member information in large print with a font size no smaller than 18 point upon request [42 CFR 438.10(d)(3)].

17.2.6.1. Written member information shall include at a minimum provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.

17.2.7. The MCO shall also make oral interpretation services available free of charge to each member or potential member for MCO covered services. This applies to all non-English languages, not just those that DHHS identifies as languages of other Major Population Groups. The beneficiary shall not to be charged for interpretation services. The MCO shall notify members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services [42 CFR 438.10(d)].The MCO shall provide auxiliary aids such as TTY/TDY and American Sign Language interpreters available free of charge to each member or potential member who requires these services [42 CFR 438.10(d)].

17.3. Member Rights

17.3.1. The MCO shall have written policies which shall be included in the member handbook and posted on the MCO website regarding member rights [42 CFR 438.100] including:

17.3.1.1. Each managed care member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;

17.3.1.2. Each managed care member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

17.3.1.3. Each managed care member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment;

17.3.1.4. Each managed care member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

17.3.1.5. Each managed care member is guaranteed the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 42 CFR 438.100; and

17.3.1.6. Each managed care member has a right to a second opinion. [42 CFR 438.206].

17.3.2. Each member is free to exercise his/her rights, and that the MCO shall assure that the exercise of those rights shall not adversely affect the way the MCO and its providers or DHHS treat the member [42 CFR 438.100(c)].

17.3.3. Each managed care member has the right to request and receive any MCO's written physician incentive plans.

17.4. Member Call Center

17.4.1. The MCO shall operate a NH specific call center Monday through Friday, except for state approved holidays. The call center shall be staffed with personnel who are knowledgeable about the MCOs plan in NH to answer member inquiries.

17.4.2. At a minimum, the call center shall be operational:

17.4.2.1. Two days per week: 8:00 am EST to 5:00 pm EST;

17.4.2.2. Three days per week: 8:00 am EST to 8:00 pm EST; and

17.4.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

17.4.3. The member call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

17.4.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

17.4.3.2. Average Speed of Answer: Ninety percent (90%) of calls will be answered with live voice within thirty (30) seconds; and

17.4.3.3. Voicemail messages shall be responded to no later than the next business day.

17.4.4. The MCO shall develop a means of coordinating its call center with the DHHS Customer Service Center.

17.4.5. The MCO shall develop a warm transfer protocol for members who may call the incorrect call center to speak to the correct representative and provide monthly reports to DHHS on the number of warm transfers made and the program to which the member was transferred.

17.5. Member Information Line

17.5.1. The MCO shall establish a member hotline that shall be an automated system that operates outside of the call center standard hours, Monday through Friday, and at all hours on weekends and holidays.

17.5.2. The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for callers to leave messages.

17.5.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages.

17.5.4. A representative of the MCO shall return messages no later than the next business day.

17.6. Marketing

17.6.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing to potential members [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.2. The MCO shall submit all MCO marketing material to DHHS for approval before distribution [§1932(d)(2)(A)(1) of the SSA; 42 CFR 438.104(b)(1)(i); SMD letter 12/30/97]. DHHS will identify any required changes to the marketing materials within fifteen (15) business days. If DHHS has not responded to a request for review by the fifteenth (15th) business day, the MCO may proceed to use the submitted materials.

17.6.3. The MCO shall comply with federal requirements for provision of information that ensures the potential member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

17.6.4. The MCO marketing materials shall not contain false or materially misleading information.

17.6.5. The MCO shall not offer other insurance products as inducement to enroll.

17.6.6. The MCO shall ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients of DHHS [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.7. The MCO's marketing materials shall not contain any written or oral assertions or statements that:

17.6.7.1. The recipient must enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

17.6.7.2. That the MCO is endorsed by CMS, the Federal or State government, or similar entity [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101]

17.6.8. The MCO shall distribute marketing materials to the entire state in accordance with §1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1 and SMM 2101. The MCO's marketing materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.7. Member Engagement Strategy

17.7.1. The MCO shall develop and facilitate an active member advisory board that is composed of members who represent its member population. At least twenty-five percent (25%) of the members of the advisory board should be receiving an LTSS service or be a support person, who is not a paid service provider or employed as an advocate, to a member receiving an LTSS service. Representation on the consumer advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. The advisory board shall meet at least quarterly. The advisory board shall meet in-person or through interactive technology including but not limited to a conference call or webinar and provide a member perspective to influence the MCO's quality improvement program,

program changes and decisions. All costs related to the member advisory board shall be the responsibility of the MCO.

17.7.2. The MCO shall hold in-person regional member meetings for two-way communication where members can provide input and ask questions and the MCO can ask questions and obtain feedback from members. Regional meetings shall be held at least twice each Agreement year. The MCO shall make efforts to provide video conferencing opportunities for members to attend the regional meetings. If video conferencing is not available then, the MCO shall use alternate technologies as available for all meetings.

17.7.3. The MCO shall report on the activities of the meetings required in Sections 17.7.1 and 17.7.2 including meeting dates, board members, topics discussed and actions taken in response to Board contributions to DHHS in the Medicaid Care Management Program Comprehensive Annual Report.

17.7.4. The MCO shall conduct a member satisfaction survey at least annually in accordance with National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) requirements to gain a broader perspective of member opinions. The MCO survey instrument is subject to DHHS approval. The results of these surveys shall be made available to DHHS to be measured against criteria established by DHHS, and to the MCO's membership [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.10(f)(6); 42 CFR 438.10(g); 42 CFR 438.6(h)].

17.7.5. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

17.8. Provider Directory

17.8.1. The MCO shall publish a Provider Directory that shall be approved by DHHS prior to publication and distribution. The MCO shall submit the draft directory and all substantive changes to DHHS for approval.

17.8.2. The Provider Directory shall include names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English language (including American Sign Language) spoken by, current contracted providers. This shall include, at a minimum; information on PCPs, specialists, Family Planning Providers, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals.

17.8.3. The Provider Directory shall provide all information according to the requirements of 42 CFR 438.10(h).

17.8.4. The MCO shall send a letter to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the member to the Provider Directory on the MCO's website and informing the member of the right to a printed version of provider directory information upon request [42 CFR 438.10(h)].

17.8.5. The MCO shall notify all members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the plan's website in a machine readable file and format as specified by the Secretary. The MCO shall update the paper copy of the Provider Directory at least monthly and shall update no later than thirty (30) calendar days after the MCO receives updated information. [42 CFR 438.10(h)(4)].

17.8.6. The MCO shall post on its website a searchable list of all contracted providers. At a minimum, this list shall be searchable by provider name, specialty, and location.

17.8.7. Thirty (30) calendar days after contract effective date or ninety (90) calendar days prior to the Program start date, whichever is later, the MCO shall develop and submit the draft Provider Directory template to DHHS for approval and thirty (30) calendar days prior to each Program Start Date the MCO shall submit the final provider directory.

17.8.8. Upon the termination of a contracted provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify enrollees who received their primary care from, or was seen on a regular basis by, the terminated provider.

17.9. Program Website

17.9.1. The MCO shall develop and maintain, consistent with DHHS standards and other applicable Federal and State laws, a website to provide general information about the MCO's program, its provider network, the member handbook, its member services, and its grievance and appeals process.

17.9.2. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes.

17.9.3. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory. The Provider Directory shall identify all providers, including primary care, specialty care, behavioral health, substance abuse, home health, home care, rehabilitation, hospital, and other providers, and include the following information for each provider:

17.9.3.1.Address of all practice/facility locations;

17.9.3.2.Gender;

17.9.3.3. Office hours;

17.9.3.4. Telephone numbers;

17.9.3.5. Website (if applicable);

17.9.3.6. Accommodations provided for people with disabilities;

17.9.3.7. Whether the provider has completed cultural competence training;

17.9.3.8.Hospital affiliations, if applicable;

17.9.3.9.Open/close status for MCO members;

17.9.3.10.Languages spoken (including American Sign Language) in each provider location;

17.9.3.11.Medical Specialty; and

17.9.3.12.Board certification, when applicable.

17.9.3.13.The MCO program content included on the website shall be:

17.9.3.14.Written in English, Spanish, and any other of the commonly encountered languages in the State;

17.9.3.15.Culturally appropriate;

17.9.3.16.Written for understanding at the 6th grade reading level; and

17.9.3.17.Geared to the health needs of the enrolled MCO program population.

17.9.3.18.The MCO shall maintain an updated list of formulary drug lists on its website. Such information shall include:

17.9.3.19.Which medications are covered (both generic and name brand); and

17.9.3.20.Which tier each medication is on.

17.9.4. The MCO's NH Medicaid Care Management website shall be compliant with the Federal Department of Justice "Accessibility of State and Local Government Websites to people with disabilities".

18. Culturally and Linguistically Competent Services

18.1. Cultural Competency Plan

18.1.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how the MCO shall ensure that services are provided in a culturally and linguistically competent manner to all Medicaid members, including those with Limited English Proficiency (LEP). The Cultural Competency Plan shall describe how the providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. The MCO shall work with DHHS Office of Minority Heath & Refugee Affairs and the New Hampshire Medical Society to address cultural and linguistic considerations as defined in the section.

18.2. General Provisions

18.2.1. The MCO shall participate in efforts to promote the delivery of services in a culturally and linguistically competent manner to all members and their families, including those with LEP and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)].

18.2.2. The MCO shall develop appropriate methods of communicating and working with its members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

18.2.3. The MCO shall develop appropriate methods for identifying and tracking members' needs for communication assistance for health encounters including preferred spoken language for health encounters, need for interpreter, and preferred language for written health information.

18.2.4. The MCO shall collect data regarding member's race, ethnicity, and spoken language in accordance with the current best practice standards from the Office of Management and Budget and/or the 2011 final standards for data collection as required by Section 4302 of the Affordable Care Act from the federal Department of Health and Human Services.

18.2.5. The MCO shall not use children or minors to provide interpretation services.

18.2.6. If the member declines offered free interpretation services, there must be a process in place for informing the member of the potential consequences of declination with the assistance of a competent interpreter to assure the member's understanding, as well as a process to document the member's declination. Interpreter services must be re-offered at every new contact. Every declination requires new documentation of the offer and decline.

18.2.7. The MCO shall respect members whose lifestyle or customs may differ from those of the majority of members.

18.2.8. The MCO shall ensure interpreter services are available to any member who requests them, regardless of the prevalence of the member's language within the overall program for all health plan and MCO services exclusive of inpatient services. The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e., will provide meaningful access) for all members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and will be based upon the unique needs and circumstances of each individual. Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the provider of the encounter service.

18.2.9. The MCO shall bear the cost of interpretive services, including American Sign Language (ASL) interpreters and translation into Braille materials available to hearing- and vision-impaired members.

18.2.10.The Member Handbook shall include information on the availability of oral and interpretive services.

18.2.11.The MCO shall communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care.

18.2.12.As a condition of receipt of Federal financial assistance, the MCO acknowledges and agrees that it must comply with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin (42 U.S.C. 2000d et seq.).

18.2.13.As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of Limited English Proficiency (LEP). To ensure compliance with Title VI, the MCO must take reasonable steps to ensure that LEP persons have meaningful access to the MCO's programs. The MCO shall provide the following assistance, including, but not limited to:

18.2.13.1.Offer language assistance to individuals who have LEP and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

18.2.13.2.Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

18.2.13.3.Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

18.2.13.4.Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

18.2.14.Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. MCOs are encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. For assistance and information regarding MCO LEP obligations, go to **http://www.lep.gov**.

19. Grievances and Appeals

19.1. General Requirements

19.1.1. The MCO shall develop, implement and maintain a Grievance System under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance and which includes a grievance process, an appeal process, and access to the State's fair hearing system. The MCO shall ensure that the Grievance System is in compliance with 42 CFR 438 Subpart F, and N.H. Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

19.1.2. The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS' review and approval prior to the first readiness review. Any proposed changes to the Grievance System must be approved by DHHS prior to implementation.

19.1.3. The Grievance System shall be responsive to any grievance or appeal of dual- eligible members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accord with this Agreement. In the event the MCO, after review, determines that the dual-eligible member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the member to the State's SHIP program, which is currently administered by Service Link Aging and Disability Resource Center.

19.1.4. The MCO shall be responsible for ensuring that the Grievance System (grievance process, appeal process, and access to the State's fair hearing system) complies with the following general requirements. The MCO must:

19.1.4.1. Give members any reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the member in providing written consent for appeals;

19.1.4.2. Acknowledge receipt of each grievance and appeal (including oral appeals), unless the enrollee or authorized provider requests expedited resolution;

19.1.4.3. Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making;

19.1.4.4. Ensure that decision makers take into account all comments, documents, records, and other information submitted by the enrollee of their

representative without regard to whether such information was submitted or considered in the initial adverse benefit determination; and

19.1.4.4.1. If deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the member's condition or disease:

a. An appeal of a denial based on lack of medical necessity;

b. A grievance regarding denial of expedited resolutions of an appeal; or

c. A grievance or appeal that involves clinical issues.

19.1.5. The MCO shall send written notice to members and providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

19.1.6. The MCO shall provide information as specified in 42 CFR § 438.10(g) about the Grievance System to providers and subcontractors at the time they enter into a contact or subcontract. The information shall include, but is not limited to:

19.1.6.1.The member's right (or provider acting on their behalf) to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

19.1.6.2.The member's right to file grievances and appeals and their requirements and timeframes for filing;

19.1.6.3.The availability of assistance with filing;

19.1.6.4.The toll-free numbers to file oral grievances and appeals;

19.1.6.5.The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

19.1.6.6.Any State-determined provider appeal rights to challenge the failure of the MCO to cover a service.

19.1.7. The MCO shall make available training to providers in supporting and assisting members in the Grievance System.

19.1.8. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the member, the dates received, the dates of each review, the dates of the grievance or appeal, and the date of resolution.

19.1.9. The MCO shall provide a report of all actions, grievances, and appeals, including all matters handled by delegated entities, to DHHS on a monthly basis.

19.1.10. The MCO shall review Grievance System information as part of the State quality strategy and in accord with this Agreement and 42 CFR 438.402. The MCO shall make such information accessible to the State and available upon request to CMS.

19.1.11. The MCO shall provide any and all provider complaint and appeal logs to DHHS.

19.2. Grievance Process

19.2.1. The MCO shall develop, implement, and maintain a grievance process that establishes the procedure for addressing member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.2.2. The grievance process shall address member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. An enrollee or the enrollee's authorized representative with written consent may file a grievance at any time.

19.2.3. Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated, may file a complaint with the MCO in accordance with He-M 204.

19.2.4. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR part 438, subpart K may file a grievance.

19.2.5. The MCO shall have policies and procedures addressing the grievance process, which comply with the requirements of this Agreement. The MCO shall submit in advance to DHHS for its review and approval, all grievance process policies and procedures and related notices to members regarding the grievance process. Any proposed changes to the grievance process must be approved by DHHS prior to implementation.

19.2.6. The MCO shall allow a member, or the member's authorized representative with the member's written consent to file a grievance with the MCO either orally or in writing [42 CFR 438.402(c)].

19.2.7. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance for one hundred percent (100%) of members filing a grievance. If the enrollee requests disenrollment, then the MCO shall resolve the grievance in time to permit

the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment.

19.2.8. The MCO shall notify members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues must be in writing.

19.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

19.3. Appeal Process

19.3.1. The MCO shall develop, implement, and maintain an appeal process that establishes the procedure for addressing member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.3.2. The MCO shall allow a member, or the member's authorized representative, or a provider acting on behalf of the member and with the member's written consent, to request an appeal orally or in writing of any MCO action [42 CFR 438.402(c)].

19.3.3. The MCO shall include as parties to the appeal, the member and the member's authorized representative, or the legal representative of the deceased member's estate.

19.3.4. For appeals of standard service authorization decisions, the MCO shall allow a member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. This shall also apply to a member's request for an expedited appeal. An oral appeal must be followed by a written, signed appeal.

19.3.5. The MCO shall ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the member or the authorized provider requests expedited resolution. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution.

19.3.6. If DHHS receives a request to appeal an action of the MCO, DHHS will forward relevant information to the MCO and the MCO will contact the member and acknowledge receipt of the appeal.

19.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

19.3.8. The MCO shall allow the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO shall inform the member of the limited time available for this in the case of expedited resolution.

19.3.9. The MCO shall provide the member and the member's representative opportunity, to receive the member's case file, including medical records, and any other documents and records considered during the appeal process free of charge prior to the hearing.

19.3.10. The MCO shall resolve one hundred percent (100%) of standard member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. The date of filing shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest. Or, in the case of a provider filing an appeal on behalf of the member, the date of filing shall be considered the date upon which the MCO receives authorization from the member for the provider to file an appeal on the member's behalf.

19.3.11. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the enrollee is deemed to have exhausted the MCO's appeals process, and the enrollee may initiate a state fair hearing.

19.3.12. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR 42 CFR part 438, subpart K may file an appeal.

19.4. Actions

19.4.1. The MCO shall allow for the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

19.4.1.1. Denial or limited authorization of a requested service, including the type or level of service;

19.4.1.2. Reduction, suspension, or termination of a previously authorized service;

19.4.1.3. Denial, in whole or in part, of payment for a service;

19.4.1.4. Failure to provide services in a timely manner, as defined by the State;

19.4.1.5. Untimely service authorizations;

19.4.1.6. Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

19.4.1.7. At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one MCO, the denial of a member's

request to obtain services outside the network, in accord with 42 CFR 438.52(b)(2)(ii).

19.5. Expedited Appeal

19.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the member, or a provider request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

19.5.1.1.The MCO must inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals.

19.5.1.2.The MCO shall make a decision on the member's request for expedited appeal and provide notice, as expeditiously as the member's health condition requires, within 72 hours after the MCO receives the appeal. The MCO may extend the 72 hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest. The MCO shall also make reasonable efforts to provide oral notice. The first date shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest.

19.5.1.3. If the MCO extends the timeframes not at the request of the enrollee, it must:

19.5.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.5.1.3.2.Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision;

19.5.1.3.3.Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.5.1.4.The MCO shall meet the timeframes in 19.5.1.2 for one hundred percent (100%) of requests for expedited appeals.

19.5.1.5.The MCO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

19.5.1.6. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

19.5.1.7. The member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the member of his/her right and the procedures to file a grievance in the notice of denial.

19.6. Content of Notices

19.6.1. The MCO shall notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing.

19.6.2. Each notice of adverse action shall conform with 42 CFR 431.210, contain and explain:

19.6.2.1. The action the MCO or its subcontractor has taken or intends to take;

19.6.2.2. The reasons for the action;

19.6.2.3. The member's or the provider's right to file an appeal;

19.6.2.4. Procedures for exercising member's rights to appeal or grieve;

19.6.2.5. Circumstances under which expedited resolution is available and how to request it; and

19.6.2.6. The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits.

19.6.3. The MCO shall ensure that all notices of adverse action be in writing and must meet the following language and format requirements:

19.6.3.1. Written notice must be translated for the individuals who speak one of the commonly encountered languages spoken in New Hampshire (as defined by the State per 42 CFR 438.10(d));

19.6.3.2. Notice must include language clarifying that oral interpretation is available for all languages and how to access it; and

19.6.3.3.Notices must use easily understood language and format, and must be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All members and potential members must be informed that information is available in alternative formats and how to access those formats.

19.6.4. The MCO shall mail the notice of adverse benefit determination by the date of the action when any of the following occur:

19.6.4.1. The enrollee has died;

19.6.4.2. The enrollee submits a signed written statement requesting service termination;

19.6.4.3. The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction will result;

19.6.4.4. The enrollee has been admitted to an institution where he or she is ineligible under the state plan for further services;

19.6.4.5. The enrollee's address is determined unknown based on returned mail with no forwarding address;

19.6.4.6. The enrollee is accepted for Medicaid services by another state, territory, or commonwealth;

19.6.4.7. A change in the level of medical care is prescribed by the enrollee's physician;

19.6.4.8. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act;

19.6.4.9. The transfer or discharge from a facility will occur in an expedited fashion.

19.7. Timing of Notices

19.7.1. Termination, suspension or reduction of services - The MCO shall provide members written notice at least ten (10) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services, except the period of advance notice shall be five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the member.

19.7.2. Denial of payment - The MCO shall provide members written notice on the date of action when the action is a denial of payment or reimbursement.

19.7.3. Standard service authorization denial or partial denial- The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

19.7.3.1.The member or the provider requests the extension; or

19.7.3.2.The MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.3.3.When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

19.7.4. Expedited process - For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

19.7.4.1.The MCO may extend the three (3) business days' time period by up to seven (7) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.5. Untimely service authorizations - The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations.

19.8. Continuation of Benefits

19.8.1. The MCO shall continue the member's benefits if:

19.8.1.1.The appeal is filed timely, meaning on or before the later of the following:

19.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action; or

19.8.1.1.2. The intended effective date of the MCO's proposed action.

19.8.1.2.The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

19.8.1.3.The services was ordered by an authorized provider;

19.8.1.4.The authorization period has not expired; and

19.8.1.5.The member requests extension of benefits, orally or in writing.

19.8.2. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

19.8.2.1.The member withdraws the appeal, in writing;

19.8.2.2.The member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision;

19.8.2.3.A State fair hearing decision adverse to the member is made; or

19.8.2.4.The authorization expires or authorization service limits are met.

19.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the member the amount paid for the services provided to the member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

19.9. Resolution of Appeals

19.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within the following timeframes:

19.9.1.1.For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within thirty (30) calendar days after receipt of the appeal, unless the MCO notifies the member that an extension is necessary to complete the appeal.

19.9.1.2.The MCO may extend the timeframes up to fourteen (14) calendar days if:

19.9.1.2.1. The member requests an extension, orally or in writing; or

19.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the member's best interest.

19.9.1.3.If the MCO extends the timeframes not at the request of the enrollee then it must:

19.9.1.3.1.Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.9.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

19.9.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.9.1.4. Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request.

19.9.2. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

19.9.3. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting provider or member may obtain the Utilization Management clinical review or decision-making criteria.

19.9.4. For notice of an expedited resolution, the MCO shall make reasonable efforts to provide oral notice.

19.9.5. For appeals not resolved wholly in favor of the member, the notice shall:

19.9.5.1. Include information on the member's right to request a State fair hearing;

19.9.5.2. How to request a State fair hearing;

19.9.5.3. Include information on the member's right to receive services while the hearing is pending and how to make the request; and

19.9.5.4. Inform the member that the member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action.

19.10. State Fair Hearing

19.10.1. The MCO shall inform members and providers regarding the State fair hearing process, including but not limited to, members right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F. The Parties to the State fair hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

19.10.2.The MCO shall ensure that members are informed, at a minimum, of the following:

19.10.2.1.That members must exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

19.10.2.2.That if a member does not agree with the MCO's resolution of the appeal, the member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date on the MCO's notice of the resolution of the appeal.

19.10.3.If the member requests a fair hearing, the MCO shall provide to DHHS and the member, upon request, and within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

19.10.4.The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit. The MCO shall consult with DHHS regarding the State fair hearing process In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate and at no additional cost. In the event the State fair hearing decision is appealed by the member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost. The Office of the Attorney General or designee shall represent the State on an appeal from a fair hearing decision by a member.

19.10.5.DHHS shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

19.11.Effect of Adverse Decisions of Appeals and Hearings

19.11.1.If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

19.11.2.If the MCO or DHHS reverses a decision to deny authorization of services, and the member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services.

19.12.Survival

19.12.1. The obligations of the MCO pursuant to Section 19 to fully resolve all grievances and appeals including, but not limited to, providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

20. Access

20.1. Network

20.1.1. The MCO shall provide documentation to DHHS showing that it is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 20 and 21.

20.1.2. The MCO's network shall have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the geographic standards in Section 20.2, the timely provision of services requirements in Section 20.4, Equal Access, and reasonable choice by members to meet their needs.

20.1.3. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the readiness review for the enrollment of NHHPP members.

20.1.4. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the first readiness review for each phase of Step 2.

20.1.5. The MCO shall submit documentation to DHHS to demonstrate that it offers an appropriate range of preventive, primary care, and specialty services and maintains an adequate network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)]:

20.1.5.1.At the second readiness review prior to the Program start date;

20.1.5.2.Forty-five (45) calendar days following the end of the semi-annual period; and

20.1.5.3.At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to:

20.1.5.3.1. Changes in services, benefits, geographic service area, or payments

20.1.5.3.2. Enrollment of a new population in the MCO [42 CFR 438.207(c)]

20.1.6. The MCO shall submit documentation quarterly to DHHS to demonstrate Equal Access to services for Step 1, 2 and NHHPP populations.

20.1.7. The MCO shall be subject to annual, external independent reviews of the timeliness of, and access to the services covered under this Agreement [42 CFR 438.204].

20.1.8. For Step 1 Implementation, the anticipated number of members in Sections 20.1.1 and 20.1.2 shall be based on the "NH Medicaid Care Management Fifty Percent Population Estimate by Zip code" report provided by DHHS.

20.2. Geographic Distance

20.2.1. The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and Equal Access to its members.

Provider/Service	Statewide
PCPs (adult & pediatric)	Two (2) within forty (40) minutes or fifteen (15) miles
Adult Specialists	One (1) within sixty (60) minutes or forty-five (45) miles
Pediatric Specialists	One within one hundred twenty (120) minutes or eighty (80) miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) miles
Mental Health Providers (adult & pediatric)	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
SUD Councilors (MLDAC) (adult & pediatric)	One (1) within forty-five (45) minutes or fifteen (15) miles
SUD Programs (Comprehensive, Outpatient, Methadone Clinics) (adult & pediatric)	One (1) within sixty (60) minutes or forty-five (45) miles.

20.3. Network Adequacy Exception Process

20.3.1. The MCO may request exceptions from the network adequacy standards [42 CFR 438.68] after demonstrating its efforts to create a sufficient network of providers to meet these standards. DHHS shall grant the MCO an exception where:

20.3.1.1. The MCO demonstrates that an insufficient number of qualified providers or facilities willing to contract with the MCO are available to meet the network adequacy standards in 20.2 and 20.4;

20.3.1.2. The MCO demonstrates to the Department's satisfaction that the MCO's failure to develop a provider network that meets the requirements of 20.2 and 20.4 is due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

20.3.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from an in-network physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist licensed by the NH Board of Medicine. RSA 167:4-d.

20.3.2. At any time the provisions of this section may apply, the MCO will work with DHHS to ensure that members have access to needed services.

20.3.3. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the provider network to ensure that necessary admissions can be made.

20.4. Timely Access to Service Delivery

20.4.1. The MCO shall make services available for members twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR 438.206(c)(1)(iii)].

20.4.2. The MCO shall require that all network providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial, and FFS patients. [42 CFR 438.206(c)(1)(ii)].

20.4.3. The MCO shall encourage its PCPs to offer after-hours office care in the evenings and on weekends.

20.4.4. The MCO's network shall meet the following minimum timely access to service delivery standards [42 CFR 438.206(c)(1)(i)]

20.4.4.1. Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

20.4.4.2. The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

20.4.4.2.1. Transitional healthcare by a provider shall be available from a primary or specialty provider for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

20.4.4.2.2. Transitional home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the member's primary care or specialty care provider or as part of the discharge plan.

20.4.4.2.3. Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

20.4.4.2.4. Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

20.4.4.2.5. Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and don't meet the definition of Emergency Medical Condition.

20.4.4.2.6. Emergency medical, SUD and psychiatric care shall be available twenty-four (24) hours per day, seven (7) days per week.

20.4.4.2.7. Behavioral health care shall be available as follows:

a. care within six (6) hours for a non-life threatening emergency;

b. care within forty-eight (48) hours for urgent care; or

c. an appointment within ten (10) business days for a routine office visit.

20.4.4.2.8. For members receiving Step 2 covered services, transitional care shall be readily available and delivered, after discharge from a nursing facility, inpatient or institutional care, in accordance with the member's discharge plan or as ordered by the member's primary care or specialty care provider. Transfers and discharges shall be done in accordance with RSA 151:21 and RSA 151:26.

20.4.5. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide a semi-annual report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v).

20.4.6. The MCO shall develop a Corrective Action Plan if there is a failure to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

20.4.7. The MCO shall monitor waiting times for appointments at approved community mental health providers and report case details on a semi-annual basis.

20.5. Women's Health

20.5.1. The MCO shall provide female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

20.5.2. The MCO shall provide access to family planning services to members without the need for a referral or prior-authorization. Additionally, members shall be able to access these services by providers whether they are in or out of the MCO's network.

20.5.2.1.Family Planning Services shall include, but not be limited to, the following:

20.5.2.1.1. Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

20.5.2.1.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

20.5.2.1.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

20.5.2.1.4. Referral of members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

20.5.2.1.5. Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and HPV vaccine

20.5.2.2. Enrollment in the MCO shall not restrict the choice of the provider from whom the member may receive family planning services and supplies [42 CFR 431.51(b)(2)].

20.5.2.3. The MCO shall only provide for abortions in the following situations:

20.5.2.3.1. If the pregnancy is the result of an act of rape or incest; or

20.5.2.3.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed [42 CFR 441.202].

20.5.3. The MCO shall not provide abortions as a benefit, regardless or funding, for any reasons other than those identified in this Agreement [42 CFR 441.202].

20.6. Indian Health

20.6.1. The term Indian for purposes of this section shall include those individuals defined in 42 CFR 438.14(a).

20.6.2. The MCO shall allow all members that are an Indian to receive covered services from an out-of-state IHCP regardless of whether it is an out-of-network provider. The MCO shall pay for covered services provided at such IHCPs as if it was an approved out-of-network service pursuant to Section 20.8.

20.6.3. Any out-of-state IHCP that serves an Indian member of the MCO may refer the member to a network provider.

20.6.4. The MCO shall pay any out-of-state IHCP who provides covered services to an Indian pursuant to this section the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's fee for service methodology.

20.6.5. The MCO shall pay any out-of-state IHCP that is also a FQHC the encounter rate as if it was an in-network FQHC. If the encounter rate is less than the published encounter rate in the Federal Register than the State will make a supplemental payment to make up the difference between the amount the MCO entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

20.6.6. The MCO shall make payment to any such IHCP in a timely manner as required under 42 CFR 447.45 and 42 CFR 447.46.

20.7. Access to Special Services

20.7.1. The MCO shall ensure members have access to DHHS-designated Level I and Level II trauma centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.

20.7.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, hospice programs, and licensed long term care facilities with Medicare-certified skilled nursing beds. To the extent that the above specialty services are available within New Hampshire, the plan shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable.

20.7.3. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude New Hampshire providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

20.8. Out-of-Network Providers

20.8.1. If the MCO's network is unable to provide necessary medical, behavioral, and SUD services covered under the Agreement to a particular member, the MCO shall adequately and in a timely manner cover these services for the member through out-of-network sources [42 CFR 438.206(b)(4)]. The MCO shall inform the out-of-network provider that the member cannot be balance billed.

20.8.2. The MCO shall coordinate with out-of-network providers regarding payment. For payment to out-of-network, or non-participating providers, the following requirements apply:

20.8.2.1. If the MCO offers the service through an in-network provider(s), and the member chooses to access non-emergent services from an out-of-network provider, the MCO is not responsible for payment.

20.8.2.2. If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the MCO and the out-of-network provider.

20.8.3. The MCO shall ensure that cost to the member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

20.9. Second Opinion

20.9.1. The MCO shall provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no greater cost to the member than allowed by DHHS [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a second opinion in its Member Handbook.

20.10. Provider Choice

20.10.1. The MCO shall allow each member to choose his or her health professional to the extent possible and appropriate [42 CFR 438.3(l)].

21. Network Management

21.1. Provider Network

21.1.1. The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered medical, behavioral health, SUD, and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

21.1.1.1. Current and anticipated New Hampshire Medicaid enrollment;

21.1.1.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the covered New Hampshire population;

21.1.1.3. The number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services;

21.1.1.4. The number of network providers not accepting new or any New Hampshire Medicaid patients;

21.1.1.5. The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by New Hampshire members;

21.1.1.6. Accessibility of provider practices for members with disabilities [42 CFR 438.206(b)(1)];

21.1.1.7. Adequacy of the primary care network to offer each member a choice of at least two appropriate primary care providers that are accepting new Medicaid patients; and

21.1.1.8. Required access standards identified in this Agreement

21.1.2. In developing its network, the MCO's provider selection policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

21.1.3. The MCO shall not employ or contract with providers excluded from participation in federal health care programs.

21.1.4. The MCO shall not employ or contract with providers who fail to provide Equal Access to services.

21.1.5. The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of all members including those with LEP and those with unique cultural needs.

21.1.6. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory, as specified in Section 17.9 of this Agreement.

21.2. Network Requirements

21.2.1. The MCO shall ensure its providers and subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement.

21.2.2. All providers shall be licensed and or certified in accordance with the laws of the state in which they provide the covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program. All provider types that may obtain a National Provider Identifier (NPI) shall have an NPI in accordance with 45 CFR Part 162, Subpart D.

21.2.3. All providers in the MCO's network are required to be enrolled as New Hampshire Medicaid providers. DHHS may waive this requirement for good cause on a case-by-case basis.

21.2.4. In all contracts with health care professionals, the MCO shall comply with requirements in 42 CFR 438.214, NCQA standards, and RSA 420-J:4, which includes selection and retention of providers, credentialing and re-credentialing requirements, and non-discrimination (42 CFR 438.12(a)(2); 42 CFR 438.214].

21.2.5. The MCO shall not require a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

21.2.6. The MCO's Agreement with health care providers shall be in writing, shall be in compliance with applicable federal and state laws and regulations, and shall include the requirements in this Agreement.

21.2.7. The MCO shall submit all model provider contracts to DHHS for review during the Readiness Review process. The MCO shall resubmit the model provider contracts any time it makes substantive modifications to such Agreements. DHHS retains the right to reject or require changes to any provider Agreement.

21.2.8. The MCO shall negotiate rates with providers in accordance with Section 9 of this Agreement, unless otherwise specified in this Agreement.

21.2.9. The MCO shall reimburse private duty nursing agencies for private duty nursing services provided on or after April 1, 2016 at the fee-for-for service rate established by DHHS. The MCO shall provide the following information to determine if access to private duty nursing services is increasing:

21.2.10. The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

21.2.11. The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

21.2.12. The MCO shall submit model provider contracts related to the implementation of NHHPP to DHHS prior to the beginning of enrollment in NHHPP. The contract will provide for:

21.2.12.1. An in-state provider of services included in Step 1 must provide services to both the MCO's Step 1 and NHHPP members, except for SUD providers and chiropractors; provided, however, that exceptions to this requirement may be made upon a request by the MCO and approved by DHHS for providers that only want to provide coverage for Step 1 Services.

21.2.12.2. The provider shall provide equal availability of services and access to both Step 1 and NHHPP members unless an exception to the requirement in section 21.2.10.1 was approved for the provider and the provider is not required to provide coverage for NHHPP Services.

21.2.12.3. The MCO shall pay the provider for services at a rate not more than nor less than the amounts established according to Section 21.2.10.4.

21.2.12.4. The MCO shall reimburse providers for NHHPP services according to the NHHPP Provider Fee Schedule posted at **https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms** as of August 15, 2017 and incorporated herein. DHHS shall provide the MCO sixty (60) days notice prior to any change to the Schedule. Services falling outside the published NHHPP Provider Fee Schedule shall be paid at a rate determined by the Department and enforced in the sixty (60) calendar day notification period.

21.2.12.5. The MCO shall allow a participating provider thirty (30) days to review contract modifications to an existing contract relating to the implementation of the NHHPP.

21.2.13.The MCO provider Agreement shall require providers in the MCO network to accept the member's Medicaid ID Card as proof of enrollment in the MCO until the member receives his/her MCO ID Card.

21.2.14.The MCO shall maintain a provider relations presence in New Hampshire as approved by DHHS.

21.2.15.The MCO shall prepare and issue Provider Manual(s) upon request to all Network Providers, including any necessary specialty manuals (e.g., behavioral health). For newly contracted and credentialed providers, the MCO shall issue copies of the Provider Manual(s) no later than seven (7) calendar days after inclusion in the network. The provider manual shall be available on the web and updated no less than annually.

21.2.16.The MCO shall provide training to all providers and their staff regarding the requirements of this Agreement including the grievance and appeal system. The MCO's provider training shall be completed within thirty (30) calendar days of entering into a contract with a provider. The MCO shall provide ongoing training to new and existing providers as required by the MCO, or as required by DHHS.

21.2.17.Provider materials shall comply with state and federal laws and DHHS and NHID requirements. The MCO shall submit any Provider Manual(s) and provider training materials to DHHS for review and approval sixty (60) calendar days prior to any substantive revisions. Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

21.2.18.The MCO shall operate a toll-free telephone line for provider inquiries from 8 a.m. to 5 p.m. EST, Monday through Friday, except for State-approved holidays. The provider toll free line shall be staffed with personnel who are knowledgeable about the MCO's plan in New Hampshire. The provider call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

21.2.18.1.Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

21.2.18.2.Average Speed of Answer: Eighty percent (80%) of calls will be answered with live voice within thirty (30) seconds; and

21.2.18.3.Ninety percent (90%) of voicemail messages shall be responded to no later than the next business day.

21.2.19.The MCO shall maintain a Transition Plan providing for continuity of care in the event of Agreement termination, or modification limiting service to members, between the MCO and any of its contracted providers, or in the event of site closing(s) involving a primary care provider with more than one location of service.

The Transition Plan shall describe how members will be identified by the MCO and how continuity of care will be provided.

21.2.20. The MCO shall ensure that after regular business hours the provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a member. The MCO shall have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent medical, behavioral health or LTSS related condition or an emergency medical or behavioral health condition.

21.2.21. The MCO shall notify DHHS and affected current members in writing of a provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. Within three (3) calendar days following the effective date of the termination the MCO shall have a Transition Plan in place for all affected members.

21.2.22. If a member is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the MCO shall notify the member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a Transition Plan for the affected members.

21.2.23. The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the provider network. As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued member access to needed service and how the MCO will maintain compliance with its contractual obligations for member access to needed services. A significant change is defined as:

21.2.23.1. A decrease in the total number of PCPs by more than five percent (5%);

21.2.23.2. A loss of all providers in a specific specialty where another provider in that specialty is not available within sixty (60) minutes or forty-five (45) miles;

21.2.23.3. A loss of a hospital in an area where another contracted hospital of equal service ability is not available within forty-five (45) miles or sixty (60) minutes; or

21.2.23.4. Other adverse changes to the composition of the network, which impair or deny the members' adequate access to in-network providers.

21.2.24.The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its network, the MCO shall give the affected providers written notice of the reason for its decision. [42 CFR 438.12(a)(1) ; 42 CFR 438.214(c); SMD letter 02/20/98)].

21.2.25.The requirements in 42 CFR 438.12 (a) may not be construed to:

21.2.25.1.Require the MCO to contract with providers beyond the number necessary to meet the needs of its member;

21.2.25.2.Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

21.2.25.3.Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)].

21.3. Screening and Enrollment

21.3.1. No later than January 1, 2018, the MCO shall ensure that all of its network providers are enrolled with DHHS Medicaid.

21.3.2. No later than November 1, 2017, the MCO shall provide to DHHS all identifying information for its enrolled network providers including:

21.3.2.1.Name;

21.3.2.2.Specialty;

21.3.2.3.Date of Birth;

21.3.2.4.Social Security number;

21.3.2.5.National Provider identifier;

21.3.2.6.Federal taxpayer identification number; and

21.3.2.7.State license or certification number of the provider.

21.4. Provider Credentialing and Re-Credentialing

21.4.1. The MCO shall demonstrate to DHHS that its providers are credentialed according to the requirements of 42 CFR 438.206(b)(6), current NCQA standards, Code of Administrative Rules He-M 403, and RSA 420-J:4.

21.4.2. The MCO shall submit to DHHS its credentialing standards relating to the implementation of Choices for Independence waiver services.

21.4.3. The MCO shall have written policies and procedures to review, approve and at least every three (3) years recertify the credentials of all participating physician and all other licensed providers who participate in the MCO's network [42 CFR 438.214(a); 42 CFR 438.214(b) (1&2); RSA 420-J:4]. At a minimum, the scope and structure of a MCO's credentialing and re-credentialing processes shall be consistent NCQA standards and NHID, and relevant state and federal regulations relating to provider credentialing and notice. The MCO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with NCQA delegated credentialing requirements and any comparable requirements defined by DHHS.

21.4.4. The MCO shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: within thirty (30) calendar days for primary care providers; within forty-five (45) calendar days for specialists, SUD providers, chiropractors, Nursing Facilities and CFI service providers. [RSA 420-J:4). The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying the provider of the MCO's decision.

21.4.5. The re-credentialing process shall occur in accordance with NCQA guidelines. The re-credentialing process shall take into consideration provider performance data including, but not be limited to: member complaints and appeals, quality of care, and appropriate utilization of services.

21.4.6. The MCO shall maintain a policy that mandates board certification levels that, at a minimum, meets the ninety (90) percentile rates indicated in NCQA standards (HEDIS Medicaid All Lines of Business National Board Certification Measures as published by NCQA in Quality Compass) for PCPs and specialty physicians in the provider network. The MCO shall make information on the percentage of board-certified PCPs in the provider network and the percentage of board-certified specialty physicians, by specialty, available to DHHS upon request.

21.4.7. The MCO shall provide that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number [42 CFR 493.1 and 42 CFR 493.3].

21.4.8. The MCO shall not employ or contract with providers, business managers, owners or others excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or 42 CFR 1000.

21.4.9. The MCO shall ensure that providers whose Medicare certification is a precondition of participation in the Medicaid program obtain certification within one year of enrollment in MCO's provider network.

21.4.10. The MCO shall notify DHHS when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

21.5. Provider Engagement

21.5.1. The MCO shall, at a minimum, develop and facilitate an active provider advisory board that is composed of a broad spectrum of provider types. Representation on the provider advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. This advisory board shall include representation from CFI service providers. This advisory board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the meetings shall be provided to DHHS within thirty (30) calendar days of the meeting.

21.5.2. The MCO shall conduct a provider satisfaction survey, approved by DHHS and administered by a third party, on a statistically valid sample of each major provider type; PCP, specialists, hospitals, pharmacies, DME and Home Health providers, Nursing Facilities and CFI service providers. DHHS shall have input to the development of the survey. The survey shall be conducted semi-annually the first year after the program start date and at least once an Agreement year thereafter to gain a broader perspective of provider opinions. The results of these surveys shall be made available to DHHS and published on the DHHS website.

21.5.3. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

21.6. Anti-Gag Clause for Providers

21.6.1. The MCO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

21.6.1.1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

21.6.1.2.For any information the member needs in order to decide among all relevant treatment options;

21.6.1.3.For the risks, benefits, and consequences of treatment or non-treatment; or

21.6.1.4.For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [§1923(b)(3)(D) of the SSA; 42 CFR 438.102(a)(1)(i), (ii), (iii), and (iv); SMD letter 2/20/98].

21.7. Reporting

21.7.1. Provider Participation Report: Provide provider participation reports on an annual basis by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of member access to health care.

21.7.2. Provider Quality Report Card: Ability to provide dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc.

22. Quality Management

22.1. General Provisions

22.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO shall work in collaboration with members and providers to actively improve the quality of care provided to members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate into the MCO's quality improvement activities.

22.1.2. The MCO shall support and comply with the most current version of the Quality Strategy for the New Hampshire Medicaid Care Management Program.

22.1.3. The MCO shall have an ongoing quality assessment and performance improvement program for the operations and the services it furnishes for members [42 CFR 438.330(b); and SMM 2091.7].

22.1.4. The MCO shall approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and shall:

22.1.4.1. Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

22.1.4.2. Foster data-driven decision-making;

22.1.4.3. Solicit member and provider input on the prioritization and strategies for QAPI activities;

22.1.4.4. Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and member and provider satisfaction;

22.1.4.5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements;

22.1.4.6. Support re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions as appropriate; and

22.1.4.7. The MCO shall undertake a member experience of care survey;

22.1.4.7.1. The MCO shall deploy the CMS Home and Community Based Care Service Experience of Care Survey, Testing Experience and Functional Tools (TEFT) as early as 6 months but not later than 9 months from Step 2 Phase 2 start date, if ready for deployment.

22.1.4.7.2. The MCO shall deploy an in-person patient experience survey (PES) if the CMS Home and Community Based Care Service Experience of Care Survey is not ready for deployment with this same timeframe.

22.1.4.7.3. The MCO shall use a DHHS approved, external vendor and statistically sound methodology to conduct the member experience of care survey.

22.1.5. The MCO shall have mechanisms that detect both underutilization and overutilization of services.

The MCO shall develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the requirements of this Agreement. The MCOs shall also meet the requirements of for the QAPI Program [42 CFR 438.330; SMM 2091.7].

22.1.6. The MCO shall submit a QAPI Program Annual Summary in a format and timeframe specified by DHHS or its designee for its approval. The MCO shall keep participating physicians and other Network Providers informed and engaged in the QAPI Program and related activities. The MCO shall include in provider contracts a requirement securing cooperation with the QAPI.

22.1.7. The MCO shall maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO shall designate a senior executive responsible for the QAPI Program and the Medical Director shall have substantial involvement in QAPI Program activities. At a minimum, the MCO shall ensure that the QAPI Program structure:

22.1.7.1.Is organization-wide, with clear lines of accountability within the organization;

22.1.7.2.Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;

22.1.7.3.Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

22.1.7.4.Evaluates the effectiveness of clinical and non-clinical initiatives.

22.1.8. If the MCO sub-contracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO shall maintain detailed files documenting work performed by the sub-contractor. The file shall be available for review by DHHS or its designee upon request.

22.1.9.

22.1.10.The MCO shall integrate behavioral health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services provided to members. The MCO shall collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, and psycho-social outcomes, resulting from the integration and coordination of physical and behavioral health services.The MCO shall conduct any performance improvement projects required by CMS and a minimum of four (4) performance improvement projects, subject to DHHS approval, per year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one (1) of these projects shall have a behavioral health focus. At least one (1) of these projects shall have a home and community based waiver focus. The MCO shall report the status and results of each project to DHHS as requested and shall report on the status results of the CMS performance improvement projects described in 42 CFR 438.330.

22.1.11.The performance improvement projects shall involve the following:

22.1.11.1.Measurement of performance using statistically valid, national recognized objective quality indicators;

22.1.11.2.Implementation of system interventions to achieve improvement in the access to and quality of care;

22.1.11.3.Evaluation of the effectiveness of the interventions based on any performance measures required by CMS as outlined in 42 CFR 438.330(c); and

22.1.11.4.Planning and initiation of activities for increasing or sustaining improvement; and

22.1.11.5. Reporting on the status and results to DHHS on an annual basis.

22.1.12.Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

22.1.13.The MCO shall have a plan to assess and report the quality and appropriateness of care furnished to members with special needs in order to identify any ongoing special conditions of a member that require a course of treatment or regular care monitoring The plan must be submitted to DHHS for review and approval. The assessment mechanisms must use appropriate health care professionals.[42 CFR 438.208(c)(2); 42 CFR 438.330].

22.1.14.The MCO's Medical Director and Quality Improvement Director will participate in quarterly Quality Improvement meetings with DHHS and the other MCOs contracted with DHHS to discuss quality related initiatives and how those initiatives could be coordinated across the MCOs.

22.1.15.The MCOs shall be required to be accredited by NCQA, including all applicable Medicaid Standards and Guidelines and the MCOs must authorize NCQA to provide DHHS a copy of its most recent accreditation review, including:

22.1.15.1. Accreditation status, survey type, and level (as applicable);

22.1.15.2.Accreditation results, including recommended actions or improvements, corrective actions plans, and summaries of findings; and

22.1.15.3.Expiration date of the accreditation.

22.2. Practice Guidelines and Standards

22.2.1. The MCO shall adopt evidence-based clinical practice guidelines built upon high quality data and strong evidence. Such practice guidelines shall consider the needs of the MCO's members, be adopted in consultation with Network Providers, and be reviewed and updated periodically, as appropriate.

22.2.2. The MCO shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

22.2.3. The MCO shall make practice guidelines available, including, but not limited to, the web, to all affected providers and, upon request, to members and potential members.

22.2.4. The MCO's decisions regarding utilization management, member education, and coverage of services shall be consistent with the MCO's clinical practice guidelines [42 CFR 438.236(d)].

22.3. External Quality Review Organization

22.3.1. The MCO shall collaborate with DHHS's External Quality Review Organization (EQRO) as outlined in 42 CFR 438.358 to assess the quality of care and services provided to members and to identify opportunities for MCO improvement. To

facilitate this process, the MCO shall supply data, including but not limited to claims data and medical records, to the EQRO.

22.4. Evaluation

22.4.1. The MCO shall prepare a written report within ninety (90) calendar days at the end of each Agreement year on the QAPI that describes:

22.4.1.1.Completed and ongoing Quality management activities, including all delegated functions;

22.4.1.2.Performance trends on QAPI measures to assess performance in quality of care and quality of service;

22.4.1.3.An analysis of whether there have been any demonstrated improvements in the quality of care or service; and

22.4.1.4.An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement

22.4.2. The annual evaluation report shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

22.4.3. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, members, and appropriate MCO staff, as well as posted on the web. The MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

22.5. Quality Measures

22.5.1. MCO shall report annually, according to the then current industry/regulatory standard definitions, the following quality measure sets:

22.5.1.1.CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP;

22.5.1.2.CMS Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid;

22.5.1.3.NCQA Medicaid Accreditation HEDIS/CAHPS Measures, which shall be validated by submission to NCQA; and

22.5.1.4.All available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment; and

22.5.1.5. Any CMS mandated measures outlined in 42 CFR 438.330(c)(1)(i).

22.5.2. If additional measures are added to the NCQA or CMS measure sets, MCO shall include those new measures. For measures that are no longer part of the measures sets, DHHS may at its option continue to require those measures.

22.5.3. In addition MCO shall submit other quality measures as specified by DHHS in Exhibit O in a format to be specified by DHHS.

22.5.4. DHHS shall provide the MCO with ninety (90) calendar days notice of any additions or modifications to the quality measures as specified by DHHS in Exhibit O.

22.5.5. Each Data Year as defined by NCQA HEDIS specifications, or other twelve (12) month period determined by DHHS, at DHHS discretion, DHHS may select four (4) measures to be included in the Quality Incentive Program (QIP). DHHS shall notify the MCO of the four (4) measures to be included in the QIP no later than three (3) months prior to the start of the period for which data will be collected to evaluate the program.

22.5.6. For each measure selected by DHHS for the QIP, DHHS will monitor MCO performance to determine baseline measures and levels of improvement.

22.5.7. Should DHHS choose QIPs and implement withholds for QIP performance, in the event of changes to the Medicaid Care Management program or material circumstances beyond DHHS or the MCOs' control, which DHHS determines would unduly limit all MCOs' ability to reasonably perform and achieve the withhold return threshold, DHHS will evaluate the impact of the circumstances and make such changes as required, at the discretion of DHHS.

22.5.8. At such time DHHS provides access to Medicare data sets to the MCOs, the MCO shall integrate expanded Medicare data sets into its Care Coordination and Quality Programs and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual members. The MCO shall:

22.5.8.1.Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from care coordination of the dual members;

22.5.8.2.Include Medicare data in DHHS quality reporting; and

22.5.8.3.Sign data use agreements and submit data management plans as required by CMS.

23. Utilization Management

23.1. Policies & Procedures

23.1.1. The MCO's policies and procedures related to the authorization of services shall be in compliance with 42 CFR 438.210 and NH RSA Chapter 420-E:2.

23.1.2. The MCO shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services [42 CFR 438.210(b)(1)].

23.1.3. The MCO shall submit its written utilization management policies, procedures, and criteria to DHHS for approval as part of the first readiness review. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.4. The MCO shall submit its written utilization management policies, procedures, and criteria specific to each phase of Step 2 Phase I to DHHS for approval as part of the first readiness review. Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs and a subsequent person-centered planning process. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.5. The MCO's written utilization management policies, procedures, and criteria shall, at a minimum, conform to the standards of NCQA.

23.1.6. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)].

23.1.7. The MCO's written utilization management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Further such policies, procedures and criteria shall address, at a minimum, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information.

23.1.8. The MCO's written utilization management policies, procedures, and criteria shall be:

23.1.8.1.Developed with input from appropriate actively practicing practitioners in the MCO's service area;

23.1.8.2.Updated at least biennially and as new treatments, applications, and technologies emerge;

23.1.8.3.Developed in accordance with the standards of national accreditation entities;

23.1.8.4.Based on current, nationally accepted standards of medical practice;

23.1.8.5.If practicable, evidence-based; and

23.1.8.6.Be made available upon request to DHHS, providers and members.

23.1.9. The MCOs shall work in good faith with DHHS develop prior authorization forms with consistent information and documentation requirements from providers wherever feasible. Providers shall be able to submit the prior authorizations forms electronically, by mail, or fax. The MCOs shall submit a proposed plan for the development of common prior authorization processes within ninety (90) calendar days of the NHHPP Program Start Date.

23.1.10.The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including, but not limited to, interrater reliability monitoring, and consult with the requesting provider when appropriate and at the request of the provider submitting the authorization [42 CFR 438.210(b)(2)].

23.1.11.The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)(3)].

23.1.12.Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member [42 CFR 438.210(e)].

23.1.13.Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

23.1.14. The MCOs shall follow the transition of care policy developed by DHHS, which is consistent with 42 CFR 438.62.

23.1.15. When a member receiving State Plan Home Health Services and Step 1 services chooses to change to another MCO, the new MCO shall be responsible for the member's claims as of the effective date of the member's enrollment in the new MCO except as specified in Section 31.2.17. Upon receipt of prior authorization information from DHHS, the new MCO shall honor prior authorizations in place by the former MCO for fifteen (15) calendar days or until the expiration of previously issued prior authorizations, whichever comes first. The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 23.4.2.1.

23.1.16. Prior authorizations in place for long term services and supports at the time a member transitions to an MCO will be honored until the earliest of (a) the authorization's expiration date, (b) the member's needs changes, (c) the provider loses its Medicaid status or (d) otherwise approved by DHHS. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO. In the event that the prior authorization specifies a specific provider, that MCO will continue to utilize that provider regardless of whether the provider is participating in the MCO network until such time as services are available in the MCO's network. The MCO will ensure that the member's needs are met continuously and will continue to cover services under the previously issued prior authorization until the MCO issues new authorizations that address the member's needs.

23.1.17. Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire.

23.2. Medical Necessity Determination

23.2.1. The MCO shall specify what constitutes "medically necessary services" in a manner that:

23.2.1.1. Is no more restrictive than the State Medicaid program; and

23.2.1.2. Addresses the extent to which the MCO is responsible for covering services related to the following [42 CFR 438.210(a)]:

23.2.1.2.1. The prevention, diagnosis, and treatment of health impairments;

23.2.1.2.2. The ability to achieve age-appropriate growth and development; and

23.2.1.2.3. The ability to attain, maintain, or regain functional capacity.

23.2.2. For members twenty-one (21) years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are [He-W 530.01(f)]:

23.2.2.1. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

23.2.2.2. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

23.2.2.3. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

23.2.2.4. Not experimental, investigative, cosmetic, or duplicative in nature.

23.2.3. For EPSDT services the following definition of medical necessity shall be used: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service He-W546.01(f).

23.2.4. The MCO must provide the criteria for medical necessity determinations for mental health or substance use disorder benefits to any enrollee, potential enrollee, or contracting provider upon request.

23.3. Necessity Determination

23.3.1. For long term services and supports the following definition of necessity shall be used: "Necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term services and supports within the limits of current waivers, statutes, administrative rules, and/or Medicaid State Plan amendments.

23.4. Notices of Coverage Determinations

23.4.1. The MCO shall provide the requesting provider and the member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

23.4.2. The MCO shall make utilization management decisions in a timely manner. The following minimum standards shall apply:

23.4.2.1.Urgent determinations: The determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for ninety-eight percent (98%) of requests, unless the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the MCO shall notify the member or member's representative within twenty-four (24) hours of receipt of the request and shall advise the member or member's representative of the specific information necessary to make a determination. The member or member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information.

23.4.2.2.Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

23.4.2.3.Routine determinations: The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but in no event exceed the following timeframes for ninety-five percent (95%) of requests:

23.4.2.3.1. Fourteen (14) calendar days after the receipt of a request:

a. An extension of up to fourteen (14) calendar days is permissible if:

i. the member or the provider requests the extension; or

ii. the MCO justifies a need for additional information and that the extension is in the member's interest;

23.4.2.3.2. Two (2) calendar days for diagnostic radiology.

23.4.2.4.The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

23.4.2.5.The member or the provider requests the extension; or

23.4.2.6.The MCO justifies a need for additional information and how the extension is in the member's interest.

23.4.2.7.If such an extension is necessary due to a failure of the member or member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the member or member's representative shall be given at least forty- five (45) calendar days from receipt of the notice within which to provide the specified information. Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

23.4.2.8.Determination for Services that have been delivered: The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the member fails to provide sufficient information to determine the request, the MCO shall notify the member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the member shall be given at least forty-five (45) calendar days to provide the required information. The thirty (30) calendar day period for determination shall be tolled until such time as the member submits the required information.

23.4.3. Whenever there is an adverse determination, the MCO shall notify the ordering provider and the member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

23.5. Advance Directives

23.5.1. The MCO shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489.

23.5.2. The MCO shall adhere to the definition of advance directives as defined in 42 CFR 489.100.

23.5.3. The MCO shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCO [42 CFR 422.128].

23.5.4. The MCO shall not condition the provision of care or otherwise discriminate against an enrollee or potential enrollee based on whether or not the individual has executed an advance directive.

23.5.5. The MCO shall provide information in the member handbook with respect to the following:

23.5.5.1.The member's rights under the state law. The information provided by the MCO shall reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change [42 CFR 438.3(j)(3) and (4)].

23.5.5.2.The MCO's policies respecting the implementation of those rights including a statement of any limitation regarding the implementation of advance directives as a matter of conscience

23.5.5.3.That complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State Agency [42 CFR 438.3(;)(1); 42 CFR 438.10(g)(2); 42 CFR 422.128; 42 CFR 489 (subpart I); 42 CFR 489.100].

24. MCIS

24.1. System Functionality

24.1.1. The MCO Managed Care Information System (MCIS) shall include, but not be limited to:

24.1.1.1. Management of Recipient Demographic Eligibility and Enrollment and History

24.1.1.2. Management of Provider Enrollment and Credentialing

24.1.1.3. Benefit Plan Coverage Management, History and Reporting

24.1.1.4. Eligibility Verification

24.1.1.5. Encounter Data

24.1.1.6. Weekly Reference File Updates

24.1.1.7. Service Authorization Tracking, Support and Management

24.1.1.8. Third Party Coverage and Cost Avoidance Management

24.1.1.9. Financial Transactions Management and Reporting

24.1.1.10. Payment Management (Checks, EFT, Remittance Advices, Banking)

24.1.1.11. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)

24.1.1.12. Call Center Management

24.1.1.13. Claims Adjudication

24.1.1.14. Claims Payments

24.1.1.15. Quality of Services (QOS) metrics

24.2. Information System Data Transfer

24.2.1. Effective communication between the MCO and DHHS will require secure, accurate, complete and auditable transfer of data to/from the MCO and DHHS management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

24.2.1.1.DHHS read access to all NH Medicaid Care Management data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

24.2.1.2.Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

24.2.1.3.Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state.

24.2.1.4.Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

24.2.1.5.MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

24.2.1.6.Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and provide for source to target or source to specification mappings;

24.2.1.7.Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

24.2.1.8.A given day's data transmissions, as specified in 24.5.9, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions will be included in the next batch transmission.

24.2.2. The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

24.2.3. The State shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.

24.3. Ownership and Access to Systems and Data

24.3.1. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data will be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

24.4. Records Retention

24.4.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than seven (7) years from the date of termination of this Agreement. Records involving matters that are the subject of litigation shall be retained for a period of not less than seven (7) years following the termination of litigation. Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

24.4.2. Upon expiration of the seven (7) year retention period and upon request, the subject records must be transferred to DHHS' possession. No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

24.5. MCIS Requirements

24.5.1. The MCO shall have a comprehensive, automated, and integrated Managed Care Information System (MCIS) that is capable of meeting the requirements listed below and throughout this Agreement and for providing all of the data and information necessary for DHHS to meet federal Medicaid reporting and information regulations.

24.5.2. All subcontractors shall meet the same standards, as described in this Section 24, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a subcontractor with respect to its provided functions.

24.5.3. Specific functionality related to the above shall include, but is not limited to, the following :

24.5.3.1.The MCIS membership management system must have the capability to receive, update, and maintain New Hampshire's membership files consistent with information provided by DHHS.

24.5.3.2.The MCIS shall have the capability to provide daily updates of membership information to sub-contractors or providers with responsibility for processing claims or authorizing services based on membership information.

24.5.3.3.The MCIS' provider file must be maintained with detailed information on each provider sufficient to support provider enrollment and payment and also meet DHHS' reporting and encounter data requirements.

24.5.3.4.The MCIS' claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system.

24.5.3.5.The MCIS' Services Authorization system shall be integrated with the claims processing system.

24.5.3.6.The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements.

24.5.3.7.The MCIS' credentialing system shall have the capability to store and report on provider specific data sufficient to meet the provider credentialing requirements, Quality Management, and Utilization Management Program Requirements.

24.5.3.8.The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in member, provider, claims and authorization files, and in order to enable encounter data to be utilized for member profiling, provider profiling, claims validation, fraud, waste and abuse monitoring activities, and any other research and reporting purposes defined by DHHS.

24.5.3.9.The encounter data system shall have a mechanism in place to receive, process, and store the required data.

24.5.3.10.The MCO system shall be compliant with the requirements of HIPAA, including privacy, security, National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format. This also includes IRS Pub 1075 where applicable.

24.5.4. MCIS capability shall include, but not be limited to the following:

24.5.4.1.Provider network connectivity to Electronic Data Interchange (EDI) and provider portal systems;

24.5.4.2.Documented scheduled down time and maintenance windows as agreed upon with DHHS for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

24.5.4.3.DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes, and procedures (approved by the State) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

24.5.4.4.DHHS access to user acceptance test environment for externally accessible systems including websites and secure portals;

24.5.4.5.Documented instructions and user manuals for each component; and

24.5.4.6.Secure access.

24.5.5. MCIS Up-time

24.5.5.1.Externally accessible systems, including telephony, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours per day, seven (7) days per week, three-hundred-sixty-five (365) days per year, except for scheduled maintenance upon notification of and pre-approval by DHHS. Maintenance period cannot exceed four (4) consecutive hours without prior DHHS approval.

24.5.5.2.MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions will result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

24.5.6. Systems operations and support shall include, but not be limited to the following:

24.5.6.1.On-call procedures and contacts

24.5.6.2.Job scheduling and failure notification documentation

24.5.6.3.Secure (encrypted) data transmission and storage methodology

24.5.6.4.Interface acknowledgements and error reporting

24.5.6.5.Technical issue escalation procedures

24.5.6.6.Business and member notification

24.5.6.7.Change control management

24.5.6.8.Assistance with User Acceptance Testing (UAT) and implementation coordination

24.5.6.9.Documented data interface specifications – data imported and extracts exported including database mapping specifications.

24.5.6.10.Disaster Recovery and Business Continuity Plan

24.5.6.11.Journaling and internal backup procedures. Facility for storage MUST be class 3 compliant.

24.5.6.12.Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

24.5.7. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

24.5.7.1.Network diagram that fully defines the topology of the MCO's network.

24.5.7.2.State/MCO connectivity

24.5.7.3.Any MCO/subcontractor locations requiring MCIS access/support

24.5.7.4.Web access for DHHS staff, providers and recipients

24.5.8. Data transmissions from DHHS to the MCO will include, but not be limited to the following:

24.5.8.1.Provider Extract (Daily)

24.5.8.2.Recipient Eligibility Extract (Daily)

24.5.8.3.Recipient Eligibility Audit/Roster (Monthly)

24.5.8.4.Medical and Pharmacy Service Authorizations (Daily)

24.5.8.5.Commercial and Medical Third Party Coverage (Daily)

24.5.8.6.Claims History (Bi-Weekly)

24.5.8.7.Capitation payment data

24.5.9. Data transmissions from the MCO to DHHS shall include but not be limited to:

24.5.9.1.Member Demographic changes (Daily)

24.5.9.2.MCO Provider Network Data (Daily)

24.5.9.3.Medical and Pharmacy Service Authorizations (Daily)

24.5.9.4.Beneficiary Encounter Data including paid, denied, adjustment transactions by pay period (Weekly)

24.5.9.5.Financial Transaction Data

24.5.9.6.Updates to Third Party Coverage Data (Weekly)

24.5.9.7.Behavioral Health Certification Data (Monthly)

24.5.10.The MCO shall provide DHHS staff with access to timely and complete data:

24.5.10.1.All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS.

24.5.10.2.The MCO shall work collaboratively with DHHS, DHHS' MMIS fiscal agent, the New Hampshire Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement.

24.5.10.3.The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/subcontractor locations supporting the New Hampshire program.

24.5.10.4.The MCO shall utilize data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

24.5.10.5.The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including encounter data

24.5.10.6.The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this document (24.2.1.8).

24.5.10.7.Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable state and federal law.

24.5.10.8.Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

24.5.11.The MCIS shall include web access for use by and support to enrolled providers and members. The services shall be provided at no cost to the provider or members. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

24.5.11.1.The MCO shall create secure web access for Medicaid providers and members and authorized DHHS staff to access case-specific information.

24.5.11.2.The MCO shall manage provider and member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist providers and members with gaining access and utilizing the web portal.

24.5.11.3.Providers will have the ability to electronically submit service authorization requests and access and utilize other utilization management tools.

24.5.11.4.Providers and members shall have the ability to download and print any needed Medicaid MCO program forms and other information.

24.5.11.5.Providers shall have an option to e-prescribe as an option without electronic medical records or hand held devices.

24.5.11.6.MCO shall support provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es).

24.5.11.7.Providers shall have access to drug information.

24.5.11.8.The website shall provide an e-mail link to the MCO to allow providers and members or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website.

24.5.11.9.The website shall be secure and HIPAA compliant in order to ensure the protection of Protected Health Information and Medicaid recipient confidentiality. Access shall be limited to verified users via passwords and any other available industry standards. Audit logs must be maintained reflecting access to the system and random audits will be conducted.

24.5.11.10.The MCO shall have this system available no later than the Program Start Date.

24.5.11.11.Support Performance Standards shall include:

24.5.11.11.1.Email inquiries – one (1) business day response

24.5.11.11.2.New information posted within one (1) business day of receipt

24.5.11.11.3.Routine maintenance

24.5.11.11.4.Standard reports regarding portal usage such as hits per month by providers/members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports.

24.5.11.11.5.Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO must redirect user to site to install appropriate browser.

24.5.12.Critical systems within the MCIS support the delivery of critical medical services to members and reimbursement to providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

24.5.12.1.The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to New Hampshire within twenty-four (24) hours of incident onset.

24.5.12.2.The MCO shall ensure that the New Hampshire PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements as defined in Section 24.5.13.

24.5.12.3.The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction. Archiving processes shall not modify the data composition of DHHS' records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

24.5.12.4.The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between providers, provider billing agents/clearing houses, or DHHS and the MCO. Audit logs of activities will be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

24.5.12.5.Thirty (30) calendar days prior to the beginning of each State Fiscal Year, the MCO shall submit the following documents and corresponding checklists for DHHS' review and approval:

24.5.12.5.1.Disaster Recovery Plan

24.5.12.5.2.Business Continuity Plan

24.5.12.5.3.Security Plan

24.5.12.5.4.The MCO shall provide the following documents. If after the original documents are submitted the MCO modifies any of them, the revised documents and corresponding checklists shall be submitted to DHHS for review and approval:

a. Risk Management Plan

b. Systems Quality Assurance Plan

c. Confirmation of 5010 compliance and Companion Guides

d. Confirmation of compliance with IRS Publication 1075

e. Approach to implementation of ICD-10 and ultimate compliance

24.5.13.Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements shall be part of the change management process:

24.5.13.1.The complete system shall have proper configuration management/change management in place (to be reviewed and approved by DHHS). The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

24.5.13.2.The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent. DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

24.5.13.3.The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day. The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

24.5.13.4.A New Hampshire program centralized electronic repository shall be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

24.5.13.5.The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any member.

24.5.13.6.The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

24.5.14.DHHS, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

24.5.14.1.The System Readiness Review may include a desk review and/or an onsite review.

24.5.14.2.If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

24.5.14.3.If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency.

24.5.15.Systems enhancements developed specifically, and data accumulated, as part of the New Hampshire Care Management program remain the property of the State of New Hampshire.

24.5.15.1.Source code developed for this program shall remain the property of the vendor but will be held in escrow.

24.5.15.2.All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

24.5.15.3.The MCO shall not destroy or purge DHHS' data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be

retrievable for review and or reporting by DHHS in the timeframe set forth by DHHS.

24.5.16. The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute ad-hoc queries to support DHHS data and information needs. DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

24.5.17. Quality of Service (QOS) Metrics:

24.5.17.1. System Integrity: The system shall ensure that both user and provider portal design, and implementation is in accordance with Federal, standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

24.5.17.2. The security of the care management processing system must minimally provide the following three types of controls to maintain data integrity that directly impacts QOS . These controls shall be in place at all appropriate points of processing:

24.5.17.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

24.5.17.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

24.5.17.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

24.5.17.2.4. System Administration: Ability to comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with Agreement terms and conditions. Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions at no additional cost.

25. Data Reporting

25.1. General Provisions

25.1.1. The MCO shall make all collected data available to DHHS upon request and upon the request of CMS [42 CFR 438.242(b)(4)].

25.1.2. The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility [42 CFR 438.242(a)].

25.1.3. The MCO shall collect data on member and provider characteristics as specified by DHHS and on services furnished to members through a MCIS system or other methods as may be specified by DHHS [42 CFR 438.242(b)(2)].

25.1.4. The MCO shall ensure that data received from providers are accurate and complete by:

25.1.4.1. Verifying the accuracy and timeliness of reported data;

25.1.4.2. Screening the data for completeness, logic, and consistency; and

25.1.4.3. Collecting service information in standardized formats to the extent feasible and appropriate [42 CFR 438.242(b)(3)].

25.2. Encounter Data

25.2.1. The MCO shall submit encounter data in the format and content, timeliness, completeness, and accuracy as specified by the DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS.

25.2.2. All encounter data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

25.2.2.1. The MCO shall provide support to DHHS to substantiate the validity, integrity and reconciliation of DHHS reports that utilize the MCO encounter data.

25.2.3. Submission of encounter data to DHHS does not eliminate the MCO's responsibility under state statute to submit member and claims data to the Comprehensive Healthcare Information System [NH RSA 420-G:1,1 II. (a)]

25.2.4. The MCO shall ensure that encounter records are consistent with the DHHS requirements and all applicable state and federal laws.

25.2.5. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

25.2.6. The MCO shall use appropriate member identifiers as defined by DHHS.

25.2.7. The MCO shall maintain a record of both servicing and billing information in its encounter records.

25.2.8. The MCO shall also use appropriate provider identifiers for encounter records as directed by DHHS.

25.2.9. The MCO shall have a computer and data processing system sufficient to accurately produce the data, reports, and encounter record set in formats and timelines prescribed by DHHS as defined in this Agreement.

25.2.10. The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

25.2.11. The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS. The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

25.2.12. The MCO's systems that are required to use or otherwise contain the applicable data type shall conform with current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards:

25.2.12.1. Health Care Common Procedure Coding System (HCPCS)

25.2.12.2. CPT codes

25.2.12.3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the U.S. Department of Health and Human Services (HHS).

25.2.12.4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

25.2.12.5.International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.

25.2.12.6.National Drug Codes (NDC): The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

25.2.12.7.Code on Dental Procedures and Nomenclature (CDT): The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

25.2.12.8.Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains point of service (POS) codes used throughout the health care industry.

25.2.12.9.Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

25.2.12.10.Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the Medicaid Management Information System (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

25.2.13.All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format.

25.2.14.All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and as applicable the Medicare paid amount, other insurance paid amount and expected member co-payment amount.

25.2.15.The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

25.2.16.The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

25.2.17.The MCO shall collect, and submit to the State's fiscal agent, member service level encounter data for all covered services. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

25.2.18.The MCO shall conform to all current and future HIPAA-compliant standards for information exchange. Batch and Online Transaction Types are as follows:

25.2.18.1.Batch transaction types

25.2.18.1.1.ASC X12N 820 Premium Payment Transaction

25.2.18.1.2.ASC X12N 834 Enrollment and Audit Transaction

25.2.18.1.3.ASC X12N 835 Claims Payment Remittance Advice Transaction

25.2.18.1.4.ASC X12N 837I Institutional Claim/Encounter Transaction

25.2.18.1.5.ASC X12N 837P Professional Claim/Encounter Transaction

25.2.18.1.6.ASC X12N 837D Dental Claim/Encounter Transaction

25.2.18.1.7.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.18.2.Online transaction types

25.2.18.2.1.ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

25.2.18.2.2.ASC X12N 276 Claims Status Inquiry

25.2.18.2.3.ASC X12N 277 Claims Status Response

25.2.18.2.4.ASC X12N 278/279 Utilization Review Inquiry/Response

25.2.18.2.5.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.19.Submitted encounter data shall include all elements specified by DHHS including, but not limited to, those specified in Exhibit N and detailed in the Medicaid Encounter Submission Guidelines.

25.2.20.The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims. Any exceptions will be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception. The MCO shall also use the provider identifiers as directed by DHHS for both Encounter and fee-for-service claims submissions, as applicable.

25.2.21.The MCO shall provide as a supplement to the encounter data submission a member file, which shall contain appropriate member identification numbers, the primary care provider assignment of each member, and the group affiliation of the primary care provider.

25.2.22.The MCO shall submit complete encounter data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

25.2.23.The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

25.2.24.The MCO shall provide complete and accurate encounters to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards:

25.2.24.1.Completeness

25.2.24.1.1.The MCO shall submit encounters that represent at least ninety-nine percent (99%) of the covered services provided by the MCO's network and non-network providers. All data submitted by the providers to the MCO shall be included in the encounter submissions.

25.2.24.2.Accuracy

25.2.24.2.1.Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits.

25.2.24.2.2.Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

25.2.24.2.3.One-hundred percent (100%) of member identification numbers shall be accurate and valid.

25.2.24.2.4.Ninety-eight percent (98%) of servicing provider information will be accurate and valid.

25.2.24.2.5.Ninety-eight percent (98%) of member address information shall be accurate and valid.

25.2.24.3.Timeliness

25.2.24.3.1.Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment. All encounters shall be submitted, both paid and denied claims. The paid claims shall include the MCO paid amount.

25.2.24.3.2.The MCO shall be subject to remedies as specified in Section 34 for failure to timely submit encounter data, in accordance with the accuracy standards established in this Agreement.

25.2.24.4.Error Resolution

25.2.24.4.1.For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice. For all ongoing claim encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fifteen (15) calendar days after such notice. If the MCO fails to do so, DHHS will require a Corrective Action Plan and assess liquidated damages as described in Section 34. MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

25.2.24.4.2.All sub-contracts with providers or other vendors of service shall have provisions requiring that encounter records are reported or submitted in an accurate and timely fashion.

25.2.24.5.Survival

25.2.24.5.1.All encounter data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

25.3. Data Certification

25.3.1. All data submitted to DHHS by the MCO shall be certified by one of the following:

25.3.1.1.The MCO's Chief Executive Officer;

25.3.1.2.The MCO's Chief Financial Officer; or

25.3.1.3.An individual who has delegated authority to sign for, and who reports directly to, the MCO's Chief Executive Officer or Chief Financial Officer.

25.3.2. The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, encounter data, and other information contained in contracts, proposals. The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data. The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

25.4. Data System Support for QAPI

25.4.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI requirements described in Section 21. The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of MCO providers, member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

26. Fraud Waste and Abuse

26.1. Program Integrity Plan

26.1.1. The MCO shall have a Program Integrity Plan in place that has been approved by DHHS and that shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse. The MCO is expected to be familiar with, comply with, and require compliance with, all state and federal regulations related to Medicaid Program Integrity, whether or not those regulations are listed herein, and as required in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008, and Section 1902(a)(68) of the Social Security Act.

26.1.1.1. The MCO shall retain all data, information, and documentation described in 42 CFR 438.604, 438.606, 438.608, and 438.610 for period no less than ten (10) years.

26.1.1.2. Fraud, waste and abuse investigations are targeted reviews of a provider or member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services. Cases which would be considered investigations are as follows, but not limited to:

26.1.1.2.1. review of instances which may range from outliers identified through data mining;

26.1.1.2.2. pervasive or persistent findings of routine audits to specific allegations that involve or appear to involve intentional misrepresentation in an effort to receive an improper payment;

26.1.1.2.3. notification of potential fraud, waste, and abuse through member verification of services, or complaint filed; and.

26.1.1.2.4. any reviews as defined by CMS as fraud, waste, and abuse investigation.

26.1.1.3. Routine claims audits are random reviews conducted for the purpose of verifying provider compliance with contractual requirements including, but not limited to, quality standards, reimbursement guidelines, and/or medical policies.

26.2. Fraud, Waste and Abuse Prevention Procedures

26.2.1. The MCO shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud, waste and abuse. The MCO procedures shall include, at a minimum, the following:

26.2.1.1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;

26.2.1.2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

26.2.1.3. Effective training and education for the compliance officer and the MCO's employees;

26.2.1.4. Effective lines of communication between the compliance officer and the MCO's employees;

26.2.1.5. Enforcement of standards through well-publicized disciplinary guidelines;

26.2.1.6. Provisions for internal monitoring and auditing;

26.2.1.7. Provisions for the MCO's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23; and

26.2.1.8. Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's Agreement [42 CFR 438.608(a) and (b)]

26.2.2. The MCO shall establish a Program Integrity Unit within the MCO comprised of:

26.2.2.1. Experienced Fraud, Waste and Abuse reviewers who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein; and

26.2.2.2. An experienced Fraud, Waste, and Abuse Coordinator who is qualified by having appropriate background, training, education, and experience in health care provider fraud, waste and abuse.

26.2.3. .This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud, Waste and Abuse that may be committed by providers that are paid by the MCO and/or their subcontractors. The MCO Program Integrity Plan shall also include the prevention, detection, investigation and reporting of suspected fraud by the MCO, the MCO's employees, subcontractors, subcontractor's employees, or any other third parties with whom the MCO contracts. The MCO shall refer all suspected provider fraud to the DHHS Program Integrity Unit upon discovery. The MCO shall refer all suspected member fraud to DHHS Special Investigations Unit.

26.3. Reporting

26.3.1. The MCO shall promptly report provider fraud, waste and abuse information to DHHS' Program Integrity Unit, which is responsible for such reporting to federal oversight agencies pursuant to [42 CFR 455.1(a)(1) and 42 CFR438.608].

26.3.1.1.The MCO shall perform a preliminary investigation of all incidents of suspected fraud, waste and abuse internally. The MCO shall not take any of the following actions as they specifically relate to claims involved with the investigation unless prior written approval is obtained from DHHS' Program Integrity Unit, utilizing the MCO Request to Open Investigation form:

26.3.1.1.1. Contact the subject of the investigation about any matters related to the investigation, either in person, verbally or in writing, hardcopy, or electronic;

26.3.1.1.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

26.3.1.1.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

26.3.2. The MCO shall promptly report to DHHS' Division of Client Services all information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including but not limited to:

26.3.2.1. Changes in the enrollee's residence; and

26.3.2.2. Death of an enrollee.

26.3.3. The MCO shall promptly report to DHHS' Office of Medicaid Services and the Program Integrity Unit all changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

26.3.4. The MCO shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (five (5) percent or greater) in the MCO, or any sub-contractor in which the MCO has a five percent (5%) or greater ownership interest [42 CFR 438.608(c)(2)].

26.3.5. [Intentionally left blank.]

26.3.6. The MCO shall provide written disclosure of any prohibited affiliation under §438.610 and as described in subparagraph 4.3.2 of this Agreement [42 CFR 438.608(c)(1)].The MCO shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State.

26.3.7. As an integral part of the Program Integrity function, and in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438, the MCO shall provide DHHS or its designee real time access to all of the MCO electronic encounter and claims data from the MCO's current claims reporting system. The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in section 24.5.16.

26.3.7.1. MCOs shall provide any additional data access upon written request from DHHS for any potential fraud, waste, or abuse investigation or for MCO oversight review. The additional access shall be provider within 3 business days of the request.

26.3.8. The MCO shall make claims and encounter data available to DHHS (and other State staff) using a reporting system that is compatible with DHHS' system(s).

26.3.9. The MCO, their subcontractors, their contracted providers, their subcontractor's providers, and any subcontractor's subcontractor's providers shall cooperate fully with Federal and State agencies and contractors in any program integrity related investigations and subsequent legal actions. The MCO, their subcontractors and their contracted providers, subcontractor's providers, and any subcontractor's subcontractor's providers shall, upon written request and as required by this Agreement or state and/or federal law, make available any and all administrative, financial and medical records relating to the delivery of items or services for which MCO monies are expended. In addition, and as required by this Agreement or state and/or federal law, such agencies shall, also be allowed access to the place of business and to all MCO records of any contractor, their subcontractor or their contracted provider, subcontractor's providers, and any subcontractor's subcontractor's providers.

26.3.9.1. The MCO is responsible for program integrity oversight of its subcontractors. In accordance with federal regulations, CMS requires MCO contracts to contain provisions giving states' Program Integrity Units audit and access authority over MCOs and their subcontractors to include direct on site access to ordinal policies and procedures, claims processing, and provider credentialing for validation purposes at the expense of the MCO.

26.3.10. The MCO shall have a written process approved by DHHS for Recipient Explanation of Medicaid Benefits, which shall include tracking of actions taken on responses, as a means of determining and verifying that services billed by providers were actually provided to members. The MCO shall provide DHHS with a quarterly EOB activity report, including, but not limited to, tracking of all responses received, action taken by the MCO, and the outcome of the activity. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the MCO.

26.3.11. The MCO shall maintain an effective fraud, waste and abuse-related provider overpayment identification, recovery and tracking process. This process shall include

a methodology for a means of estimating overpayment, a formal process for documenting communication with providers, and a system for managing and tracking of investigation findings, recoveries, and underpayments related to fraud, waste and abuse investigations. DHHS and the AG Medicaid Fraud Unit shall have unrestricted access to information and documentation related to the NH Medicaid program for use during annual MCO Program Integrity audits and on other occasions as needed as a means of verifying and validating MCO compliance with the established policies, procedures, methodologies, and investigational activity regarding provider fraud, waste and abuse.

26.3.12.The MCO shall provide DHHS with a monthly report of all Program Integrity, in process and completed during the month, including fraud, waste and abuse by the MCO, the MCO's employees, subcontractors, subcontractor's employees, and contracted providers. [42 CFR 455.17]. The MCO will supply at a minimum:

26.3.12.1.provider name/ID number,

26.3.12.2.source of complaint,

26.3.12.3.type of provider,

26.3.12.4.nature of complaint,

26.3.12.5.review activity, and

26.3.12.6.approximate dollars involved,

26.3.12.7.Provider Enrollment Safeguards related to Program Integrity;

26.3.12.8.Overpayments, Recoveries, and Claim Adjustments;

26.3.12.9.Audits/Investigations Activity;

26.3.12.10.MFCU Referrals;

26.3.12.11.Involuntary Provider Terminations; and

26.3.12.12.Provider Appeal/Hearings Activity resulting from, or related to, Program Integrity.

26.3.13.All fraud, waste and abuse reports submitted to DHHS shall be mutually developed and agreed upon between DHHS and the MCO. The reports will be submitted to DHHS in a format and mode of delivery, mutually agreed upon between DHHS and the MCO.

26.3.14.In the event DHHS is unable to produce a desired Ad Hoc report through its access to the MCO's data as provided herein, DHHS shall request in writing such Ad hoc report from the MCO and, within three (3) business days of receipt of such request, the MCO shall notify DHHS of the time required by the MCO to produce and deliver the Ad hoc report to DHHS, at no additional cost to DHHS.

26.3.15.The MCO shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the MCO discovers wasteful and or abusive incorrect billing trends with a particular provider/provider type, specific billing issue trends, or quality trends, it is the MCO's responsibility, as part of the provider audit/investigative process, to recover any inappropriately paid funds, and as part of the resolution and outcome, for the MCO to determine the appropriate remediation, such as reaching out to the provider to provide individualized or group training/education regarding the issues at hand. Within sixty (60) days of discovery, the MCO shall report overpayments identified during investigations to DHHS Program Integrity and shall include them on the monthly investigation activity report. The MCO shall still notify Program Integrity unit to request approval to proceed with a suspected fraud or abuse investigation.

26.3.16. [Intentionally left blank.]

26.3.17.Annually, the MCO shall submit to DHHS a report of the overpayments it recovered and certify by its Chief Financial Officer that this information is accurate to the best of his or her information, knowledge, and belief [42 CFR 438.606].DHHS reserves the right to conduct peer reviews of final program integrity investigations completed by the MCO.

26.3.18.DHHS will perform an annual program integrity audit, conducted on-site at the MCO (at the expense of the MCO) to verify and validate the MCO's compliance. The review will include, but not limited to, the plan's established policies and methodologies, credentialing, provider and staff education/training, provider contracts, and case record reviews to ensure that the MCO is making proper payments to providers for services under their agreements, and pursuant to 42 CFR 438 6(g). The review will include direct access to MCO system while on site and hard copy of documentation while on site as requested. Any documentation request at the end of the on site shall be delivered to Program Integrity within 3 business days of request. The MCO shall provide DHHS staff with access to appropriate on-site private work space to conduct DHHS's program integrity contract management reviews.

26.3.19.The MCO shall meet with DHHS monthly, or as determined by DHHS, to discuss audit and investigation results and make recommendations for program improvements. DHHS shall meet with both MCOs together quarterly, or as determined by DHHS, to discuss areas of interest for past, current and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities, and to discuss and share provider audit information and results.

26.3.20.The MCO shall provide DHHS with an annual report of all investigations in process and completed during the Agreement year within thirty (30) calendar days of the end of the Agreement year. The report shall consist of, at a minimum, an aggregate of the monthly reports, as well as any recommendations by the MCO for future reviews, changes in the review process and reporting process, and any other findings related to the review of claims for fraud, waste and abuse.

26.3.21.The MCO shall provide DHHS with a final report within thirty (30) calendar days following the termination of this Agreement. The final report format shall be developed jointly by DHHS and the MCO, and shall consist of an aggregate compilation of the data received in the monthly reports.

26.3.22.The MCO shall refer all suspected provider Medicaid fraud cases to DHHS upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.

26.3.23.The MCO shall institute a Pharmacy Lock-In Program for members which has been reviewed and approved by DHHS.

26.3.23.1.If the MCO determines that a member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to members regarding the Pharmacy Lock-In determination.

26.3.24.MCOs may, with prior approval from DHHS, implement Lock-In Programs for other medical services.

26.3.25.The MCO shall provide DHHS with a monthly report regarding the Pharmacy Lock-In Program. Report format, content, design, and mode of transmission shall be mutually agreed upon between DHHS and the MCO.

26.3.26.DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit or DHHS Special Investigations Unit.

26.3.27.Subject to applicable state and federal confidentiality/privacy laws, upon written request, the MCO will allow access to all NH Medicaid medical records and claims information to State and Federal agencies or contractors such as, but not limited to Medicaid Fraud Control Unit, Recovery Audit Contractors (RAC) the Medicaid Integrity Contractors (MIC), or DHHS Special Investigations Unit.

26.3.27.1.The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency (State and Federal) or their contractors, whether administrative, civil, or criminal. Such cooperation shall include providing, upon written request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in

medical or pharmaceutical questions or in any matter related to an investigation.

26.3.28. The MCO's MCIS system shall have specific processes and internal controls relating to fraud, waste and abuse in place, including, but not limited to the following areas:

26.3.28.1. Prospective claims editing;

26.3.28.2. NCCI edits;

26.3.28.3. Post-processing review of claims; and

26.3.28.4. Ability to pend any provider's claims for pre-payment review if the provider has shown evidence of credible fraud [42 CFR 455.21] in the Medicaid Program.

26.3.29. The MCO and their subcontractors shall post and maintain DHHS approved information related to Fraud, Waste and Abuse on its website, including but not limited to provider notices, updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

26.3.30. The MCO and their subcontractors shall be subject to on-site reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests as a result of an annual or targeted on-site review (at the expense of the MCO).

26.3.31. DHHS shall conduct investigations related to suspected provider fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for any and all types of claims older than six months for which the MCO does not have an active investigation.

26.3.32. DHHS shall validate the MCO and their subcontractors' performance on the program integrity scope of services to ensure the MCO and their subcontractors are taking appropriate actions to identify, prevent, and discourage improper payments made to providers, as set forth in 42 CFR 455 – Program Integrity.

26.3.33. DHHS shall establish performance measures to monitor the MCO compliance with the Program Integrity requirements set forth in this Agreement.

26.3.34. DHHS shall notify the MCO of any policy changes that impact the function and responsibilities required under this section of the Agreement.

26.3.35. DHHS shall notify the MCO of any changes within its agreement with its fiscal agent that may impact this section of this Agreement as soon as reasonably possible.

26.3.36.The MCO(s) shall report to DHHS all identified providers prior to being investigated, to avoid duplication of on-going reviews with the RAC, MIC, MFCU and, using the MCO Request to Open Investigation Form. DHHS will either approve the MCO to proceed with the investigation, or deny the request due to potential interference with an existing investigation.

26.3.37.The MCO(s) shall maintain appropriate record systems for services to members pursuant to 42 CFR 434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff, or its designee, to MCO(s) NH Medicaid related data files. Such information shall include, but not be limited to:

26.3.37.1.Recipient – First Name, Last Name, DOB, gender, and identifying number;

26.3.37.2.Provider Name and number (rendering, billing and Referring);

26.3.37.3.Date of Service(s) Begin/End;

26.3.37.4.Place Of Service;

26.3.37.5.Billed amount/Paid amount;

26.3.37.6.Paid date;

26.3.37.7.Standard diagnosis codes (ICD-9-CM and ICD-10-CM), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim);

26.3.37.8.Paid, denied, and adjusted claims;

26.3.37.9.Recouped claims and reason for recoupment;

26.3.37.10.Discharge status;

26.3.37.11.Present on Admission (POA);

26.3.37.12.Length of Stay;

26.3.37.13.Claim Type;

26.3.37.14.Prior Authorization Information;

26.3.37.15.Detail claim information;

26.3.37.16.Provider type;

26.3.37.17.Category of Service;

26.3.37.18.Admit time and discharge date;

26.3.37.19.Admit code;

26.3.37.20.Admit source;

26.3.37.21.Covered days;

26.3.37.22.TPL information;

26.3.37.23.Units of service;

26.3.37.24.EOB;

26.3.37.25.MCO ID#;

26.3.37.26.Member MCO enrollment date;

26.3.37.27.If available, provider time in and time out for the specific service(s) provided;

26.3.37.28.Data shall be clean, not scrubbed; and

26.3.37.29.And any other data deemed necessary by DHHS

26.3.38.The MCO shall provide DHHS with the following monthly reports as required by CMS:

26.3.38.1.Date of Death.

26.3.39.The MCO shall provide DHHS with any new reports as identified and required by state and federal regulation. The timing, format, content and mode of transmission will be mutually agreed upon between DHHS and the MCO.

27. Third Party Liability

DHHS and the MCO will cooperate in implementing cost avoidance and cost recovery activities. The rights and responsibilities of the parties relating to members and Third Party Payors are as follows:

27.1. MCO Cost Avoidance Activities

27.1.1. The MCO shall have primary responsibility for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans, and workers compensation. The MCO must attempt to avoid initial payment of claims, whenever possible, when federal or private health insurance resources are available. To support that responsibility, the MCO must implement a file transfer protocol between the DHHS MMIS and the MCO's MCIS to receive Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138. MCO shall require its subcontractors to promptly and consistently report COB daily information to the MCO.

27.1.2. The MCO shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

27.1.3. The number of claims cost avoided by the MCO's claims system, including the amount of funds, the amounts billed, the amounts not collected, and the amounts denied, must be reported weekly to DHHS in delimited text format.

27.1.4. The MCO shall maintain records of all COB collection efforts and results and report such information either through monthly electronic data transfers or access rights for DHHS to the MCO's data files. The data extract shall be in the delimited text format. Data elements may be subject to change during the course of the Agreement. The MCO shall accommodate changes required by DHHS and DHHS shall have access to all billing histories and other COB related data.

27.1.5. The MCO shall provide DHHS with a detailed claim history of all claims for a member, including adjusted claims, on a monthly basis based on a specific service date parameter requested for accident and trauma cases. This shall be a full replacement file each month for those members requested. These data shall be in the delimited text format. The claim history shall have, at a minimum, the following data elements:

27.1.5.1.Member name;

27.1.5.2.Member ID;

27.1.5.3.Dates of service;

27.1.5.4.Claim unique identifier (transaction code number);

27.1.5.5.Claim line number;

27.1.5.6.National Diagnosis Code;

27.1.5.7.Diagnosis code description;

27.1.5.8.National Drug Code;

27.1.5.9.Drug code description;

27.1.5.10.Amount billed by the provider;

27.1.5.11.Amount paid by the MCO;

27.1.5.12.Amount of other insurance recovery, name or Carrier ID;

27.1.5.13.Date claim paid;

27.1.5.14.Billing provider name; and

27.1.5.15.Billing provider NPI.

27.1.6. The MCO shall provide DHHS with a monthly file of COB collection effort and results. These data shall be in a delimited text format. The file should contain the following data elements:

27.1.6.1.Medicaid member name;

27.1.6.2.Medicaid member ID;

27.1.6.3.Insurance Carrier, other public payer, PBM, or benefit administrator ID;

27.1.6.4.Insurance Carrier, other public payer, PBM, or benefit administrator name;

27.1.6.5.Date of Service;

27.1.6.6.Claim unique identifier (transaction code number);

27.1.6.7.Date billed to the insurance carrier, other public payer, PBM, or benefit administrator;

27.1.6.8.Amount billed;

27.1.6.9.Amount recovered;

27.1.6.10.Denial reason code;

27.1.6.11.Denial reason description; and

27.1.6.12.Performing provider.

27.1.7. The MCO and its subcontractors shall not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations nor bill or pursue collection from a member for services. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third Party Liability is established at the time the claim is adjudicated.

27.2. DHHS Cost Avoidance and Recovery Activities

27.2.1. DHHS shall be responsible for:

27.2.1.1.Medicare and newly eligible members' initial insurance verification and submitting this information to the MCO;

27.2.1.2.Cost avoidance and pay and chase of those services that are excluded from the MCO;

27.2.1.3.Accident and trauma recoveries;

27.2.1.4.Lien, Adjustments and Recoveries and Transfer of Assets pursuant to § 1917 of the SSA;

27.2.1.5.Mail order co-pay deductible pharmacy program for Fee for Service and HIPP (Health Insurance Premium Payment) program;

27.2.1.6.Veterans Administration benefit determination;

27.2.1.7.Health Insurance Premium Payment Program; and

27.2.1.8.Audits of MCO collection efforts and recovery.

27.3. Post-Payment Recovery Activities

27.3.1. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources.

27.3.2. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts.

27.3.3. Other resources with regard to Third Party Liability include but are not limited to: recoveries from personal injury claims, liability insurance, first party automobile medical insurance, and accident indemnity insurance.

27.4. MCO Post Payment Activities

27.4.1. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources, including a claim involving Workers' Compensation or where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible or collection through either legal action or traditional subrogation and collection procedures.

27.4.2. The MCO shall be responsible for Reviewing claims for accident and trauma codes as required under 42 C.F.R. §433.138 (e). The MCO shall specify the guideline used in determining accident and trauma claims and establish a procedure to send the DHHS Accident Questionnaire to Medicaid members, postage pre-paid, when such potential claim is identified. The MCO shall instruct members to return the Accident Questionnaire to DHHS. The MCO shall provide the guidelines and procedures to DHHS for review and approval. Any changes to procedures must be submitted to DHHS at least thirty days for approval prior to implementation.

27.4.3. Due to potential time constraints involving accident and trauma cases and due to the large dollar value of many claims which are potentially recoverable by DHHS, the MCO must identify these cases before a settlement has been negotiated. Should DHHS fail to identify and establish a claim prior to settlement due to the MCO's untimely submission of notice of legal involvement where the MCO has received such notice, the amount of the actual loss of recovery shall be assessed against the MCO. The actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by DHHS.

27.4.4. The MCO has the latter of eighteen (18) months from the date of service or twelve (12) months from the date of payment of health-related insurance resources to initiate recovery and may keep any funds that it collects. The MCO must indicate its intent to recover on health-related insurance by providing to DHHS an electronic file of those cases that will be pursued. The cases must be identified and a file provided to DHHS by the MCO within thirty (30) days of the date of discovery of the resource.

27.4.5. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a Medically Necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

27.5. DHHS Post Payment Recovery Activity

27.5.1. DHHS retains the sole and exclusive right to investigate, pursue, collect and retain all Other Resources, including accident and trauma. DHHS is assigned the MCO's subrogation rights to collect the "Other Resources" covered by this provision. Any correspondence or Inquiry forwarded to the MCO (by an attorney, provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forward to DHHS.

27.5.2. The MCO may neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by DHHS under the scope of these "Other Resources" shall be retained by DHHS.

27.5.3. DHHS may pursue, collect and retain recoveries of all health-related insurance cases; provided, however, that if the MCO has not notified DHHS of its intent to pursue a case identified for recovery before the latter of eighteen (18) months after the date of service or twelve (12) months after the date of payment, such cases not identified for recovery by the MCO will become the sole and exclusive right of DHHS to pursue, collect and retain. The MCO must notify DHHS through the prescribed electronic file process of all outcomes for those cases identified for pursuit by the MCO.

27.5.4. Should DHHS lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in billing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable Claim shall be assessed against the MCO.

28. Compliance with State and Federal Laws

28.1. General

28.1.1. The MCO, its subcontractors, and the providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

28.1.2. The MCO 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].

28.1.3. The MCO shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

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

28.1.3.2.Related rules: Title 42 Chapter IV;

28.1.3.3.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);

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

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

28.1.3.6.Regulations promulgated thereunder: 42 CFR 457;

28.1.3.7.Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

28.1.3.8.Patient Protection and Affordable Care Act of 2010;

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

28.1.3.10.State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

28.1.3.11.American Recovery and Reinvestment Act; and

28.1.3.12. Any waivers approved by the Centers for Medicare & Medicaid Services.

28.1.4. The MCO will not release and make public statements or press releases concerning the program without the prior consent of DHHS.

28.1.5. The MCO shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and the MCO, 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.

28.2. Non-Discrimination

28.2.1. The MCO shall require its providers and 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 or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

28.2.2. ADA Compliance

28.2.2.1.The MCO shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA.

28.2.2.1.1. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

28.2.2.2.The MCO shall submit to DHHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the MCO's knowledge. The MCO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by the MCO and shall be available for inspection by the DHHS. The MCO warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA. Where applicable, the MCO shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

28.2.2.3.The MCO shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all members who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

28.2.2.4.The MCO shall forward to DHHS copies of all grievances alleging discrimination against members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability for review and appropriate action within three (3) business days of receipt by the MCO.

28.2.3. Non-Discrimination in employment:

28.2.3.1.The MCO shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. The MCO 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. The MCO 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.

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

28.2.3.3.The MCO 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 the MCO'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.

28.2.3.4.The MCO 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.

28.2.3.5.The MCO 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.

28.2.3.6.In the event of the MCO'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 the MCO 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.

28.2.3.7.The MCO 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. The MCO 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 the MCO

becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

28.2.4. Non-Discrimination in Enrollment

28.2.4.1. The MCO shall and shall require its providers and subcontractors to accept assignment of an member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

28.2.4.2. The MCO shall and shall require its providers and subcontractors to not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

28.2.5. Non-Discrimination with Respect to Providers

28.2.5.1. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's members, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the MCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

28.3. Changes in Law

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

29. Administrative Quality Assurance Standards

29.1. Claims Payment Standards

29.1.1. The MCO shall pay or deny ninety-five percent (95%) of clean claims within thirty (30) days of receipt, or receipt of additional information [42 CFR 447.46; 42 CFR 447.45(d)(2), (d)(3), (d)(5), and (d)(6)].

29.1.2. The MCO shall pay interest on any clean claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

29.1.3. The MCO shall pay or deny all claims within sixty (60) calendar days of receipt.

29.1.4. Additional information necessary to process incomplete claims shall be requested from the provider within thirty (30) days from the date of original claim receipt.

29.1.5. For purposes of this requirement, New Hampshire DHHS has adopted the claims definitions established by CMS under the Medicare program, which are as follows:

29.1.5.1."clean" claim: a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and

29.1.5.2."incomplete" claim: a claim that is denied for the purpose of obtaining additional information from the provider.

29.1.6. Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or electronic funds transfer is issued to the service provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

29.2. Quality Assurance Program

29.2.1. The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS on a monthly basis.

29.2.2. Monthly reporting shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

29.2.3. The MCO shall implement Corrective Action Plans to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

29.3. Claims Financial Accuracy

29.3.1. Claims financial accuracy measures the accuracy of dollars paid to providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

29.4. Claims Payment Accuracy

29.4.1. Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay ninety-seven percent (97%) of claims accurately.

29.5. Claims Processing Accuracy

29.5.1. Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process ninety-five percent (95%) of all claims correctly.

30. Privacy and Security of Members

30.1. General Provisions

30.1.1. The MCO shall be in compliance with privacy policies established by governmental agencies or by State or federal law.

30.1.2. The MCO shall provide sufficient security to protect the State and DHHS data in network, transit, storage, and cache.

30.1.3. In addition to adhering to privacy and security requirements contained in other applicable laws and statutes, the MCO shall execute as part of this Agreement a Business Associates Agreement governing the permitted uses and disclosure and security of Protected Health Information.

30.1.4. The MCO shall ensure that it uses and discloses individually identifiable health information in accordance with HIPAA privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable [42 CFR 438.224]; complies with federal statutes and regulations governing the privacy of drug and alcohol abuse patient records (42 CFR, Part 2.33), and all applicable state statutes and regulations, including but not limited to: R.S.A. 167:30: protects the confidentiality of all DHHS records with identifying medical information in them.

30.1.5. With the exception of submission to the Comprehensive Healthcare Information System or other requirements of State or federal law, claims and member data on New Hampshire Medicaid members may not be released to any party without the express written consent of DHHS.

30.1.6. The MCO shall ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information [42 CFR 438.208(b)].

31. Finance

31.1. Financial Standards

31.1.1. In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with New Hampshire Insurance Department regulations, and any other relevant laws and regulations.

31.1.2. The MCO shall maintain a risk-based capital (RBC) ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

31.1.3. With the exception of payment of a claim for a medical product or service that was provided to a member, and that is in accordance with a written Agreement with the provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

31.1.3.1. RBC ratio was less than 2.0 for the most recent year filing, per R.S.A. 404-F:14 (III); and

31.1.3.2. MCO was not in compliance with the NHID solvency requirement.

31.1.4. The MCO shall notify DHHS within ten (10) calendar days when its Agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

31.1.5. The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

31.1.6. The MCO shall not be responsible for DSH/GME (IME/DME) payments to hospitals. DSH and GME amounts are not included in capitation payments.

31.1.7. The MCO shall submit data on the basis of which DHHS determines that the MCO has made adequate provision against the risk of insolvency.

31.2. Capitation Payments

31.2.1. Preliminary capitation rates for non NHHPP members for the agreement period through June 30, 2019 are shown in Exhibit B. For each of the subsequent years of the Agreement actuarially sound per member, per month capitated rates will be calculated and certified by the DHHS's actuary.

31.2.2. Capitation rates for NHHPP members are shown in Exhibit B and were determined as part of Agreement negotiations, any best and final offer process, and the DHHS actuary's soundness certification.

31.2.3. Capitation rate cell is determined as of the first day of the capitation month and does not change during the entire month regardless of member changes (e.g., age).

31.2.4. DHHS will make a monthly payment to the MCO for each member enrolled in the MCO's plan. Capitation payments shall only be made for Medicaid-eligible enrollees and be retained by the MCOs for those enrollees. The capitation rates, as set forth in Exhibit B, will be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis as follows:

31.2.4.1. The Chronic Illness and Disability Payment System and/or Medicaid Rx risk adjuster (CDPS + Rx, Medicaid Rx) will be used to risk adjust MCO capitation payments;

31.2.4.2. A risk score will be developed for members with six (6) months or more months of Medicaid eligibility (either FFS or managed care) inclusive of three (3) months of claims run out in the base experience period. For members with less than six (6) months of eligibility, a score equal to the average of those scored beneficiaries in each cohort will be used; and

31.2.4.3. The MCO risk score for a particular rate cell will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population enrolled in the Care Management program. For rate cells with an opt-out provision, the MCO risk score will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population that is eligible to enroll in the Care Management program (FFS eligibles + MCO members).

31.2.4.4. [Intentionally left blank.]

31.2.5. DHHS reserves the right to terminate or implement the use of a risk adjustment process for specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates.

31.2.6. The capitation payment for Medicaid Managed Care members will be made retrospectively with a two (2) month delay. For example, a payment will be made within five (5) business days of the first day in October 2012 for services provided in July 2012.

31.2.7. Section 31.2.6 notwithstanding, capitation payments for NHHPP members will be paid in the month of service.

31.2.8. Capitation payment settlements will be made at three (3) month intervals. DHHS will recover capitation payments made for deceased members, or members who were later determined to be ineligible for Medicaid and/or for Medicaid managed care or need rate cell or kick payment corrections. DHHS will pay MCO for retroactive member assignments, corrections to kick payments, behavioral health certification level correction or other rate assignment corrections.

31.2.9. Capitation payments for members who became ineligible for services in the middle of the month will be prorated based on the number of days eligible in the month.

31.2.10. The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement [42 CFR 438.608(c)(3)].

31.2.11. For each live birth, DHHS will make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all maternity expenses, including all delivery and postpartum care. In the event of a multiple birth DHHS will only make only one maternity kick payment. A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

31.2.12.For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2012 and August 2012 for a baby born any time in July 2012. Enrolled babies will be covered under the MCO capitated rates thereafter. For each live birth, for Fiscal Year 2019, the newborn kick payment will be made for both newborns with and without Neonatal Abstinence Syndrome. Each type of payment is distinct and only one payment is made per newborn.

31.2.13.The MCO shall submit information on maternity and newborn events to DHHS. The MCO shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

31.2.14.

31.2.15.DHHS will inform the MCO of any required program revisions or additions in a timely manner. DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

31.2.16. When requested by DHHS, the MCO shall submit base data to DHHS to ensure actuarial soundness in development of the capitated rates.

31.2.17. The MCO's Chief Financial Officer shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate [42 CFR 438.606].

31.2.18. In the event an enrolled Medicaid member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive full capitation payment for that member. The entity responsible for coverage of the member at the time of admission as an inpatient, i.e. either DHHS or another MCO, shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

31.2.19. Payment for behavioral health rate cells shall be determined based on a member's CMHC behavioral certification level and a member having had an encounter at a CMHC in the last 6 months. Changes in the certification level for a member shall be reflected as of the first of each month and does not change during the month.

31.2.20. The SFY 2019 MCM Capitation rates include directed payments of $5 million to the CMHCs across all programs and populations, pending approval by CMS, to ensure timely access to high-quality care. MCOs are required to pay these amounts directly to the Community Mental Health Centers (CMHCs) according to criteria defined by the Department and approved by CMS. The directed payments will be based on the utilization and delivery of services for Medicaid beneficiaries that receive Community Mental Health Program services delivered at CMHCs, regardless of the basis of their eligibility for Medicaid (i.e., services delivered to members identified as SPMI, SMI, low utilizer and SED children). These amounts are to be paid directly to the providers by the MCOs and do not include additional allowance for administrative expense or risk margin. The Department reserves the right to modify the Exhibit O to support any CMS required reporting related to directed payment.

31.2.21. Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the New Hampshire Insurance Administrative Fund (Fund) pursuant to R.S.A. 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NH Insurance Department.

31.2.22. For any member with claims exceeding five hundred thousand dollars ($500,000) for the fiscal year, after applying any third party insurance off set, DHHS will reimburse fifty percent (50%) of the amount over five hundred thousand dollars ($500,000) after all claims have been recalculated based on the DHHS fee schedule for the services. For a member whose services may be projected to exceed five hundred thousand dollars ($500,000) in MCO claims, the MCO shall advise DHHS. Prior approval from the Medicaid Director is required for subsequent services provided to the member.

31.3. Medicaid Loss Ratio

31.3.1. The MCO shall determine the Medicaid Loss Ratio ("MLR") experienced in accordance with 42 CFR 438.8.

31.3.2. The MCO shall submit MLR summary reports quarterly to DHHS, which shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year. Specifically, the MCO shall provide separate summary reports for NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program. The MCO must attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. Such summary reports shall be based on a template provided and developed by DHHS within sixty (60) days of the effective date of this Agreement.

31.3.3. The MCO and its subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

31.4. NHHPP Risk Protection Structure

31.4.1. DHHS will implement risk adjustment and risk corridors for the NHHPP Medically Frail and NHHPP Transitional populations.

31.4.1.1. Risk adjustment – (MCO Revenue Reallocation) – Similar to the risk adjustment process for the current Medicaid Step 1 population under the MCM program, risk adjustment will shift revenue from MCOs with lower acuity populations to MCOs with higher acuity populations. The risk adjustment component will only apply to the NHHPP Medically Frail population. The risk adjustment process is revenue neutral. The NHHPP Transitional population is expected to have very short enrollment duration and therefore will not be risk adjusted.

31.4.2. Risk adjustment – Methodology – Acuity will be measured using the CDPS+Rx, a diagnosis and pharmacy based risk adjuster that will also be used for the current Medicaid population. Key differences in the risk adjustment process for the NHHPP Medically Frail population include:

31.4.2.1. DHHS will use concurrent risk adjustment for the NHHPP Medically Frail population. DHHS will use SFY 2019 claims and the standard CDPS+Rx concurrent risk weights to estimate SFY 2019 acuity (as opposed to prospective models that use a prior year's claims to estimate current acuity).

31.4.2.2. Risk adjustment transfer payments will be made as part of the contract period settlement, not as prospective payments.

31.4.3. Risk corridors – DHHS will establish a target medical loss ratio (MLR) of 89.3% based on NHHPP pricing assumptions and perform a separate calculation for the NHHPP Medically Frail and NHHPP Transitional populations:

31.4.3.1. Administrative and margin allowance of 8.9% of the capitation rate prior to state premium tax.

31.4.3.2. New Hampshire state premium tax of 2%.

31.4.3.3. DHHS and each MCO will share the financial risk of actual results that are above or below the MLR target as shown in the table below:

New Hampshire Department of Health and Human Services New Hampshire Health Protection Program Population Risk Corridor Program		
Actual MLR Compared to Target MLR	**MCO Share**	**DHHS Share**
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

31.4.3.4. The NHHPP Medically Frail risk corridor calculation will be applied after the risk adjustment calculation.

31.4.4. For SFY 2019, risk protection settlement will occur after the SFY 2019 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.4.1. June 30, 2019: End of NHHPP contract period

31.4.4.2. December 31, 2019: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.4.3. January 31, 2020: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.4.4. April 30, 2020: DHHS releases settlement payment report to MCOs

31.4.4.5. May 31, 2020: DHHS makes / receives final settlement payments to / from MCOs

31.4.5. For SFY 2018, risk protection settlement will occur after the SFY 2018 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.5.1. June 30, 2018: End of NHHPP contract period

31.4.5.2. December 31, 2018: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.5.3. January 31, 2019: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.5.4. April 30, 2019: DHHS releases settlement payment report to MCOs

31.4.5.5. May 31, 2019: DHHS makes / receives final settlement payments to / from MCOs

31.4.6. For SFY 2017, risk protection settlement will occur after the SFY 2017 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.6.1. June 30, 2017: End of NHHPP contract period

31.4.6.2. December 31, 2017: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2017 dates of service paid through December 31, 2017)

31.4.6.3. January 31, 2018: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.6.4. April 30,.2018: DHHS releases settlement payment report to MCOs

31.4.6.5. May 31, 2018 DHHS makes / receives final settlement payments to / from MCOs

31.4.7. For SFY 2016, risk protection settlement will occur after the SFY 2016 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.7.1. June 30, 2016: End of NHHPP contract period

31.4.7.2. December 31, 2016: Cutoff date for encounter data to be used in the risk protection settlement calculations (January 2016 – June 2016 dates of service paid through December 31, 2016)

31.4.7.3. January 31, 2017: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.7.4. April 30, 2017: DHHS releases settlement payment report to MCOs

31.4.7.5. May 31, 2017: DHHS makes / receives final settlement payments to / from MCOs

31.4.8. For September 2014 – December 2015 risk protection settlement:

31.4.8.1. August 31, 2016: DHHS intends to release settlement payment report to MCOs

31.4.8.2. September 30, 2017: DHHS intends to make / receive final settlement payments to / from MCOs.

31.5. Financial Responsibility for Dual-Eligibles

31.5.1. The MCO shall pay any Medicare coinsurance and deductible amount up to what New Hampshire Medicaid would have paid for that service, whether or not the Medicare provider is included in the MCO's provider network. These payments are included in the calculated capitation payment.

31.6. Premium Payments

31.6.1. DHHS is responsible for collection of any premium payments from members. If the MCO inadvertently receives premium payments from members, it shall inform the member and forward the payment to DHHS.

31.7. Sanctions

31.7.1. If the MCO fails to comply with the financial requirements in Section 31, DHHS may take any or all of the following actions:

31.7.1.1. Require the MCO to submit and implement a Corrective Action Plan

31.7.1.2. Suspend enrollment of members to the MCO after the effective date of sanction

31.7.1.3. Terminate the Agreement upon forty-five (45) calendar days written notice

31.7.1.4. Apply liquidated damages according to Section 34

31.8. Medical Cost Accruals

31.8.1. The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims.

31.9. Audits

31.9.1. The MCO shall allow DHHS and/or the NHID to inspect and audit any of the financial records of the MCO and its subcontractors. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)].

31.9.2. The MCO shall file annual and interim financial statements in accordance with the standards set forth below. This Section 31.9.2 will supersede any conflicting requirements in Exhibit C of this Agreement.

31.9.3. Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners ("NAIC"), annual audited financial statements that have been audited by an independent Certified Public Accountant. Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

31.9.4. The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the Insurance Department.

31.9.5. The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

31.10.Member Liability

31.10.1.The MCO shall not hold its Medicaid members liable for:

31.10.1.1. The MCO's debts, in the event of the MCO's insolvency [42 CFR 438.116(a); SMM 2086.6];

31.10.1.2. The covered services provided to the member, for which the State does not pay the MCO;

31.10.1.3. The covered services provided to the member, for which the State, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or

31.10.1.4. Payments for covered services furnished under an Agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided those services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(a), (b) and (c); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.2. Subcontractors and referral providers may not bill members any amount greater than would be owed if the entity provided the services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.3. The MCO shall cover continuation of services to members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency [SMM 2086.6B].

31.11. Denial of Payment

31.11.1. Payments provided for under the Agreement will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in [§1903(m)(5)(B)(ii) of the SSA; 42 CFR 438.726(b); 42 CFR 438.730(e)].

31.12. Federal Matching Funds

31.12.1. Federal matching funds are not available for amounts expended for providers excluded by Medicare, Medicaid, or Children's Health Insurance Program (CHIP), except for emergency services [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and §1903(i)(2) of the SSA; SMD letter 12/30/97]. Payments made to such providers are subject to recoupment from the MCO by DHHS.

31.13. Health Insurance Providers Fee

31.13.1. Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposed an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

31.13.1.1.To the extent such fees exist:

31.13.1.1.1.The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement no later than 120 days following its review and acceptance of the Contractor's Adjusted Fee.

31.13.1.1.2. To claim reimbursement for the Contractor's Adjusted Fee, the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:

Attn: Medicaid Finance Director

New Hampshire Medicaid Managed Care Program

129 Pleasant Street

Concord, NH 03304

32. Termination

32.1. Transition Assistance

32.1.1. Upon receipt of notice of termination of this Agreement by DHHS, the MCO 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 vendor or to perform the work itself.

32.1.1.1. Transition Plan

32.1.1.1.1. MCO must prepare a Transition Plan which is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date.

32.1.1.2. Data

32.1.1.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, 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.

32.1.1.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO shall transmit the information and records required 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.

32.2. Service Authorization

32.2.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received. Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS.

32.2.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

32.3. Claims Responsibilities

32.3.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

32.3.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

32.4. Termination for Cause

32.4.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if the MCO [42 CFR 438.610(c)(3); 42 CFR 434.6(a)(6)]:

32.4.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any member, including significant marketing abuses;

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

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

32.4.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS' notice and written request for compliance;

32.4.1.5. Violates state or federal law or regulation;

32.4.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

32.4.1.7. Becomes insolvent;

32.4.1.8. Fails to meet applicable requirements in sections §1932, §1903 (m) and §1905(t) of the SSA [42 CFR 438.708]. In the event of a termination by DHHS pursuant to 42 CFR 438.708, DHHS shall provide the MCO with a pre-termination hearing in accordance with 42 CFR 438.710;

32.4.1.9. 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

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

32.4.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance.

32.4.2. If DHHS terminates this Agreement for cause, the MCO 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 MCO. 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 reasonable attributable to the MCO's failure to perform any service in accordance with the terms of this Agreement.

32.5. Termination for Other Reasons

32.5.1. Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for sixty (60) calendar days after written notice thereof by the other party.

32.5.2. In the event the MCO gives written notice that it does not accept the actuarially sound capitation rates established by DHHS for Year 2 or later of the program, the MCO and DHHS will have thirty (30) days from the date of such notice or thirty (30) calendar days from the expiration of the rates indicated in Exhibit B, whichever comes later, to attempt to resolve the matter without terminating the agreement. If no resolution is reached in the above thirty (30) calendar days period, then the contract will terminate ninety (90) calendar days thereafter, or at the time that all members have been disenrolled from the MCO's plan, whichever date is earlier. In the event of such termination, the MCO shall accept the lesser of the most recently agreed to capitation rates or the new annual capitation rate for each rating category as payment in full for Covered Services and all other services required under this Agreement delivered to Members until all Members have been disenrolled from the MCO's plan consistent with any mutually agreed upon transition plans to protect Members.

32.6. Final Obligations

32.6.1. DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Amounts due to MCO for unpaid premiums, risk settlement, ABA therapies, High Dollar Stop Loss, shall be paid to MCO within one year of date of termination.

32.7. Survival of Terms

32.7.1. 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:

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

32.7.1.2. 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.

32.8. Notice of Hearing

32.8.1. Except because of change in circumstances or in the event DHHS terminates this Agreement pursuant to subsections (1), (2), (3) or (10 of Section 32.3.1, DHHS shall give the MCO ninety (90) days advance, written notice of termination of this Agreement and shall provide the MCO with an opportunity to protest said termination and/or request an informal hearing in accordance with 42 CFR 438.710. This notice shall specify the applicable provisions of this Agreement and the effective date of termination, which shall not be less than will permit an orderly disenrollment of members to the Medicaid FFS program or transfer to another MCO.

33. Agreement Closeout

33.1. Period

33.1.1. A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day the MCO is responsible for coverage of specific beneficiary groups or operating under this Agreement. During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS. Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

33.2. Data

33.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new MCO and/or DHHS shall define the information required during this period and the time frames for submission.

33.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO 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.

33.2.3. The MCO shall be responsible for continued submission of data to the Comprehensive Healthcare Information System during and after the transition in accordance with NHID regulations.

33.3. Service Authorizations

33.3.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with the new MCO to process service authorization requests received. Disputes between the MCO and the new MCO regarding service authorizations shall be resolved by DHHS.

33.3.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

33.4. Claims Responsibilities

33.4.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

33.4.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

34. Remedies

34.1. Reservation of Rights and Remedies

34.1.1. 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 MCO 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.

34.2. Liquidated Damages

34.2.1. DHHS and the MCO agree that it will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards indicated below throughout the life of this Agreement. Any breach by the MCO will delay and disrupt DHHS's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable.

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

34.2.3. DHHS shall make all assessments of liquidated damages. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify the MCO as specified in Section 34.10 of this Agreement.

34.2.4. The MCO shall submit a written Corrective Action Plan to DHHS, within five business days of notification, for review and approval prior to implementation of corrective action.

34.2.5. The MCO agrees that as determined by DHHS, failure to provide services meeting the performance standards below will result in liquidated damages as specified. The MCO agrees to abide by the Performance Standards and Liquidated Damages specified, provided that DHHS has given the MCO data required to meet performance standards in a timely manner. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

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

34.2.7. Liquidated damages may be assessed for each day, incidence or occurrence, as applicable, of a violation or failure.

34.2.8. The amount of liquidated damages assessed by DHHS to the MCO shall not exceed three percent (3%) of total expected yearly capitated payments, based on average annual membership from start date, for the MCO.

34.2.9. Liquidated damages related to timely processing of membership, claims and or/encounters shall be waived until such time as DHHS's file transfer systems and processes are operational.

34.3. Category 1

34.3.1. Liquidated damages up to $100,000 per violation or failure may be imposed for Category 1 events. Category 1 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.3.1.1. Acts that discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll an enrollee, except as permitted under law or under this Agreement, or any practice that would reasonably be expected to discourage enrollment by an enrollee whose medical condition or history indicates probable need for substantial future medical services. [42 CFR 700(b)(3) and 42 CFR 704(b)(2)].

34.3.1.2. A determination by DHHS that a recipient was not enrolled because of a discriminatory practice; $15,000 for each recipient subject to the $100,000 overall limit in 42 CFR 704(b)(2).

34.3.1.3.A determination by DHHS that a member found eligible for CFI services was relocated to a Nursing Facility due to MCO's failure to arrange for adequate in-home services in compliance with this Agreement and He-E801.09.

34.3.1.4. Misrepresentations of actions or falsifications of information furnished to CMS or the State.

34.3.1.5. Failure to comply with material requirements in this Agreement.

34.3.1.6. [Intentionally left blank.]

34.3.1.7. Failure to meet the Administrative Quality Assurance Standards specified in Section 29 of this Agreement.

34.3.1.8. Failure of the MCO to assume full operation of its duties under this Agreement in accordance with the implementation and transition timeframes specified herein.

34.4. Category 2

34.4.1. Liquidated damages up to $25,000 per violation or failure may be imposed for Category 2 events. Category 2 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.4.1.1. Misrepresentation or falsification of information furnished to a member, potential member, or health care provider.

34.4.1.2. Distribution, directly, or indirectly, through any agent or independent MCO, marketing materials that have not been approved by the State or that contain false or materially misleading information.

34.4.1.3. Violation of any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

34.4.1.4. Imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program; a maximum of $25,000 or double the amount of the charges, whichever is greater. The State will deduct the amount of the overcharge and return it to the affected member.

34.4.1.5. Failure to resolve member Appeals and Grievances within the timeframes specified in Section 19 of this Agreement.

34.4.1.6. Failure to ensure client confidentiality in accordance with 42 CFR 166 and 45 CFR 164; an incident of non-compliance shall be assessed as per member and/or per HIPAA regulatory violation.

34.4.1.7. Violation of a subcontracting requirement in this Agreement.

34.4.1.8. Failure to provide medically necessary services that the MCO is required to provide under law, or under this Agreement, to a member covered under this Agreement.

34.5. Category 3

34.5.1. Liquidated damages up to $10,000 per violation or failure may be imposed for Category 3 events. Category 3 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.5.1.1. Late, inaccurate, or incomplete turnover or termination deliverables.

34.6. Category 4

34.6.1. Liquidated damages up to $5,000 per violation or failure may be imposed for Category 4 events. Category 4 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.6.1.1. Failure to meet staffing requirements as specified in Section 6.

34.6.1.2. Failure to submit reports not otherwise addressed in this Section within the required timeframes.

34.7. Category 5

34.7.1. Liquidated damages as specified below may be imposed for Category 5 events. Category 5 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.7.1.1. Failure to provide a sufficient number of providers in order to ensure member access to all covered services and to meet the geographic access standards and timely access to service delivery specified in this Agreement:

34.7.1.1.1. $1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan;

34.7.1.1.2. $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan.

34.7.1.2. Failure to submit readable, valid health care data derived from Claims, Pharmacy or Encounter data in the required form or format, and timeframes required by the terms of this Agreement:

34.7.1.2.1. $5,000 for each day the submission is late;

34.7.1.2.2. for submissions more than thirty (30) calendar days late, DHHS reserves the right to withhold five percent (5%) of the aggregate

capitation payments made to the MCO in that month until such time as the required submission is made.

34.7.1.3. Failure to implement the Disaster Recovery Plan (DRP):

34.7.1.3.1. Implementation of the DRP exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2.

34.7.1.3.2. Implementation of the DRP exceeds the proposed time by more than two (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per day beginning with day 3 and up to day 5.

34.7.1.3.3. Implementation of the DRP exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days: twenty five thousand dollars ($25,000) per day beginning with day 6 and up to day 10.

34.7.1.3.4. Implementation of the DRP exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per day beginning with day 11.

34.7.1.4. Unscheduled system unavailability occurring during a continuous five (5) business day period:

34.7.1.4.1. Greater than or equal to two (2) and less than twelve (12) hours cumulative; up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof.

34.7.1.4.2. Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative; up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof.

34.7.1.4.3. Greater than or equal to twenty-four (24) hours cumulative; up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

34.7.1.5. Failure to correct a system problem not resulting in system unavailability within the allowed timeframe:

34.7.1.5.1. One (1) to fifteen (15) calendar days late; two hundred and fifty dollars ($250) per calendar day for days 1 through 15.

34.7.1.5.2. Sixteen (16) to thirty (30) calendar days late; five hundred dollars ($500) per calendar day for days 16 through 30.

34.7.1.5.3. More than thirty (30) calendar days late; one thousand dollars ($1,000) per calendar day for days 31 and beyond.

34.7.1.6. Failure to meet telephone hotline performance standards:

34.7.1.6.1. One thousand dollars ($1,000) for each percentage point that is below the target answer rate of ninety percent (90%) in thirty (30) seconds.

34.7.1.6.2. One thousand dollars ($1,000) for each percentage point that is above the target of a one percent (1%) blocked call rate.

34.7.1.6.3. One thousand dollars ($1,000) for each percentage point that is above the target of a five percent (5%) abandoned call rate.

34.7.1.7. The MCO shall resolve one hundred percent (100%) of standard member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO

34.8. Suspension of Payment

34.8.1. Payment of capitation payments shall be suspended when:

34.8.1.1. The MCO fails to cure a default under this Agreement within thirty (30) days of notification;

34.8.1.2. Failing to act on identified Corrective Action Plan;

34.8.1.3. Failure to implement approved program management or implementation plans;

34.8.1.4. Failure to submit or act on any transition plan, or corrective action plan, as specified in this Agreement; or

34.8.1.5. Upon correction of the deficiency or omission, capitation payments shall be reinstated.

34.9. Administrative and Other Remedies

34.9.1. In addition to other liquidated damages described in Category 1-5 events, DHHS may impose the following other remedies:

34.9.1.1. Appointment of temporary management of the MCO, as provided in 42 CFR 438.706, if DHHS finds that the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

34.9.1.2. Suspending enrollment of new members and/or changing auto-assignment of new members to the MCO.

34.9.1.3. Granting members the right to terminate enrollment without cause and notifying affected members of their right to disenroll.

34.9.1.4. Suspension of payment to the MCO for members enrolled after the effective date of the remedies and until CMS or DHHS is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur.

34.9.1.5. Termination of the Agreement if the MCO 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.

34.9.1.6. Civil monetary fines in accordance with 42 CFR 438.704.

34.9.1.7. Additional remedies allowed under State statute or regulation that address area of non-compliance specified in 42 CFR 438.700.

34.10.Notice of Remedies

34.10.1.Prior to the imposition of either liquidated damages or any other remedies under this Agreement, including termination for breach, with the exception of requirements related to the Implementation Plan, DHHS will issue written notice of remedies that will include, as applicable, the following:

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

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

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

34.10.1.4.Request for a Corrective Action Plan;

34.10.1.5.The timeframe and procedure for the MCO to dispute DHHS's determination. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

34.10.1.6. If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor.

35. Dispute Resolution Process

35.1. Informal Dispute Process

35.1.1. In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) days following the action or decision, the MCO may protest such action or decision by the delivery of a notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. The MCO 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 of the time, format and location of the presentations. At the conclusion of the presentations, the Director will consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation. The Director may appoint a designee to hear and determine the matter. If the Director or designee affirms the action or decision and the action or decision relates to termination of this Agreement, DHHS shall give enrollees of the MCO notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

35.2. No Waiver

35.2.1. The MCO's exercise of its rights under Section 34.1 shall not limit, be deemed a waiver of, or otherwise impact the parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A or any applicable provisions of the N.H. Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

36. Confidentiality

36.1. Confidentiality of Records

36.1.1. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Agreement shall be confidential and shall not be disclosed by the MCO, provided however, that pursuant to state laws and the regulations and administrative rules 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 Agreement; 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 MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian. In the case of records protected by 42 CFR Part 2.33, the individual must provide consent and notice as specified by 42 CFR Part 2.33.

36.2. MCO Owned or Maintained Data or Information

36.2.1. 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 the MCO. Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. The MCO acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense. If the MCO fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2018 – December 31, 2018

Medicaid Care Management

Base Population	Capitation Rate
Low Income Children and Adults - Age 2-11 Months	$221.27
Low Income Children and Adults - Age 1-18 Years	135.52
Low Income Children and Adults - Age 19+ Years	470.38
Foster Care / Adoption	336.48
Breast and Cervical Cancer Program	1,830.36
Severely Disabled Children	1,048.08
Elderly and Disabled Adults	1,095.12
Dual Eligibles	234.95
Newborn Kick Payment	2,917.40
Maternity Kick Payment	2,832.00
Neonatal Abstinence Syndrome Kick Payment	9,626.54
NF Resident and Waiver Rate Cell	
Nursing Facility Residents – Medicaid Only – Under 65	2,603.77
Nursing Facility Residents – Medicaid Only – 65+	1,335.68
Nursing Facility Residents – Dual Eligibles – Under 65	276.77
Nursing Facility Residents – Dual Eligibles – 65+	96.42
Community Residents – Medicaid Only – Under 65	3,068.24
Community Residents – Medicaid Only – 65+	1,547.31
Community Residents – Dual Eligibles – Under 65	1,245.48
Community Residents – Dual Eligibles – 65+	448.61
Developmentally Disabled Adults – Medicaid Only	828.65
Developmentally Disabled Adults – Dual Eligibles	250.04
Developmentally Disabled and IHS Children	1,243.43
Acquired Brain Disorder – Medicaid Only	1,453.36
Acquired Brain Disorder – Eligibles Dual	340.97
Behavioral Health Population Rate Cells	
Severe / Persistent Mental Illness – Medicaid Only	2,345.98
Severe / Persistent Mental Illness – Dual Eligibles	1,716.98
Severe Mental Illness – Medicaid Only	1,717.87
Severe Mental Illness – Dual Eligibles	1,031.39
Low Utilizer – Medicaid Only	1,427.57
Low Utilizer – Dual Eligibles	686.12
Serious Emotionally Disturbed Child	953.64

NH Health Protection Program, Transitional Population

Eligibility Category	Capitation Rate
Transitional Population	$510.62
Maternity Kick Payment	2,832.00

NH Health Protection Program, Medically Frail

Eligibility Category	Capitation Rate
Medically Frail	$1,007.86

January 1, 2019 – June 30, 2019

Medicaid Care Management

Base Population	Capitation Rate
Low Income Children and Adults - Age 0-11 Months	$221.91
Low Income Children and Adults - Age 1-18 Years	140.00
Low Income Children and Adults - Age 19+ Years	471.71
Foster Care / Adoption	379.36
Breast and Cervical Cancer Program	1,887.58
Severely Disabled Children	1,054.48
Elderly and Disabled Adults	1,099.84
Dual Eligibles	235.91
Newborn Kick Payment	2,931.19
Maternity Kick Payment	2,842.09
Neonatal Abstinence Syndrome Kick Payment	9,591.63
NF Resident and Waiver Rate Cell	
Nursing Facility Residents – Medicaid Only – Under 65	2,549.46
Nursing Facility Residents – Medicaid Only – 65+	1,338.46
Nursing Facility Residents – Dual Eligibles – Under 65	275.73
Nursing Facility Residents – Dual Eligibles – 65+	93.70
Community Residents – Medicaid Only – Under 65	3,190.23
Community Residents – Medicaid Only – 65+	1,585.40
Community Residents – Dual Eligibles – Under 65	1,245.37
Community Residents – Dual Eligibles – 65+	442.63
Developmentally Disabled Adults – Medicaid Only	853.68
Developmentally Disabled Adults – Dual Eligibles	252.14
Developmentally Disabled and IHS Children	1,281.80
Acquired Brain Disorder – Medicaid Only	1,509.30
Acquired Brain Disorder – Eligibles Dual	343.57
Behavioral Health Population Rate Cells	
Severe / Persistent Mental Illness – Medicaid Only	2,375.43
Severe / Persistent Mental Illness – Dual Eligibles	1,724.91
Severe Mental Illness – Medicaid Only	1,724.75
Severe Mental Illness – Dual Eligibles	1,039.57
Low Utilizer – Medicaid Only	1,460.97
Low Utilizer – Dual Eligibles	690.06
Serious Emotionally Disturbed Child	976.57

Granite Advantage Health Care Program

Eligibility Category	Capitation Rate
Medically Frail	$993.36
Non-Medically Frail	$423.21

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for State Fiscal Year 2019, to be served among all contracts is 1,788,648. Accordingly, the price limitation for SFY 2019 among all contracts is $803,103,161 based on the projected members per month.

3. Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement within 30 days following its review and acceptance of the Contractor's Adjusted Fee.

To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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 BOSTON MEDICAL CENTER HEALTH PLAN, INC. is a Massachusetts Nonprofit Corporation registered to transact business in New Hampshire on December 08, 2011. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **662906**
Certificate Number: **0004218702**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 5th day of December A.D. 2018.

William M. Gardner
Secretary of State

BOSTON MEDICAL CENTER HEALTH PLAN, INC.

Clerk's Certificate of Vote

I, David Beck, the duly elected and qualified Clerk of Boston Medical Center Health Plan, Inc. (BMCHP), a Massachusetts non-profit corporation organized under Chapter 180 of the General Laws of Massachusetts, do hereby certify that the Board of Trustees of the Corporation approved the following votes on February 14, 2012:

VOTED: To delegate authority to the Finance Committee of the Board of Trustees to authorize Boston Medical Center Health Plan, Inc. (BMCHP) to enter into a capitation agreement with the New Hampshire Department of Health and Human Services to provide Medicaid managed care to eligible New Hampshire residents if awarded a contract pursuant to the competitive procurement.

FURTHER
VOTED: To authorize and direct Kate Walsh, President and CEO, Thomas Traylor, Treasurer, Vice-President of Federal and State Relations for Boston Medical Center, or Scott O'Gorman, Interim Executive Director, acting singly or jointly, to execute, deliver and file such documents and papers and to take such actions, from time to time in the name of and on behalf of BMCHP, as each of them may deem necessary or appropriate to implement and effect the full intent and purpose of the foregoing resolutions, and to approve their authority to execute and deliver any such agreements, documents, instruments or other papers and to take any such further actions shall be conclusively evidenced by the execution and delivery thereof or the taking thereof.

I further certify that the Finance Committee of the BMCHP Board of Trustees approved the following vote on March 9, 2012:

VOTED: That BMCHP is hereby authorized to enter into a three-year Medicaid care management contract with the New Hampshire Department of Health and Human Services with coverage effective July 1, 2011 [sic], subject to satisfactory negotiation of final contract terms.

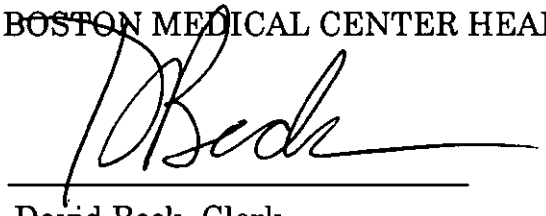
I further certify that the BMCHP Board of Trustees approved the following vote on April 10, 2018:

VOTED: To authorize and direct Kate Walsh, President and CEO, Susan M. Coakley, President, Michael Guerriere, Treasurer, or Matthew Herndon, Clerk, acting singly or jointly, to execute, deliver and file

such documents and papers and to take such actions, from time to time in the name of and on behalf of Boston Medical Center Health Plan, Inc., as each of them may deem necessary or appropriate, to implement and effect the full intent and purpose of applicable resolutions, and to approve their authority to execute and deliver any such agreements, documents, instruments or other papers and to take any such further actions shall be conclusively evidenced by the execution and delivery thereof or the taking thereof.

IN WITNESS WHEREOF, I have hereunto set my hand on this 5th day of December 2018.

BOSTON MEDICAL CENTER HEALTH PLAN, INC.



David Beck, Clerk

CERTIFICATE OF INSURANCE

DATE: 5/22/2018

Strategic Risk Solutions (Cayman) Ltd.
Governors Square 2 Floor Building 3
23 Lime Tree Bay Ave.
P.O. Box 1159
Grand Cayman KY1-1102
Cayman Islands

This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.

INSURED

Boston Medical Center
One Boston Medical Center Place
Boston, MA 02118

COMPANY AFFORDING COVERAGE

A **BOSTON MEDICAL CENTER INSURANCE COMPANY, LTD.**

COVERAGES

This is to certify that the Policies listed below have been issued to the Named Insured 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.

TYPE OF INSURANCE	CO. LTR.	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY	A	BMCIC-PR-A-18	06/30/2018	06/30/2019	EACH OCCURENCE	$2,000,000
					AGGREGATE	$2,000,000
COMMERCIAL GENERAL LIABILITY					PERSONAL & ADV INJURY	$
					EACH OCCURRENCE	$
CLAIMS MADE					FIRE DAMAGE	$
OCCURRENCE					MEDICAL EXPENSES	$
PROFESSIONAL LIABILITY	A				EACH OCCURENCE	$
					AGGREGATE	$
EXCESS/UMBRELLA LIABILITY	A				EACH OCCURENCE	$
					AGGREGATE	$

DESCRIPTION OF OPERATIONS/LOCATIONS/VECHICLES/SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)

Evidencing coverage is in effect

CERTIFICATE HOLDER

State of New Hampshire, Department of
Health and Human Services
129 Pleasant Street
Concord NH 03301

CANCELLATION

Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.

AUTHORIZED REPRESENTATIVES

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 5/22/2018

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 have ADDITIONAL INSURED provisions or 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 Marsh & McLennan Agency LLC - New England 100 Front St, Ste 800 Worcester MA 01608	CONTACT NAME: PHONE (A/C, No, Ext): 888-850-9400 FAX (A/C, No): 866-795-8016 E-MAIL ADDRESS: MMA.NewEngland.CLines@marshmc.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Hartford Fire Insurance Company — 19682
INSURED BOSTOMEDIC1 Boston Medical Center Health Plan Two Copley Place, Suite 600 Boston MA 02116	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 1712868879 **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	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			08WEEH9897	5/30/2018	5/30/2019	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

CERTIFICATE HOLDER	CANCELLATION
Dept of Health & Human Services, Attn: Commissioner of DHHS, State of New Hampshire 129 Pleasant St Concord NH 03301	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

6A mac

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

JEFFREY A. MEYERS
COMMISSIONER

May 29, 2018

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to enter into **Sole Source Contracts through** amending the expiring existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116. The contract for SFY 2019 synchronizes the existing Medicaid Care Management (MCM) Program re-procurement as legislatively required and adjusts for the delay in the initial MCM program start-up. It is impractical to contract with new Managed Care Organizations (MCOs) for a one year period given the lead time to procure and establish new MCOs. Also, with the planned transition under SB313 to the Granite Advantage Health Care Program from the New Hampshire Health Protection Program, aside from a problematic procurement, it would require up to three transitions in a six month period for beneficiaries.

The adjusted actuarially certified rate structure under the **Sole Source Contracts** is $655,426,236.40, **prospectively.** The SFY capitation rate for SFY 19 increases by 3.72%, which approximates with experience over the preceding years of the MCM program, and is lower than the national trend of 4.9% under the President's Medicaid budget projections. The pre-existing aggregate average administrative cost allowance of 8% remains in place as does the operating margin allowance of up to 1.5%. Effective upon a Governor and Executive Council approval, the combined aggregate total is $3,557,921,400.41 all Medicaid Care Management program contracts.

Governor and Executive Council approved the original agreements on May 9, 2012, Item #54A, and approved subsequent amendments on June 19, 2013, Item #67A; February 12, 2014, Item #25; April 9, 2014, Item #44; June 18, 2014, Item #65A; July 16, 2014, Late Item "A"; December 23, 2014, Item #11; June 24, 2015, Item #30; August 5, 2015, Tabled Item 'A'; December 16, 2015, Late Item 'A3'; January 27, 2016, Item #7B; March 9, 2016, Item #10A; June 29, 2016. Late Item 'A2'; October 5, 2016, Item #12A; June 21, 2017, Tabled Item #18, and December 6, 2017, Item #7B.

Funds are 50% Federal and 50% General Funds for the currently eligible Medicaid population except for the NH Health Protection Program services funds are 94% Federal and 6% Other for Calendar Year 2018; and 93% Federal and 7% Other for Calendar Year 2019.

Funds to support this request are available in the following accounts in SFY 2019:

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000.00	$460,000,000.00	$490,897,701.00
NH Health Protection Program: 010-047-3099-102	$0	$0.00	$193,000,000.00	$218,624,347.94
TOTAL	$0	$250,000,000.00	$653,000,000.00	$709,522,048.94

Fund Name and Account Number	SFY17	SFY18 Amendment 15	SFY19 Amendment 15	SFY19 Amendment 16
Medicaid Care Mgmt: 010-047-79480000-101	$538,601,671.35	$539,100,917.00	$548,245,172.00	$581,336,172.00
NH Health Protection Program: 010-047-3099-102	$134,015,403.72	$78,255,123.00	$42,381,032.20	$74,090,064.40
TOTAL	$672,617,075.07	$617,356,040.00	$590,626,204.20	$655,426,236.40

Fund Name and Account Number	Total
Medicaid Care Mgmt: 010-047-79480000-101	$2,859,936,461.35
NH Health Protection Program: 010-047-3099-102	$697,984,939.06
TOTAL	$3,557,921,400.41

EXPLANATION

The purpose of these amendments is to change the actuarial certified rate structure as required annually under the Centers for Medicare and Medicaid (CMS) approvals for operating a managed care program under the two managed care health plan agreements. In addition to rate changes, other key contract changes follow in the next two paragraphs.

These rates reflect the adoption of a new covered service for the treatment of adolescents with substance use disorder at the Sununu Youth Center and instituting new Behavioral Health Crisis Treatment Center program adopted in the State budget.

Applied Behavioral Analysis (ABA) to help children with autism is transitioning from fee for service to the MCM program to better integrate services and manage the cost of care. The rates also reflect the provision for a one year fee schedule adjustment and directed payments, pending approval by CMS, to Community Mental Health Centers (CMHCs) for maintaining and enhancing the access, utilization, and delivery of services to individuals enrolled in the MCM program.

The Department is prospectively amending the existing individual agreements with the state's two managed care health plans to commence July 1, 2018 and to reflect an updated actuarially certified rate structure.

Exhibit B to the Agreement reflects the adjusted capitated rate information for SFY 2019. Tables 1 through 3 below show the average per member per month, percentage changes, and annualized dollar impact in the capitation rates for the program including Medically Frail and Transitional populations. These three tables illustrate that overall capitation payment structure.

Table 1
New Hampshire Department of Health and Human Services
Medicaid Care Management Program Capitation Rates
Summary of SFY 2019 Capitation Rate Change Components
Based on Projected SFY 2019 MCO Enrollment by Rate Cell

Rate Component	Rate Change	PMPM Impact	Annualized Dollar Impact
Rate Change Prior to Program Changes	2.65%	**$9.39**	$13,935,000
SFY 2019 Program Changes:			
Opioid Addiction Treatment Cost Trend Adjustment	1.69%	$5.98	$8,871,000
CMHC Temporary Fee Schedule Increase	1.07%	3.78	5,606,000
Inclusion of ABA Services	0.74%	2.61	3,874,000
Sununu Youth Center Services	0.17%	0.60	897,000
Implementation of Behavioral Health Crisis Treatment Center Services	0.04%	0.16	230,000
White Mountain Community Center FQHC Lookalike Status	0.03%	0.10	147,000
CMHC Workforce Expansion Directed Payment	-0.09%	(0.32)	(469,000)
Total Program Changes	**3.65%**	**$12.91**	**$19,156,000**
Total SFY 2018 - SFY 2019 Rate Change	**6.30%**	**$22.30**	**$33,091,000**

Table 2
New Hampshire Department of Health and Human Services
Medically Frail Population Capitation Rates
Summary of SFY 2019 Capitation Rate Change Components
Based on Projected SFY 2019 MCO Enrollment by Rate Cell

Rate Component	Rate Change	PMPM Impact	Annualized Dollar Impact
Rate Change Prior to Program Changes	-18.5%	($223.39)	($14,032,000)
SFY 2019 Program Changes:			
Opioid Addiction Treatment Cost Trend Adjustment	3.3%	39.25	2,459,000
CMHC Temporary Fee Schedule Increase	0.4%	5.31	333,000
Inclusion of ABA Services	0.00%	0.00	0
Sununu Youth Center Services	0.00%	0.00	0
Implementation of Behavioral Health Crisis Treatment Center Services	0.1%	0.70	44,000
White Mountain Community Center FQHC Lookalike Status	0.0%	0.07	4,000
CMHC Workforce Expansion Directed Payment	0.0%	(0.55)	(34,000)
Total Program Changes	3.7%	44.78	2,806,000
Total SFY 2018 - SFY 2019 Rate Change	-14.8%	($178.61)	($11,226,000)

Table 3
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
Summary of July 2018 – December 2018 Capitation Rate Change Components
Based on Projected July 2019 – December 2018 MCO Enrollment by Rate Cell

Rate Component	Rate Change	PMPM Impact	Annualized Dollar Impact
Rate Change Prior to Program Changes	9.8%	$42.20	$292,000
July 2018 – December 2018 program changes:			
Opioid Addiction Treatment Cost Trend Adjustment	8.4%	36.19	250,000
CMHC Temporary Fee Schedule Increase	0.4%	1.62	11,000
Inclusion of ABA Services	0.00%	0.00	0
Sununu Youth Center Services	0.00%	0.00	0
Implementation of Behavioral Health Crisis Treatment Center Services	0.0%	0.03	0
White Mountain Community Center	0.0%	0.08	1,000
CMHC Workforce Expansion Directed Payment	0.0%	(0.03)	0
Total Program Changes	8.8%	37.89	262,000
Total SFY 2018 to July 2018 – December 2018 rate change	18.7%	$80.09	$554,000

The SFY 2019 material rate adjustments account for the trend in fiscal years 2017 and 2018 in increased frequency in utilization and corresponding cost (related thereto) for opioid addiction of a projected $11.58 million, the addition of a separate kick payment for newborns diagnosed with neonatal abstinence syndrome to more fairly recognize the costs, and the implementation of Sununu Youth Center services for adolescents with substance use disorder. The rates also reflect reduced projected prescription drug costs (3.25%) to account for rebates collected by the MCOs, reduced rates (0.9%) reflective of the improved integration of behavioral and physical health services, and the implementation of the Behavioral Health Crisis Treatment Center program.

Also included is the temporary fee schedule increase of $6.0 million ($3.0 million General Funds) for Community Mental Health Center services, directed payments of $5 million to the Community Mental Health Centers as described previously, and ABA services which are a reallocation of funds already within the State budget.

Please note that only one copy of Exhibit A and Exhibit B are attached as the Exhibits are voluminous and identical for both vendors.

Area Served: Statewide.

Source of funds: Federal financial participation rates for the currently eligible population will be 50% Federal Funds as appropriated by Congress for the entire period of this amendment, and 50% General Funds. Federal financial participation rates for the New Hampshire Health Protection Program services are 94% Federal Funds and 6% Other Funds in Calendar Year 2018, and 93% Federal Funds and 7% Other Funds in Calendar Year 2019, as appropriated by Congress.

In the event that Federal funds become no longer available or are decreased below the 94% level for the New Hampshire Health Protection Program population in CY 2018 or CY 2019, consistent with RSA 126-A: 5-b, c General Funds will not be requested to support this program; and medical services for the new adult population would end consistent with RSA 126-A:5-b,c and the Special Terms and Conditions of the Premium Assistance Program Demonstration.

Respectfully submitted,

Henry D. Lipman, FACHE
Medicaid Director

Approved by:

Thomas D. Pristow, MSW, ACSW
Deputy Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

May 31, 2018

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a **sole source** contract amendment with the state's two managed care health plans, Granite State Health Plan d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan d/b/a Well Sense Health Plan, Schrafft's Business Center, 529 Main Street Charlestown, MA 02129 as described below and referenced as DoIT No. 2012-074P.

The purpose of this amendment is to change the actuarial certified rate structure as required annually under the Centers for Medicare and Medicaid approvals for operating a managed care program under the two managed care health plan agreements identified above.

This amendment will commence on July 1, 2018 for the 2019 State Fiscal Year. Effective upon Governor and Council Approval , the combined aggregate total is $3,557,921,400.41 for all Medicaid Care Management program contracts.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/ck
DoIT #2012-074P
cc: Bruce Smith, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #16 to the
Medicaid Care Management Contract

This 16th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment Sixteen") dated this 24th day of May, 2018, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Granite State Health Plan, Inc., (hereinafter referred to as "the Contractor"), a New Hampshire Corporation with a place of business at 2 Executive Park Drive, Bedford, NH 03110.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013, Item #, 67A, Amendment #2 February 12, 2014, Item #25, Amendment #3 April 9, 2014, Item #44, Amendment #4 June 18, 2014, Item #65A, Amendment #5 July 16, 2014, Late Item "A", Amendment #6 December 23, 2014, Item #11, Amendment #7 June 24, 2015, Item #30, Amendment #8 August 5, 2015, Tabled Item "A", Amendment #9 December 16, 2015, Late Item "A3", Amendment #10 January 27, 2016, Item #7B, Amendment #11 March 9, 2016, Item #10A, Amendment #12 June 29, 2016, Late Item "A2", Amendment #13 October 5, 2016, Item #12A, Amendment #14 June 21, 2017, Tabled Item #18, and Amendment #15 December 6, 2017, Item #7B, 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to modify the price limitation, modify the scope of services to support continued delivery of these services, and modify the capitation rates, 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 to amend as follows:

1. *Form P-37, General Provisions, Block 1.8 Price Limitation to increase the Price Limitation by* $64,800,032.20 from $3,493,121,368.21 to read: $3,557,921,400.41 for a cumulative contract value for all Medicaid Care Management contracts.

2. Delete Exhibit A Amendment #13 in its entirety and replace with Exhibit A Amendment #14.

3. Delete in its entirety Exhibit B Amendment #15 and replace with Exhibit B Amendment #16.

4. Delete in its entirety Exhibit O Amendment #8 NH Medicaid Care Management Quality and Oversight Reporting – 2018 and replace with Exhibit O Amendment #9 Medicaid Care Management Quality and Oversight Reporting – 2019.

5. Delete in its entirety Standard Exhibit I Health Insurance Portability and Accountability Act Business Associate Agreement version September 2009 and replace Exhibit I Health Insurance Portability Act Business Associate Agreement version March 2014.

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

5/29/2018
Date

Name: Henry Lipman
Title: Medicaid Director

Granite State Health Plan, Inc.

5-29-18
Date

Name: Jennifer Weigand
Title: CEO

Acknowledgement of Contractor's signature:

State of New Hampshire, County of Merrimack on 29 May 2018, before the undersigned officer, personally appeared the person identified directly 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.

Lisa Marie Malanga
Signature of Notary Public or Justice of the Peace

Lisa MARIE MALANGA
Name and Title of Notary or Justice of the Peace

LISA MARIE MALANGA, Notary Public
State of New Hampshire
My Commission Expires December 20, 2022

My Commission Expires: _____

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

OFFICE OF THE ATTORNEY GENERAL

5/30/18
Date

Name: Megan A. Yeh
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:

State of New Hampshire
Department of Health and Human Services
Amendment #16 to the
Medicaid Care Management Contract

This 16th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment Sixteen") dated this 24th day of May, 2018, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Boston Medical Center Health Plan, Inc., (hereinafter referred to as "the Contractor"), a Massachusetts nonprofit corporation with a place of business at Schraffts Business Center, 529 Main Street, Charlestown, MA, 02129.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013, Item #, 67A, Amendment #2 February 12, 2014, Item #25, Amendment #3 April 9, 2014, Item #44, Amendment #4 June 18, 2014, Item #65A, Amendment #5 July 16, 2014, Late Item "A", Amendment #6 December 23, 2014, Item #11, Amendment #7 June 24, 2015, Item #30, Amendment #8 August 5, 2015, Tabled Item "A", Amendment #9 December 16, 2015, Late Item "A3", Amendment #10 January 27, 2016, Item #7B, Amendment #11 March 9, 2016, Item #10A, Amendment #12 June 29, 2016, Late Item "A2", Amendment #13 October 5, 2016, Item #12A, Amendment #14 June 21, 2017, Tabled Item #18, and Amendment #16 December 6, 2017, Item #7B, 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to modify the price limitation, modify the scope of services to support continued delivery of these services, and modify the capitation rates, 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 to amend as follows:

1. Form P-37, General Provisions, Block 1.4 Contractor Address to read:

   Schraffts Business Center
   529 Main Street
   Charlestown MA 02129

2. Form P-37, General Provisions, Block 1.8 Price Limitation to increase the Price Limitation by $64,800,032.20 from $3,493,121,368.21 to read: $3,557,921,400.41 for a cumulative contract value for all Medicaid Care Management contracts.

3. Delete Exhibit A Amendment #13 in its entirety and replace with Exhibit A Amendment #14.

4. Delete in its entirety Exhibit B Amendment #15 and replace with Exhibit B Amendment #16.

5. Delete in its entirety Exhibit O Amendment #8 NH Medicaid Care Management Quality and Oversight Reporting – 2018 and replace with Exhibit O Amendment #9 Medicaid Care Management Quality and Oversight Reporting – 2019.

6. Delete in its entirety Standard Exhibit I Health Insurance Portability and Accountability Act Business Associate Agreement version September 2009 and replace Exhibit I Health Insurance Portability Act Business Associate Agreement version March 2014.

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

May 29, 2018
Date

Name: Henry Lipman
Title: Medicaid Director

Boston Medical Center Health Plan, Inc.

5/25/18
Date

Name:
Title:

Acknowledgement of Contractor's signature:

State of Mass, County of Suffolk on 5/25/18, before the undersigned officer, personally appeared the person identified directly 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

Margaret Melanson
Name and Title of Notary or Justice of the Peace

My Commission Expires: April 25, 2019

MARGARET MELANSON
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
April 25, 2019

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

OFFICE OF THE ATTORNEY GENERAL

5/30/18
Date

Name: Megan A. Yorke
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

Medicaid Care Management Contract
Exhibit A - Amendment 14

Table of Contents

1. Introduction

1.1. Purpose

1.1.1. The purpose of this Agreement is to set forth the terms and conditions for the MCO's participation in the NH Medicaid Care Management Program.

1.2. Type of Agreement

1.2.1. This is a comprehensive full risk prepaid capitated contract. The MCO is responsible for the timely provision of all medically necessary services as defined under this Agreement. In the event the MCO incurs costs that exceed the capitation payments, the State of New Hampshire and its agencies are not responsible for those costs and will not provide additional payments to cover such costs.

1.3. Agreement Period

1.3.1. The Department of Health and Human Services (DHHS) and the MCO agree to extend this Agreement by 12 months to June 30, 2019 at which point this Agreement is targeted to end.

2. Glossary of Terms and Acronyms

Abuse

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. 455.2]

Administrative Review Committee

Applies appropriate risk management principles to ensure due diligence and oversight to protect the patient, community and hospital in treating high risk or high profile patients.

Acquired Brain Disorder (HCBC-ABD) Waiver

"Acquired Brain Disorder (HCBC-ABD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of services and supports to individuals age 22 years and older with traumatic brain injuries or neurological disorders who are financially eligible for Medicaid and medically qualify for institutional level of care provided with a need for specialized nursing care or specialized rehabilitation services. Covered services are identified in He-M 522.

Adequate Network of Providers

A network sufficient in numbers, types and geographic location of providers, as defined in the Agreement, to ensure that covered persons will have access to health care services without unreasonable delay.

Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of New Hampshire, relating to the provision of health care when an individual is incapacitated (42 CFR 438.6, 438.10, 422.128, and 489.100).

Agreement

"Agreement" means the entire written Agreement between DHHS and the MCO, including any Exhibits, documents, and materials incorporated by reference.

Agreement Period

Dates indicated in the P-37 of this Agreement.

Agreement Year

NH State Fiscal Year.

Appeal

"Appeal" means a request for review of an action as described in this Agreement (42 CFR 438.400(b)).

Auxiliary aids

"Auxiliary aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of programs or activities conducted by the MCO. Such aids shall include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Behavioral Health Crisis Treatment Center

"Behavioral Health Crisis Treatment Center" (BHCTC) means a treatment service center that provides 24/7 intensive, short term stabilization treatment services for individuals experiencing a mental health crisis, including those with co-occurring substance use disorder. The BHCTC accepts individuals for treatment on a voluntary basis who walk-in, are transported by first responders, or as a stepdown treatment site post emergency department visit or inpatient psychiatric treatment site. The BHCTC delivers an array of services to de-escalate and stabilize individuals at the intensity and for the duration necessary to quickly and successfully discharge, via specific after care plans, the individual back into the community or to a step-down treatment site.

Care coordination

"Care coordination" is the deliberate organization of patient care activities between two or more participants (including the individual) involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial, and long term services and supports. Organizing care involves the marshalling of personnel and other resources needed to carry out all required services and supports, and requires the exchange of information among participants responsible for different aspects of care. (42 CFR 438.208).

Effective care coordination includes the following:

- Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Employs evidence-based clinical practices;
- Coordinates care across health care settings and providers, including tracking referrals;
- Actively assists patients to take personal responsibility for their health care;
- Provides education regarding avoidance of inappropriate emergency room use;

- Emphasizes the importance of participating in health promotion activities; Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- Uses appropriate community resources to support individual patients, families and caregivers in coordinating care.
- Adheres to conflict of interest guidelines set forth by the health plan and contractor (State of NH)
- Ensures the patient is aware of all appeal and grievance processes including how to request a different care coordinator.
- Facilitates ready and consistent access to long term supports and services that are, to the extent possible, integrated with all other aspects of the member's health care.

Centers for Medicare and Medicaid Services (CMS)

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare program.

Children's Health Insurance Program

"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009.

Children with Special Health Care Needs

Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Choices for Independence (HCBC-CFI) Waiver

"Choices for Independence (HCBC-CFI) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities. This term is also known as home and community based care for the elderly and chronically ill (HCBC-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and covered services are identified in He-E 801.

Chronic Condition

"Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence and includes, but is not limited to: a mental health condition; a substance use disorder; asthma; diabetes; heart disease; or obesity, as evidenced by a body mass index over twenty-five.

Cold Call Marketing

"Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential member or a member with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

Communications Plan

"Communications Plan" means a written strategy for timely notification to DHHS regarding expected or unexpected interruptions or changes that impact MCO policy, practice, operations, members or providers. The Communications Plan shall define the purpose of the communication, the paths of communication, the responsible MCO party required to communicate, and the time line and evaluation of effectiveness of MCO messaging to DHHS and to affected parties. The Communications Plan shall also provide for the MCO to communicate with DHHS and respond to correspondence received from DHHS within one (1) business day on emergent issues and five (5) business days on non-emergent issues.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under federal or state law. Confidential Information includes, but is not limited to, Personal Information.

Conflict Free Care Coordination

"Conflict Free Care Coordination" separates clinical or non-financial eligibility determination from direct service provision. Care Coordinators and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual, their paid caregivers or to anyone financially responsible for the individual; robust monitoring and oversight are in place to promote consumer-direction and beneficiaries are clearly informed about their right to appeal or submit a grievance decisions about plans of care, eligibility determination and service delivery. State level oversight is provided to measure the quality of care coordination services and to ensure meaningful stakeholder engagement. In circumstances when one entity is responsible for providing care coordination and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

Conflict Free Care Management

(see Care Coordination)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

"Consumer Assessment of Healthcare Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey used to measure member experience of health care.

Consumer Direction

"Consumer Direction", also known as participant direction or self-direction, means a service arrangement whereby the individual or representative, if applicable, directs the services and makes the decisions about how the funds available for the individual's services are to be spent. It includes assistance and resources available to individuals in order to maintain or improve their skills and experiences in living, working, socializing, and recreating.

Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through member transitions between: facilities and home; facilities; providers; service areas; managed care contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.

Contracted Services

"Contracted Services" means covered services that are to be provided by the MCO under the terms of this Agreement.

Covered Services

"Covered Services" means health care services as defined by DHHS and State and Federal regulation.

Debarment

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Developmental Disabilities (HCBC-DD) waiver

"Developmental Disabilities (HCBC-DD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports in non-institutional settings to individuals of any age with mental retardation and/or developmental disabilities who are financially eligible for Medicaid and medically qualify for institutional level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Division for Children, Youth & Families (DCYF) Services

"Division of Children, Youth & Families (DCYF) Services" means community based services and residential treatment services as indicated in Section 8.2 Covered Services Matrix as DCYF..

Early, Periodic Screening, Diagnostic and Treatment (EPSDT)

"EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of services in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r), 42 CFR 441.50, and DHHS EPSDT program policy and billing instructions. Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The MCO shall be responsible for all services found to be medically necessary services during the EPSDT exam.

Eligible Members

"Eligible Members" means individuals determined eligible by DHHS and eligible to enroll for health care services under the terms of this Agreement.

Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

Emergency Services

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

Equal Access

"Equal Access" means Steps 1 and 2, and NHHPP members having the same access to providers and services for those services common to both populations.

Execution Date

Date Agreement approved by Governor and Executive Council.

External Quality Review (EQR)

"External Quality Review (EQR" means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the MCO or its subcontractors furnish to members (42 CFR 438.320).

External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358.

Fraud

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 C.F.R. 455.2]

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights (42 CFR 438.400(b)).

Grievance Process

"Grievance Process" means the procedure for addressing member grievances (42 CFR 438.400(b)).

Grievance System

"Grievance System" means the overall system that includes grievances and appeals handled by the MCO and access to the State fair hearings (42 CFR 438, Subpart F).

Healthcare Effectiveness Data and Information Set (HEDIS)

"Healthcare Effectiveness Data and Information Set (HEDIS)" means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes a standardized survey of members' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

Health Home

"Health Home" means coordinated health care provided to members with special health care needs. At minimum, health home services include:

- Comprehensive care coordination including, but not limited to, chronic disease management;
- Self-management support for the member, including parents of caregivers or parents of children and youth;
- Care coordination and health promotion;

- Multiple ways for the member to communicate with the team, including electronically and by phone;
- Education of the member and his or her parent or caregiver on self-care, prevention, and health promotion, including the use of patient decision aids;
- Member and family support including authorized representatives;
- The use of information technology to link services, track tests, generate patient registries and provide clinical data;
- Linkages to community and social support services;
- Comprehensive transitional health care including follow-up from inpatient to other settings;
- A single care plan that includes all member's treatment and self-management goals and interventions ; and
- Ongoing performance reporting and quality improvement.

Home and Community Based Care (HCBC)

"Home and Community Based Care (HCBC)", also known as Home and Community Based Services (HCBS), means the waiver of sections 1902 (a) (10) and 1915 (c) of the Social Security Act which allows the federal Medicaid funding of long term services and supports in non-institutional settings for individuals who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility. This includes services provided under the Choices for Independence Waiver (HCBC-CFI) waiver program, Developmental Disabilities (HCBC-DD) waiver program, Acquired Brain Disorders (HCBC-ABD) waiver program, and In Home Supports (HCBC-IHS) waiver program.

Implementation Period

"Implementation Period" means each period of time prior to Program Start Date for the following segments: Step 1, NHHPP, SUD Phases 1, 2 and 3, and Step 2 Phase 1.

Implementation Plan

"Implementation Plan" means a proposed and agreed upon written and detailed listing of all objectives, tasks, activities, time allocation, deliverables, dependencies and responsible parties required to design, develop and implement the steps and phases of the Care Management Program. The Implementation Plan(s) shall include documentation of approvals as well as document change history.

In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver

"In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to families with children diagnosed with autism and other

developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization. Covered services are identified in He-M524.

Long Term Services and Supports (LTSS)

"Long Term Services and Supports (LTSS)" means nursing facility services, all four of New Hampshire's Home and Community Based Care Waivers, and services provided to children and families through the Division for Children, Youth & Families.

Managed Care Organization (MCO)

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible DHHS members under the DHHS Care Management Program.

Marketing

"Marketing" means any communication from the MCO to a potential member or member with another DHHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the MCO or to either not enroll or end enrollment with another DHHS contracted MCO (42 CFR 438.104(a)).

Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).

Medically Frail

"Medically frail" means a member who identifies as having a physical, mental, or emotional health condition that causes limitations in activities (e.g. bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Medically Necessary Services

"Medically Necessary Services" means services that are "medically necessary" as is defined in Section 23.2.2.

Member

"Member" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having an Agreement with DHHS (42 CFR 438.10(a)).

Member Handbook

"Member Handbook" means the handbook published by the Managed Care Organization (MCO) which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Member participation in Medicaid Managed Care and which means all informing requirements as set forth in 42 CFR 438.10.

Mental Health Court

A "Mental Health Court" is a specialized court docket for certain defendants with mental illnesses that substitutes a problem solving model for traditional criminal court processing.

National Committee for Quality Assurance (NCQA)

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

Necessary Services

"Necessary Services" means services to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term service and support.

New Hampshire Community Passport (NHCP) Program or Money Follows the Person (MFP) Demonstration

"Money Follows the Person (MFP)" means a federal demonstration that assists individuals residing in nursing institutions who meet CMS eligibility requirements find suitable healthcare programs to support them in the community and then assists them to transition from nursing institution care to community care. The program's intent is to help strengthen and improve community based systems of long term care for low-income seniors and individuals with disabilities. "New Hampshire Community Passport (NHCP) Program" means the MFP program specific to New Hampshire.

New Hampshire Health Protection Program (NHHPP)

Coverage provided through the MCOs for individuals newly eligible for Medicaid based the new income levels established in Senate Bill 413, Chapter 3, Laws of 2014; provided, however, that on and after January 1, 2016, coverage under this program shall be limited to said individuals who are Medically Frail and who choose to participate in the New Hampshire Health Protection Program and those MCO members who transition from an eligibility category other than the New Hampshire Health Protection Program who have not yet begun their coverage in the Premium Assistance Program.

New Member

"New Member" means a member transferring from FFS to an MCO, or transferring from another MCO.

Non-Participating Provider

"Non-Participating Provider" means a person, health care provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with

the MCO to participate in a managed care organization's provider network, but provides health care services to members.

Participating Provider

"Participating Provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice and licensure, and who is under a written contract with the MCO to provide services to members under the terms of this Agreement.

Payment Reform Plan

"Payment Reform Plan" means an MCO's plan to engage its provider network in health care delivery and payment reform activities such as pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements, and shall contain information on the anticipated impact on member health outcomes, providers affected.

Physician Group

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Provider Incentive Plan

"Provider Incentive Plan" means any compensation arrangement between the MCO and a provider or provider group that may directly or indirectly improve the delivery of healthcare services as directed by a provider under the terms of this Agreement.

Program Management Plan

"Program Management Plan" means a proposed and agreed upon written detailed plan that includes a framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program as provided for in the Agreement. Includes documentation of approvals as well as document change history.

Program Start Date

Each date when MCO is responsible for coverage of services to its members with respect to the steps and phases of the Medicaid Care Management program.

Post-stabilization Services

"Post-stabilization Services" means contracted services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition (42 CFR 438.114 and 422.113).

Primary Care Provider (PCP)

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for

specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Agreement.

Provider

"Provider " means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Referral Provider

"Referral Provider" means a provider, who is not the member's PCP, to whom a member is referred for covered services

Regulation

"Regulation" means any federal, state, or local regulation, rule, or ordinance.

Risk

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a provider incentive plan, as defined herein.

Special Needs

Special Needs include chronic physical, developmental, behavioral or emotional conditions or adverse social circumstances resulting in need for help with related services of a type or amount beyond that required by members generally. Members with Special Needs include both Children and Adults.

Start Date of the Program

Date initial member enrollment begins.

Start of Program

Date initial member enrollment begins.

State

"State" or "state" means the State of New Hampshire

Step 1

Services as indicated in Section 8.2 Covered Services Matrix as Step 1.

Step 2

Services as indicated in Section 8.1 Covered Populations Matrix and Section 8.2 Covered Services Matrix as Step 2.

Subcontract

"Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") which relates directly or indirectly to the performance of all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

Substance Use Disorder

"Substance Use Disorder" is marked by a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. The cluster of symptoms includes tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substance or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol, tobacco and/or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use; craving or strong desire to use. Specific diagnostic criteria are specified in "Substance-Related and Addictive Disorders", in the Diagnostic and Statistical Manual of Disorders, 5th Edition, American Psychiatric Association, 2013.

Willing Provider

"Willing Provider" is a provider credentialed according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's provider agreement, including rates, and policy manual.

2.1. Acronyms

Unless otherwise indicated acronyms used in this Agreement are as follows:

Acronym	Description
ABD	Acquired Brain Disorders Waiver
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ANB	Aid to the Needy Blind
ANSA	Adult Needs and Strengths
APTD	Aid to the Permanently and Totally Disabled
ASC	Accredited Standards Committee

Acronym	Description
ASL	American Sign Language
BCCP	Breast and Cervical Cancer Program
BMH	Bureau of Mental Health
CAD	Coronary Artery Disease
CANS	Child and Adolescent Needs and Strengths Assessment
CDC	Centers for Disease Control and Prevention
CFI	Choices for Independence Waiver
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CLA	Community Living Assessment
CLAS	Cultural and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
DCYF	Division of Children, Youth & Families
DD	Developmental Disabilities Waiver
DHHS	Department of Health and Human Services (New Hampshire)
DOB	Date of Birth
DME	Durable Medical Equipment
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospitals
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EST	Eastern Standard Time

Acronym	Description
ETL	Extract Transformation Load
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HC-CSD	Home Care for Children with Severe Disabilities
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ICF	Intermediate Care Facility
IHS	In Home Supports for Children with Developmental Disabilities Waiver
IME	Indirect Medical Education
LTSS	Long term services and supports
MCO	Managed Care Organization
MCIS	Managed Care Information System
MFP	Money Follows the Person Program
MIC	Medicaid Integrity Contractor
MEAD	Medicaid for Employed Adults with Disabilities
MMIS	Medicaid Management Information System
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NHCP	New Hampshire Community Passport Program
NF	Nursing Facility
NHHPP	New Hampshire Health Protection Program
NHID	New Hampshire Insurance Department
NPI	National Provider Identifier
OAA	Old Age Assistance
OBRA	Omnibus Budget Reconciliation Act

Acronym	Description
PBM	Pharmacy Benefit Management
PCP	Primary Care Provider
PE	Presumptive Eligibility
PIN	Personal Identification Number
POA	Present on Admission
QAPI	Quality Assessment and Performance Improvement
QIP	Quality Incentive Program
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
RAC	Recovery Audit Contractors
RBC	Risk-Based Capital
RFP	Request for Proposal
RHC	Rural Health Center
RIMP	Risk Identification Mitigation Plan
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse and Mental Health Services Administration
SLMB	Special Low-Income Medicare Beneficiaries
SLRC	ServiceLink Resource Center network under the New Hampshire Aging and Disability Resource Center model
SNF	Skilled Nursing Facility
SSA	Social Security Act
SSI	Supplemental Security Income
SSAE	Statement on Standards for Attestation Engagements
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TQM	Total Quality Management

Acronym	Description
USC	United States Code
VA	Veteran's Administration

3. General Terms and Conditions

3.1. Agreement Elements

The Agreement between the parties shall consist of the following:

3.1.1. P-37 Agreement General Provisions.

3.1.2. 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 MCO.

3.1.3. Exhibit B – Capitation Rates.

3.1.4. Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS that must be adhered to in addition to those outlined in the P-37.

3.1.5. Exhibit D – Certification Regarding Drug Free Workplace Requirements – MCO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988.

3.1.6. Exhibit E – Certification Regarding Lobbying – MCO's Agreement to comply with specified lobbying restrictions.

3.1.7. 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.

3.1.8. Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – MCO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act.

3.1.9. Exhibit H – Certification Regarding Environmental Tobacco Smoke – MCO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities.

3.1.10. Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the MCO in reference to the Health Insurance Portability and Accountability Act.

3.1.11. Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.

3.1.12. Exhibit K – MCO's Program Management Plan approved by DHHS in accordance with Section 7.4 of this Agreement.

3.1.13. Exhibit L – MCO's Implementation Plan approved by DHHS in accordance with Sections 7.6-7.8 of this Agreement.

3.1.14. Exhibit M – MCO's RFP (#12-DHHS-CM-01) Technical Proposal, including any addenda, submitted by the MCO.

3.1.15. Exhibit N – Encounter Data.

3.1.16. Exhibit O –Quality and Oversight Reporting.

3.1.17. Exhibit P – Substance Use Disorder (SUD) Services.

3.2. Order of Documents.

In the event of any conflict or contradiction between or among the Agreement documents, the documents shall control in the above order of precedence.

3.3. 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 unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS and NHID.

3.4. Authority of the New Hampshire Insurance Department

Wherever, by any provision of this Agreement or by the laws and rules of the State of New Hampshire the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a Managed Care Organization in the State of New Hampshire.

3.5. Errors & Omissions

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

3.6. Time of the Essence

In consideration of the need to ensure uninterrupted and continuous Medicaid Managed Care services, time is of the essence in the performance of the Scope of Work under the Agreement.

3.7. CMS Approval of Agreement & Any Amendments

This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to the prior approval of the Centers for Medicare and Medicaid Services ("CMS."). Notwithstanding any other provision of this Agreement, DHHS agrees that enrollment for any step or phase will not commence until DHHS has received required CMS approval.

3.8. Cooperation with Other Vendors and Prospective Vendors

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. The MCO 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.

3.9. Renegotiation and Reprocurement Rights

3.9.1. Renegotiation of Agreement Terms

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

3.9.2. Reprocurement of the Services or Procurement of Additional Services

3.9.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO'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 MCO under the Agreement. DHHS shall give the MCO ninety (90) calendar days notice of intent to replace another MCO participating in the Medicaid Managed Care program or to add an additional MCO to the Medicaid Managed Care program.

3.9.3. Termination Rights Upon Reprocurement.

3.9.3.1. 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, the MCO shall have the rights and responsibilities set forth in Section 32 ("Termination"), Section 33 ("Agreement Closeout") and Section 35 ("Dispute Resolution Process").

4. Organization

4.1. Organization Requirements

4.1.1. Registrations and Licenses

The MCO shall be licensed by the New Hampshire Department of Insurance to operate as an Managed Care Organization in the State as required by New Hampshire RSA 420-B, and shall have all necessary registrations and licensures as required by the New Hampshire Insurance Department and any relevant federal and state laws and regulations. An MCO must be in compliance with the requirements of this section in order to participate in any Steps and Phases of the Medicaid Care Management program.

4.2. Articles & Bylaws

4.2.1. The MCO shall provide by the beginning of each Agreement year or at the time of any substantive changes written assurance from MCO's legal counsel that the MCO 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.

4.3. Relationships

4.3.1. Ownership and Control

4.3.1.1. The MCO shall notify DHHS of any person or corporation that has five percent (5%) or more ownership or controlling interest in the MCO, parent organization, subcontractors, and/or affiliates and shall provide

a. financial statements;

b. Date of Birth in the case of an individual;

c. Social Security numbers in the case of an individual; and

d. In the case of corporations primary business address, every business location, P.O. Box address, and tax identification number 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]. The MCO shall certify by its Chief Executive Officer that this information provided to DHHS is accurate to the best of the officer's information, knowledge, and belief [42 CFR 438.606].

4.3.1.2. The MCO shall inform DHHS and the New Hampshire Insurance Department (NHID) of its intent for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of the action.

4.3.1.3. The MCO shall inform key DHHS and NHID staff by phone and by email within one business day of when any key MCO staff learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement with DHHS.

4.3.2. Prohibited

4.3.2.1. The MCO shall not knowingly have a relationship with the following:

4.3.2.1.1. 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

4.3.2.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 4.3.2.1.

4.3.2.1.3. An individual is described as follows:

a. A director, officer, or partner of the MCO;

b. A subcontractor of the MCO;

c. A person with beneficial ownership of five percent (5%) or more of the MCO's equity; or

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

4.3.3. The MCO shall retain any data, information, and documentation regarding the above described relationships for a period no less than 10 years [42 CFR 438.3(u)].

4.3.4. The MCO shall conduct background checks on all employees actively engaged in the Care Management Program. 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.

4.3.5. The MCO shall not and shall certify it does not employ or contract, directly or indirectly, with:

4.3.5.1. 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;

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

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

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

4.3.5.5. 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.

5. Subcontractors

5.1. MCO Obligations

5.1.1. The MCO remains fully responsible for the obligations, services and functions performed by its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by MCO employees, and for the purposes of this Agreement such work will be deemed performed by the MCO. DHHS reserves 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 or use of a subcontractor.

5.1.2. The MCO shall provide written policies for all employees and subcontractors describing in detail the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the SSA including information about rights of employees to be protected as whistleblowers.

5.1.3. The MCO regardless of its written agreements with any subcontractors maintains ultimate responsibility for complying with this Agreement.

5.1.4. The MCO shall inform all subcontractors at the time of entering into an agreement with the MCO about the grievance and appeal system as described in 42 CFR 438.10(g).

5.1.5. The MCO shall have a written agreement between the MCO and each subcontractor in which the subcontractor:

5.1.5.1.Agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and MCO contract provisions;

5.1.5.2.Agrees to hold harmless DHHS and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO;

5.1.5.3.Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors;[

5.1.5.4. Agrees that the State, CMS, the HHS Inspector General, or their designees shall have the right to audit, evaluate, and inspect any premises,

physical facilities, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO Managed Care activities;

5.1.5.5. Agrees that it can be audited for ten years from the final date of the contract period or from the date of any completed audit, whichever is later; and

5.1.5.6. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk [42 CFR 438.230].

5.1.4. The MCO shall notify DHHS in writing within 10 business days if a subcontractor is cited for corrective action by any federal or state regulatory authority.

5.2. Notice and Approval

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

5.2.2. The MCO 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.

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

5.2.4. DHHS may grant a written exception to the notice requirements of 5.2.1 and 5.2.2 if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period or deems that the subcontractor is not a material subcontractor.

5.2.5. The MCO shall notify DHHS within twenty four (24) hours after receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

5.2.6. The MCO shall notify DHHS of any material breach of an agreement between the MCO and the subcontractor within twenty four (24) hours of validation that such breach has occurred.

5.3. MCO's Oversight

5.3.1. The MCO shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor in accordance with 42 CFR 438.230 and SMM 2087.4, including:

5.3.1.1. The MCO shall have a written agreement between the MCO and the subcontractor that specifies the activities and responsibilities delegated to the subcontractor and its transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate as determined by the MCO or NH DHHS. In such written agreement, the subcontractor shall also agree to perform the delegated activity and related reporting responsibilities as specified in the subcontractor agreement and the applicable responsibilities in this Agreement.

5.3.1.2. All subcontracts related to any aspect of the MCO Managed Care activities shall fulfill the applicable requirements of 42 CFR Part 438 for those responsibilities delegated to the subcontractor.

5.3.1.3. The MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

5.3.1.4. The MCO shall monitor the subcontractor's performance on an ongoing basis consistent with industry standards and State and Federal laws and regulations.

5.3.1.5. The MCO shall audit the subcontractor's care systems at least annually and when there is a substantial change in the scope or terms of the subcontract agreement.

5.3.1.6. The MCO shall identify deficiencies or areas for improvement, if any, with respect to which the MCO and the subcontractor shall take corrective action.

5.3.1.7. The MCO shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the Agreement between the MCO and DHHS.

5.3.1.8. If the MCO identifies deficiencies or areas for improvement are identified, the MCO shall notify DHHS and take corrective action within seven (7) calendar days of identification. The MCO shall provide DHHS with a copy of the Corrective Action Plan, which is subject to DHHS approval.

5.4. Transition Plan

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

6. Staffing

6.1. Key Personnel

6.1.1. The MCO shall commit key personnel to the New Hampshire Care Management program on a full-time basis. Positions considered to be key personnel are listed below, along with any specific requirements for each position:

6.1.1.1. Executive Director: Individual has clear authority over the general administration and day-to-day business activities of this Agreement.

6.1.1.2. Finance Officer: Individual is responsible for accounting and finance operations, including all audit activities.

6.1.1.3. Medical Director: Physician licensed by the NH Board of Medicine shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health). The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

6.1.1.4. The MCO will also have a physician available to the New Hampshire Care Management program with experience in the diagnosis and treatment of SUD.

6.1.1.5. Quality Improvement Director: Individual is responsible for all Quality Assessment and Performance Improvement (QAPI) program activities. This person shall be a licensed clinician with relevant experience in quality management for physical and/or behavioral healthcare.

6.1.1.6. Coordinators for the following five (5) functional areas shall be responsible for overseeing care coordination activities for MCO members with complex medical, behavioral health, developmental disability and long term care needs. They shall also serve as liaisons to DHHS staff for their respective functional areas:

6.1.1.6.1. Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

6.1.1.6.2. Behavioral Health Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within community mental health services.

6.1.1.6.3. Developmental Disabilities Coordinator: The individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

6.1.1.6.4. Substance Use Disorder Coordinator: The individual will have a minimum of a Master's Degree in a SUD related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to substance use disorders.

6.1.1.6.5. Long Term Services and Supports Coordinator: The individual will have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a LTSS related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care.

6.1.1.7. Network Management Director: Individual is responsible for development and maintenance of the MCO's provider network.

6.1.1.8. Member Services Manager: Individual is responsible for provision of all MCO member-services activities. The manager shall have prior experience with Medicaid or Medicare populations.

6.1.1.9. Utilization Management (UM) Director: Individual is responsible for all UM activities. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services and Necessary Services.

6.1.1.10. Systems Director/Manager: Individual is responsible for all MCO information systems supporting this Agreement including, but not limited to, continuity and integrity of operations, continuity flow of records with DHHS' information systems and providing necessary and timely reports to DHHS.

6.1.1.11. Claims/Encounter Manager: Individual is responsible for and is qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

6.1.1.12. Grievance Coordinator: Individual is responsible for overseeing the MCO's Grievance System.

6.1.1.13. Fraud, Waste, and Abuse Coordinator: Individual is responsible for tracking, reviewing, monitoring, and reducing fraud, waste, and abuse.

6.1.1.14. Compliance Officer: Individual is responsible for MCO's compliance with the provisions of this Agreement and all applicable state and federal regulations and statutes.

6.1.2. The MCO shall have an on-site presence in New Hampshire. The following key personnel shall be located in New Hampshire:

6.1.2.1. Executive Director

6.1.2.2. Medical Director

6.1.2.3. Quality Improvement Director

6.1.2.4. Special Needs Coordinator

6.1.2.5. Behavioral Health Coordinator

6.1.2.6. Developmental Disabilities Coordinator

6.1.2.7. Long Term Services and Supports Coordinator

6.1.2.8. Network Management Director

6.1.2.9. Fraud, Waste, and Abuse Coordinator

6.1.2.10. Grievance Coordinator

6.1.2.11. Substance Use Disorder Coordinator

6.1.2.12. Claim Encounter Manager

6.1.2.13. Provider Relations Manager

6.1.3. The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) days prior to start of program.

6.1.4. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.

6.1.5. DHHS may grant a written exception to the notice requirements of this Section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

6.2. General Staffing Provisions

6.2.1. The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 34.

6.2.2. The MCO shall ensure that all staff have appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

6.2.3. All key staff shall be available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

6.2.4. The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in New Hampshire with DHHS.

6.2.5. The MCO shall notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

6.2.6. If a member of the MCO's key staff is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit proposed alternate staff to DHHS for review and approval, which approval shall not be unreasonably withheld.

6.3. Staffing Contingency Plan

6.3.1. The MCO shall, deliver to DHHS a Staffing Contingency Plan within thirty (30) calendar days of signing this Agreement and after any substantive changes to the Staffing Contingency Plan. The Plan shall include but is not limited to:

6.3.1.1. The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the Agreement;

6.3.1.2. Allocation of additional resources to the Agreement in the event of inability to meet any performance standard;

6.3.1.3. Replacement of key personnel with staff with similar qualifications and experience;

6.3.1.4. Discussion of time frames necessary for obtaining replacements;

6.3.1.5. MCO's capabilities to provide, in a timely manner, replacements/additions with comparable experience; and

6.3.1.6. The method of bringing replacements/additions up-to-date regarding this Agreement.

7. Program Management and Planning

7.1. General

7.1.1. The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to members enrolled in the New Hampshire Medicaid Program and provide for all aspects of managing such program, including claims processing and operational reports. The MCO shall establish and demonstrate audit trails for all claims processing and financial reporting carried out by the MCO's staff, system, or designated agents.

7.2. Representation and Warranties

7.2.1. The MCO warrants that all Managed Care 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.

7.2.2. The MCO acknowledges that in entering this Agreement, DHHS has relied upon representations made by the MCO in its RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda, with respect to delivery of Managed Care. In reviewing and approving the program management and planning requirements of this Section, DHHS reserves the right to require the MCO to develop plans that are substantially and materially consistent with the representations made in the MCO's RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda.

7.3. Audit Requirements

7.3.1. No later than forty (40) business days after the end of the State Fiscal Year each June 30, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period. DHHS will share the report with internal and external auditors of the State of New Hampshire and federal oversight agencies. The SSAE 16 Type 2 report shall include:

7.3.1.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period.

7.3.1.2. Written assertion by the MCO's management about whether:

7.3.1.2.1. The aforementioned description fairly presents the system in all material respects;

7.3.1.2.2. The controls were suitably designed to achieve the control objectives stated in that description; and

7.3.1.2.3. The controls operated effectively throughout the specified period to achieve those control objectives.

7.3.1.3. Report of the MCO's auditor, which:

7.3.1.3.1. Expresses an opinion on the matters covered in management's written assertion; and

7.3.1.3.2. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

7.3.2. The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO. If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

7.3.3. The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

7.3.4. DHHS, CMS, the Office of the Inspector General, the Comptroller General, and their designees have the right to inspect and audit any records of the MCO, or its subcontractors and conduct on-site reviews of the MCO's operations at the MCO's expense. These on-site visits may be unannounced. The MCO shall fully cooperate with DHHS' on-site reviews. This right exists for ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

7.3.5. DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing Corrective Action Plans and review MCO compliance with requirements and standards as specified in this Agreement.

7.3.6. The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.

7.4. Program Management and Communications Plans

7.4.1. The MCO shall submit a Program Management Plan (PMP) to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Annually, thereafter, the MCO shall submit an updated PMP to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.4.1.1. The PMP shall elaborate on the general concepts outlined in the MCO's proposal and the section headings of Exhibit A;

7.4.1.2. The PMP shall describe how the MCO will operate in New Hampshire by outlining management processes such as communications, workflow, overall systems as detailed in the section headings of Exhibit A, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to member and provider experiences; and

7.4.1.3. The PMP shall outline the MCO integrated organizational structure including New Hampshire-based resources and its support from corporate, subcontractors, and workgroups or committees.

7.4.1.4. The MCO shall submit a Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the scheduled start date of the program. Thereafter, the MCO shall submit an updated Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5. Emergency Response Plan

7.5.1. The MCO shall submit an Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Thereafter, the MCO shall submit an updated Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5.2. The plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

7.5.2.1. Employee training;

7.5.2.2. Essential business functions and key employees within the organization necessary to carry them out;

7.5.2.3. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; and

7.5.2.4. Communication with staff, members, providers, subcontractors and suppliers when normal systems are unavailable;

7.5.2.5. Plans to ensure continuity of services to providers and members;

7.5.2.6. How the MCO will coordinate with and support DHHS and the other MCOs; and

7.5.2.7. How the plan will be tested, updated and maintained.

7.6. Step 1 Program Implementation Plan

7.6.1. Submission and Contents of the Plan

7.6.1.1. The MCO shall submit a "Step 1 Program Implementation Plan" (Step 1 Implementation Plan) to DHHS for review and approval no later than fourteen (14) calendar days after the signing of this Agreement. The Step 1 Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for implementation of the Plan:

7.6.1.1.1. Provider credentialing/contracting;

7.6.1.1.2. Provider payments;

7.6.1.1.3. Member Services;

7.6.1.1.4. Member Enrollment;

7.6.1.1.5. Pharmacy Management;

7.6.1.1.6. Care Coordination;

7.6.1.1.7. Utilization Management;

7.6.1.1.8. Grievance System;

7.6.1.1.9. Fraud, Waste, and Abuse;

7.6.1.1.10. Third-Party Liability;

7.6.1.1.11. MCIS ;

7.6.1.1.12. Financial management; and

7.6.1.1.13. Provider and member communications.

7.6.1.2. The Step 1 Program Implementation Plan shall become an addendum to this Agreement as Exhibit L.

7.6.2. Implementation

7.6.2.1. Upon approval of the Step 1 Implementation Plan, the MCO shall implement the Plan as approved covering the Step 1 populations and services identified in Sections 8.1 and 8.2 of this Agreement.

7.6.2.2. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.6.2.3. The MCO must obtain prior written approval from DHHS for any changes or deviations from the submitted and approved Plan.

7.6.2.4. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.6.2.4.1. Progress on Step 1 Implementation Plan;

7.6.2.4.2. Risks/Issues and mitigation strategy;

7.6.2.4.3. Modifications to the Step 1 Implementation Plan;

7.6.2.4.4. Progress on any Corrective Action Plans;

7.6.2.4.5. Program delays; and

7.6.2.4.6. Upcoming activities.

7.6.2.5. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.6.3. Readiness Reviews

7.6.3.1. DHHS intends to conduct two (2) readiness reviews of the MCO during the implementation phase prior to the Program Start Date. The first review shall take place thirty (30) days after contract effective date or scheduled after DHHS has verified that at least two MCOs have satisfied the DHHS Substantial Provider Network reporting requirements, whichever comes later, and will take place ninety(90) calendar days prior to the Program Start Date. The second review shall take place thirty (30) calendar days prior to the Program Start Date. The MCO shall fully cooperate with DHHS during these readiness reviews. During the readiness reviews, DHHS shall assess the MCO's progress towards a successful program implementation through regular reporting activities. The review shall include validation of readiness in multiple areas, including but not limited to:

7.6.3.1.1. MCO's ability to pay a claim;

7.6.3.1.2. MCO's network adequacy;

7.6.3.1.3. MCO's member transition plan;

7.6.3.1.4. MCO's system preparedness;

7.6.3.1.5. MCO's member experience procedures;

7.6.3.1.6. Grievance System; and

7.6.3.1.7. MCO subcontracts.

7.6.3.2. DHHS may adjust the timing, number and requirements of Readiness Reviews at its sole discretion.

7.6.3.3. Should the MCO fail to pass either readiness review, the MCO shall submit a Corrective Action Plan to DHHS sufficient to ensure the MCO passes the readiness review and shall complete implementation on schedule. This Corrective Action Plan shall be integrated into the overall program Step 1 Implementation Plan as a modification subject to review and approval by DHHS. DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified and/or apply liquidated damages as provided in Section 34.

7.6.3.4. During the first one hundred and eighty (180) days following the effective date of this Agreement or within ninety (90) days prior to the Program Start Date, whichever comes later, DHHS may give tentative approval of the MCO's required policies and procedures.

7.6.3.5. DHHS may at its discretion suspend application of the remedies specified in Section 34, except for those required under 42 CFR 700 and Section 1903(m) or Section 1932 of the Social Security Act, provided that the MCO is in compliance with any Corrective Action Plans developed during the readiness period, unless the MCO fails to meet the start date of the NH Medicaid Care Management program.

7.6.3.6. The start date of the Medicaid Care Management program shall be when at least two MCOs have met the readiness requirements 7.6.3.1.

7.7. Step 2 Program Implementation Plans

7.7.1. Implementation of Step 2 will take place as follows:

7.7.1.1. Phase 1. Mandatory Enrollment populations indicated in Section 8.1 – Program Start Date February 1, 2016.

7.8. NHHPP Program Implementation Plan

7.8.1. Submission and Contents of the NHHPP Implementation Plan

7.8.1.1. The MCO shall submit a NHHPP Implementation Plan to DHHS for review and approval no later than fourteen days (14) calendar days after signing the related contract amendment. The Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for the implementation of the Plans:

7.8.1.1.1. Provider credentialing/contracting for SUD and chiropractic providers;

7.8.1.1.2. Provider agreements and or amendments for services provided to NHHPP members;

7.8.1.1.3. Paying NHHPP providers according to the methodology prescribed by DHHS Section 21.2.10.4;

7.8.1.1.4. Sufficient provider capacity to serve NHHPP population without compromising access for Step 1 members;

7.8.1.1.5. Production of new Member handbooks or updates to reflect the differences for the NHHPP plan members;

7.8.1.1.6. Implementation of a process by which to reduce inappropriate emergency room utilization;

7.8.1.1.7. Implementation of new member co-payments and cost sharing as required in Medicaid Care Management; and

7.8.1.1.8. Call center training for NHHPP related inquiries.

7.8.2. NHHPP Implementation

7.8.2.1. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.8.2.2. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.8.2.2.1. Progress on NHHPP Implementation Plan;

7.8.2.2.2. Risks/Issues and mitigation strategy;

7.8.2.2.3. Modifications to the NHHPP Implementation Plan;

7.8.2.2.4. Progress on any Corrective Action Plans;

7.8.2.2.5. Program delays; and

7.8.2.2.6. Upcoming activities.

7.8.2.3. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.8.3. NHHPP Readiness Review

7.8.3.1. DHHS intends to conduct one (1) readiness review no sooner than thirty (30) days prior to the enrollment of NHHPP members. The MCO shall fully cooperate with DHHS during this review.

8. Covered Populations and Services

8.1. Covered Populations Matrix

The MCO shall provide managed care services to population groups deemed by DHHS to be eligible for managed care. The planned phase-in of population groups is depicted in the matrix below.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[1]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Beckett) - With Member Opt Out	X			
HC-CSD (Katie Beckett) - Mandatory Enrollment		X		
Children with special health care needs (enrolled in Special Medical Services / Partners in Health) - Mandatory Enrollment		X		
Children with Supplemental Security Income (SSI) - Mandatory Enrollment		X		
M-CHIP	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			

[1] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
Pregnant Women	X			
Native Americans and Native Alaskans w/ member opt out[2]	X			
Native Americans and Native Alaskans - Mandatory Enrollment (w/CMS waiver)		X		
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
Members with VA Benefits				X
NHHPP Enrollees			X	
Medically Frail			X	
Family Planning Only Benefit				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X
Health Insurance Premium Payment Program (HIPP)				X

8.2. Covered Services Matrix Overview

The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with CMS-approved Medicaid State Plan, to its members, reflecting the planned phase-in.

[2] Per 42 USC §1396u-2(a)(2)(c); however, NH has no recognized tribes.

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Maternity & Newborn Kick Payments	x	x	x	
Inpatient Hospital	x	x	x	
Outpatient Hospital[3]	x	x	x	
Inpatient Psychiatric Facility Services Under Age 21[4]	x	x	x	
Physicians Services	x	x	x	
Advanced Practice Registered Nurse	x	x	x	
Rural Health Clinic & FQHC	x	x	x	
Prescribed Drugs[5]	x	x	x	
Community Mental Health Services	x	x	x	
Psychology	x	x	x	
Ambulatory Surgical Center	x	x	x	
Laboratory (Pathology)	x	x	x	
X-Ray Services	x	x	x	
Family Planning Services	x	x	x	
Medical Services Clinic (mostly methadone clinic)	x	x	x	
Physical Therapy[6]	x	x	x	
Occupational Therapy[7]	x	x	x	

[3] Including facility and ancillary services for dental procedures

[4] Under age 22 if individual admitted prior to age 21

[5] Except as indicated in Section 14.1.15

[6] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Speech Therapy[8]	X	X	X	
Audiology Services	X	X	X	
Podiatrist Services	X	X	X	
Home Health Services	X	X	X	
EPSDT Services[9]	X	X	X	
Private Duty Nursing	X	EPSDT only	X	
Adult Medical Day Care	X	EPSDT only	X	
Personal Care Services	X	EPSDT only	X	
Hospice	X	X	X	
Optometric Services Eyeglasses	X	X	X	
Furnished Medical Supplies & Durable Medical Equipment	X	X	X	
Non-Emergent Medical Transportation [10]	X	X	X	
Ambulance Service	X	X	X	
Wheelchair Van	X	X	X	
Independent Care Management	X	EPSDT only	X	

[7] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[8] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[9] EPSDT includes Applied Behavioral Analysis Services.

[10] Also includes mileage reimbursement for medically necessary travel

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
Home Visiting Services	x	x[11]		
Acquired Brain Disorder Waiver Services				
Developmentally Disabled Waiver Services				
Choices for Independence Waiver Services				
In Home Supports Waiver Services				
Skilled Nursing Facility				
Skilled Nursing Facility Atypical Care				
Inpatient Hospital Swing Beds, SNF				
Intermediate Care Facility Nursing Home				
Intermediate Care Facility Atypical Care				
Inpatient Hospital Swing Beds, ICF				
Glencliff Home				
Developmental Services Early Supports and Services				
Home Based Therapy – DCYF				
Child Health Support Service – DCYF				
Intensive Home and Community Services – DCYF				
Placement Services – DCYF				
Private Non-Medical Institutional For Children – DCYF				
Crisis Intervention – DCYF				
Substance use disorder services as per He-W	x	x	x	

[11] Provided within the SUD benefit

Services	Step 1	NH HPP	Step 2 Phase 1	Excl./ FFS
513				
Chiropractic services (NHHPP population only)		x		
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)[12]				
Medicaid to Schools Services				x
Dental Benefit Services[13]				x
Behavioral Health Crisis Treatment Center	x	x	x	
Services provided in an IMD pursuant to an approved waiver[14]	x	x	x	

8.3. Covered Services Additional Provisions

8.3.1. While the MCO may provide a higher level of service and cover additional services than required by DHHS, the MCO shall, at a minimum, cover the services identified at least up to the limits described in N.H. Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by informing the MCO [42 CFR 438.210(a)(1) and (2)]. Changes to the Medicaid State Plan, state statutes and rules shall be done in accordance with Federal and state requirements.

8.3.2. Pursuant to 42 CFR 438.3, the MCO shall provide enrollees with services or settings that are in lieu of services or settings described in 8.2 that are authorized by DHHS, which include, Medical Nutrition & Diabetes Self Management. The MCO shall not require the enrollee to use these alternate services.

8.3.3. Pursuant to 42 CFR 438.6, the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any enrollee that is receiving treatment in an institution for

[12] e.g. Cedarcrest

[13] except facility and ancillary services for dental procedures

[14] The Department anticipates that the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver will be approved by July of 2018.

mental disease (IMD) for the primary treatment of a psychiatric disorder that is not a state owned or operated facility. The MCO shall not pay for any days in a given month if the enrollee exceeds fifteen (15) days in an IMD for that month. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for in lieu of services at 42 CFR 438.3(e)(2)(i) through (iii).

8.3.4. Effective November 1, 2014, with the exception of HCBC waiver participants and nursing facility residents, the MCO shall require co-payment for services for members deemed by DHHS to have annual incomes at or above 100% of the FPL as follows:

8.3.4.1. Co-payments for drug prescriptions of up to $1 for generic drugs and $2 for brands and compound drugs for Step 1 members with annual incomes higher than 100% of the FPL, and for Step 2 members with annual incomes higher than 100% of the FPL consistent with the beneficiary and service exemptions as found in federal regulations and the approved Medicaid State Plan; and

8.3.4.2. Co-payments for drugs prescriptions of up to $1 for generic drugs and $4 for brands and compound drugs for NHHPP members with annual incomes higher than 100% of the FPL.

8.3.5. Effective 3/1/2016, the MCO Shall require point-of-service copayment for services for members deemed by DHHS to not be exempt from cost-sharing and have incomes above 100 percent of the federal poverty level as follows:

8.3.6. For Medicaid recipients subject to copayments:

8.3.6.1. A copay of $1.00 will be required for each preferred prescription drug and each refill of a preferred prescription drug.

8.3.6.2. A copay of $2.00 will be required for each non-preferred prescription drug and each refill of a nonpreferred prescription drug, unless the prescribing provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the copay for the non-preferred drug will be $1.00.

8.3.6.3. A copay of $1.00 will be required for a prescription drug that is not identified as either a preferred or nonpreferred prescription drug.

8.3.6.4. Copays are not required for family planning products or for Clozaril (Clozapine) prescriptions. All Cost sharing shall be applied consistent with beneficiary and service exemptions as found at 42 USC §§ 1396-o and 1396o-1, 42 C.F.R. §447.50 - 447.90, and New Hampshire's Medicaid State Plan.

8.3.7. Those individuals, who meet the definition of an Indian in 42 CFR 438.14(a), are exempt from any premiums or cost-sharing including copayments.

8.3.8. The MCO may, with DHHS approval, require co-payment for services that do not exceed current Medicaid co-payment amounts established by DHHS.

8.3.9. The MCO shall with no disruption in service delivery to members or providers transition these services into managed care from fee-for-service (FFS).

8.3.10. All services shall be provided in accordance with 42 CFR 438.210.

8.3.11. The MCO shall adopt written policies and procedures to verify that services are actually provided [42 CFR 455.1(a)(2)].

8.3.12. The MCO shall comply with provisions of RSA 167:4-d by providing access to telemedicine services to Medicaid members for specialty care only.

8.3.13. The MCO shall cover services consistent with 45 CFR 92.207(b) including gender reassignment surgery.

8.4. Emergency Services

8.4.1. The MCO shall cover and pay for emergency services at rates that are no less than the equivalent DHHS fee-for-service rates if the provider that furnishes the services has an agreement with the MCO [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98].

8.4.2. If the provider that furnishes the emergency services has no agreement with the MCO, the MCO shall cover and pay for the emergency services in compliance with 1932(b)(2)(D) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98.

8.4.3. In accordance with the Deficit Recovery Act of 2005, the MCOs will cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall pay non-contracted providers of Emergency and Post-Stabilization services an amount no more than the amount that would have been paid under the DHHS Fee-For-Service system in place at the time the service was provided.

8.4.4. The MCO shall not deny treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(ii)(A); SMD letter 2/20/98].

8.4.5. The MCO shall not deny payment for treatment obtained when a representative, such as a network provider, of the MCO instructs the member to seek emergency services [42 CFR 438.114(c)(1)(ii)(B); SMD letter 2/20/98].

8.4.6. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

8.4.7. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or DHHS of the member's screening and treatment within ten (10) calendar days of presentation for emergency services [42 CFR 438.114(d)(1)(ii)].

8.4.8. The MCO may not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient [42 CFR 438.114(d)(2)].

8.4.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment [42 CFR 438.114(d)(3)].

8.5. Post-Stabilization Services

8.5.1. Post-stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for post-stabilization services obtained within or outside the MCO that are pre-approved by a MCO provider or other MCO representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i); SMD letter 8/5/98]

8.5.2. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii); SMD letter 8/5/98.]

8.5.3. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain, improve or resolve the member's stabilized condition if:

8.5.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

8.5.3.2. The MCO cannot be contacted; or

8.5.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with a MCO physician and the treating physician may continue with care of the patient until a MCO physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)].

8.5.4. The MCO shall limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the MCO. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv); SMD letter 8/5/98]

8.5.5. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

8.5.5.1. A MCO physician with privileges at the treating hospital assumes responsibility for the member's care;

8.5.5.2. A MCO physician assumes responsibility for the member's care through transfer;

8.5.5.3. A MCO representative and the treating physician reach an agreement concerning the member's care; or

8.5.5.4. The member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3); SMD letter 8/5/98]

9. Payment Reform Plan

9.1. Payment Reform Plan Timeline

9.1.1. The MCO shall submit within sixty (60) calendar days from a Program Start Date and sixty (60) calendar days prior to the start of each Agreement year, its Payment Reform Plan to engage its provider network in health care delivery and payment reform activities, subject to review and approval by DHHS. These activities may include, but are not limited to, pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements.

9.1.1.1. DHHS shall respond to the MCO regarding the Payment Reform Plan within thirty (30) calendar days of receipt.

9.1.2. The MCO shall submit a report to DHHS describing its performance against the MCO's healthcare delivery and Payment Reform Plan within ninety (90) calendar days of the end of each year of the Agreement.

9.1.2.1. The report shall indicate, by provider type, the number and percentage participating in each type of payment reform activities.

9.1.2.2. DHHS will evaluate the MCO's performance and make payments to the MCO, if warranted, within ninety (90) calendar days of receipt of the report. DHHS shall provide the MCO with a written explanation of DHHS's evaluation of the MCO's performance within thirty (30) days of the MCO's request.

9.1.2.3. In the event that MCO disputes DHHS's evaluation of MCO's performance, MCO will have thirty (30) calendar days from receipt of DHHS's written explanation to submit a written request for reconsideration along with a description of MCO's reasons for the dispute, after which DHHS shall meet with the MCO within a reasonable time frame to achieve a good faith resolution of the disputed matter.

9.2. Payment Reform Plan Content

9.2.1. The Payment Reform Plan shall contain:

9.2.1.1. Information on the anticipated impact on member health outcomes of each specific activity, providers affected by the specific activity, outcomes anticipated as a result of the implementation of a process by which to reduce inappropriate emergency room use, an implementation plan for each activity and an implementation milestone to be met by the end of each year of the Agreement for each activity;

9.2.1.2. A process to ensure Equal Access to services; and

9.2.1.3. A process for engaging LTSS providers in health care delivery and payment reform activities.

9.3. Payment Reform Plan Compliance Requirements

9.3.1. The MCO's Payment Reform Plan(s) shall be in compliance with the following requirements:

9.3.1.1. FQHCs and RHCs will be paid at minimum the encounter rate paid by DHHS at the time of service.

9.3.1.2. The Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

9.3.1.3. The MCO's provider incentive plan shall comply with requirements set forth in 42 CFR 422.208 and 42 CFR 422.210 [42 CFR 438.6(h)].

9.3.1.4. The MCO's payment reform plan must comply with state and federal laws requiring nonpayment to a Contracted Provider for hospital-acquired conditions and for provider preventable conditions. The MCO shall report to NH DHHS all provider-preventable conditions in a form and frequency as specified by the State [42 CFR 438.3(g)].

9.3.1.5. The MCO may not make payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.6. The MCO shall provide information on its provider incentive program to any New Hampshire recipient upon request (this includes the right to adequate and

timely information on the plan) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.6(h)].

9.3.1.7. The MCO shall report whether services not furnished by physician/group are covered by an incentive plan. No further disclosure is required if the incentive plan does not cover services not furnished by the physician/group [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.7.1. The MCO shall report the type of incentive arrangement (e.g., withhold, bonus, capitation) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.8. The MCO shall report the percent of withhold or bonus (if applicable) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.9. The MCO shall report panel size, and if patients are pooled, the approved method used [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.10. If the physician/group is at substantial financial risk, the MCO shall report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss [§1903(m)(2)(A)(x)of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.11. Primary Care reimbursement to follow DHHS policy and to comply with 42 CFR 438, 42 CFR 441 and 42 CFR 447 II.A.5

9.3.1.11.1. MCO shall pass on the full benefit of the payment increase to eligible providers; and

9.3.1.11.2. MCO shall adhere to the definitions and requirements for eligible providers and services as specified in Section 1902(a)(13)(C), as amended by the Affordable Care Act of 2010 (ACA) and federal regulations; and

9.3.1.11.3. MCO shall submit sufficient documentation, as per DHHS policy, to DHHS to validate that enhanced rates were made to eligible providers.

10. Care Coordination Program

10.1. Minimum Care Coordination Program Components

10.1.1. The MCO shall implement a comprehensive care array of care coordination services that have at a minimum the following components:

10.1.1.1. Care Coordination

10.1.1.2. Support of Patient-Centered Medical Homes and Health Homes

10.1.1.3. Non-Emergent Medical Transportation

10.1.1.4. Wellness and Prevention programs

10.1.1.5. Chronic Care Coordination programs

10.1.1.6. High Risk/ High Cost Member Management programs

10.1.1.7. A Special Needs program

10.1.1.8. Coordination and Integration with Social Services and Community Care

10.1.1.9. A Long Term Services and Supports Program

10.2. Care Coordination: Role of the MCO

10.2.1. The MCO shall develop a strategy for coordinating all care for all members. Care coordination for its members includes coordination of primary care, specialty care, and all other MCO covered services as well as services provided through the fee-for-service program and non-Medicaid community based services. Care coordination shall promote and assure service accessibility, focus attention to individual needs, actively assist members or their caregiver to take personal responsibility for their health care, provide education regarding the use of inappropriate emergency room care, emphasize the importance of participating in health promotion activities, provide for continuity of care, and assure comprehensive coordinated and integrated culturally appropriate delivery of care.

10.2.2. The MCO shall ensure that services provided to children are family driven and based on the needs of the child and the family. The MCO shall support the family in having a primary decision making role in the care of their children utilizing the Substance Abuse and Mental Health Services Administration (SAMHSA) core elements of a children's services system of care. The MCO shall employ the SAMHSA principles in all children's behavioral health services assuring they:

10.2.2.1. Are person centered;

10.2.2.2. Include active family involvement;

10.2.2.3. Deliver behavioral health services that are anchored in the community;

10.2.2.4. Build upon the strengths of the member and the family;

10.2.2.5. Integrate services among multiple providers and organizations working with the child; and

10.2.2.6. Utilize a wraparound model of care within the context of a family driven model of care.

10.2.2.6.1. MCO shall submit a written policy to DHHS describing the integrated model of care including but not limited to the involvement of each member and family in the development of the plan.

10.2.3. The MCO will ensure that its providers are providing services to children, youth members, and their families in accordance with RSA 135-F.

10.2.4. The MCO shall provide a written policy to DHHS for approval that ensures that services to individuals who are homeless are to be prioritized and made available to those individuals.

10.3. Care Coordination: Role of the Primary Care Provider

10.3.1. MCO Cooperation with Primary Care Provider

10.3.1.1. The MCO shall implement procedures that ensure that each member has access to an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with 42 CFR 438.208(b)(1) through (6).

10.3.1.2. The MCO shall submit a written plan that describes the development, implementation and evaluation of programs to assess and support, wherever possible, primary care providers to act as a patient centered medical home. A patient centered medical home shall include all of the five key domains outlined by the Agency for Healthcare Research and Quality (AHRQ):

10.3.1.2.1. Comprehensive care;

10.3.1.2.2. Patient-centered care;

10.3.1.2.3. Coordinated care;

10.3.1.2.4. Accessible services; and

10.3.1.2.5. Quality and safety.

10.3.1.3. DHHS recognizes that there is a variety of ways in which these domains can be addressed in clinical practices. External accreditation is not required by DHHS to qualify as a medical home. The MCO's support to primary care providers acting as patient centered medical homes shall include, but is not limited to, the development of systems, processes and information that promote coordination of the services to the member outside of that provider's primary care practice.

10.4. Care Coordination: Role of Obstetric Providers

10.4.1. If, at the time of entering the MCO as a new member, the member is transferring from another MCO within the state system, is in her first trimester of pregnancy and is receiving, medically necessary covered prenatal care services, as defined within this Agreement as covered services, before enrollment the MCO shall be responsible for the costs of continuation of medically necessary prenatal care services, including prenatal care, delivery, and postpartum care.

10.4.2. If the member is receiving services from an out-of-network provider prior to enrollment in the MCO, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services until such time as the MCO can reasonably transfer the member to a network provider without impeding service delivery that might be harmful to the member's health.

10.4.3. If the member, at the time of enrollment, is receiving services from a network provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider through the postpartum period.

10.4.4. In the event a member entering the MCO, either as a new member or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services at the time of enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider, whether an out-of-network or in network provider, through the postpartum period.

10.4.5. Postpartum care includes the first postpartum visit, any additional visits necessary to manage any complications related to delivery, and completion of the medical record.

10.4.6. The MCO shall develop and maintain policies and procedures, subject to DHHS approval, regarding the transition of any pregnant members.

10.5. Non-Emergent Transportation (NEMT)

10.5.1. The MCO shall be required to arrange for the non-emergent medical transportation of its members to ensure members receive medically necessary services covered by the New Hampshire Medicaid program regardless of whether those medically necessary services are covered by the MCO. The MCO shall ensure that a member's lack of personal transportation is not a barrier to accessing care.

10.5.2. The MCO and/or any subcontractors shall be required to perform background checks on all non-emergent medical transportation providers.

10.5.3. The MCO shall provide quarterly reports to DHHS on its non-emergent medical transportation activities to include but not be limited to:

10.5.3.1. NEMT requests delivered by mode of transportation;

10.5.3.2. NEMT request authorization approval rates by mode of transportation;

10.5.3.3. NEMT scheduled trip results by outcome;

10.5.3.4. NEMT services delivered by type of medical service;

10.5.3.5. NEMT service use by population; and

10.5.3.6. Number of transportation requests that were delivered late and not on time.

10.5.3.6.1. On-time shall be defined as less than or equal to fifteen (15) minutes after the appointed time; and

10.5.3.6.2. Transportation requests for methadone services will be excluded from the calculation of late and not-on-time services.

10.5.3.7. Member cancellations of scheduled trips by reason for member cancellations.

10.6. Wellness and Prevention

10.6.1. The MCO shall develop and implement wellness and prevention programs for its members.

10.6.2. The MCO shall, at a minimum, develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs in consultation with DHHS.

10.6.3. The MCO shall, at minimum, provide primary and secondary preventive care services, rated A or B, in accordance with the recommendations of the U.S.

Preventive Services Task Force, and for children, those preventive services recommended by the American Academy of Pediatrics Bright Futures Program.

10.6.4. The MCO may substitute generally recognized accepted guidelines for the requirements set forth in 10.6.3, provided that such substitution is approved in advance by DHHS. The MCO shall provide members with a description of preventive care benefits to be used by the MCO in the member handbook and on the MCO's website.

10.6.5. The MCO shall provide members with general health information and provide services to help members make informed decisions about their health care needs. The MCO shall encourage patients to take an active role in shared decision making.

10.6.6. The MCO shall also participate in other public health initiatives at the direction of DHHS.

10.7. Member Health Education

10.7.1. The MCO shall develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of empowering patients to actively participate in their healthcare.

10.7.2. The MCO shall conduct a Health Needs Assessment for all new members within the following timeframes from the date of enrollment in the MCO:

10.7.2.1. thirty (30) calendar days for pregnant women, children with special health care needs, adults with special health care needs; and

10.7.2.2. ninety (90) calendar days for all other members, including members residing in a nursing facility longer than 100 days.

10.7.2.3. The MCO shall document at least three attempts to conduct the screen. If unsuccessful, the MCO shall document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.

10.7.3. The MCO will submit their Health Needs Assessment forms to DHHS for review and approval.

10.7.4. The MCO shall report quarterly, with reports due the last day of the month following the reporting quarter, with the first report due January 31, 2015. Reports shall include:

10.7.4.1. the number of members and the percentage of eligible members who completed a Health Needs Assessment in the quarter;

10.7.4.2. the percentage of eligible members who completed the Health Needs Assessment in the prior year; and

10.7.4.3. the percentage of members eligible for chronic care coordination, high cost/high risk care coordination, complex care coordination and/or the MCO's special needs program who completed a Health Needs Assessment in the prior year.

10.7.5. The MCO shall actively engage members in both wellness program development and in program participation and shall provide additional or alternative outreach to members who are difficult to engage or who utilize the emergency room inappropriately.

10.8. Chronic Care Coordination, High Risk/High Cost Member and Other Complex Member Management

10.8.1. The MCO shall develop effective care coordination programs that assist members in the management of chronic and complex health conditions, as well as those clients that demonstrate high utilization of services indicating a need for more intensive management services. The MCO may delegate the chronic and complex care member management to a patient centered medical home or health home provided that all the criteria for qualifying as a patient centered medical home or a health home and the additional conditions of this section have been met. These programs shall incorporate a "whole person" approach to ensure that the member's physical, behavioral, developmental, and psychosocial needs are comprehensively addressed. The MCO or its delegated entity shall ensure that the member, and/or the member's care giver, is actively engaged in the development of the care plan.

10.8.2. The MCO shall submit status reports to DHHS on MCO care coordination activities and any delegated medical home or health home activities as requested or required by DHHS.

10.8.3. The MCO shall at, a minimum, provide chronic care coordination services for members with the following or other chronic disease states who are appropriate for such care coordination services based on MCO's methodologies, which have been approved by DHHS, for identifying such members:

10.8.3.1. Diabetes, in coordination with the forthcoming federal diabetes initiative;

10.8.3.2. Congestive Heart Failure (CHF);

10.8.3.3. Chronic Obstructive Pulmonary Disease (COPD);

10.8.3.4. Asthma;

10.8.3.5. Coronary Artery Disease (CAD), in coordination with the Million Hearts Campaign;

10.8.3.6. Obesity;

10.8.3.7. Mental Illness;

10.8.3.8. Requiring wound care.

10.8.4. The MCO shall report on the number and types of members receiving chronic care coordination services.

10.9. Special Needs Program

10.9.1. The MCO shall create an organizational structure to function as patient navigators to:

10.9.1.1. Reduce any barriers to care encountered by members with special needs

10.9.1.2. Ensure that each member with special needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists as appropriate

10.9.1.3. Support in accessing all covered services appropriate to the condition or circumstance.

10.9.2. The MCO shall identify special needs members based on the member's physical, developmental, behavioral condition, or adverse social circumstances, including but not limited to:

10.9.2.1. A member with at least two chronic conditions;

10.9.2.2. A member with one chronic condition and is at risk for another chronic condition;

10.9.2.3. A member with one serious and persistent mental health condition;

10.9.2.4. A member living with HIV/AIDS;

10.9.2.5. A member who is a child in foster care;

10.9.2.6. A member who is a child and a client of DCYF receiving services through a court order; and

10.9.2.7. A member who is homeless.

10.9.3. The MCO shall assess, pursuant to 42 CFR 438.208(c)(2), and reach out to members identified with special needs and their PCP to inform them of additional services and supports available to them through the MCO's special needs program.

10.9.4. The MCO shall share the results of its identification and assessment of any enrollee with special health care needs as described in this section with the State so that those activities will not be duplicated.

10.9.5. The MCO shall ensure enrollees determined to have special health care needs as described in this section and who need a course of treatment or regular care monitoring, will have direct access to a specialist as appropriate for the enrollee's condition and identified needs.

10.9.6. For enrollees with special health needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.9.7. The MCO shall report on the number and types of members in the special needs program.

10.10.Coordination and Integration with Social Services and Community Care

10.10.1.The MCO shall develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including not limited to:

10.10.1.1. Juvenile Justice and Adult Community Corrections;

10.10.1.2. Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

10.10.1.3. Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

10.10.1.4. Public Health Agencies;

10.10.1.5. Schools;

10.10.1.6. Step 2 Programs and Services;

10.10.1.7. The court system;

10.10.1.8. ServiceLink Resource Network; and

10.10.1.9. Housing

10.10.1.9.1. Veterans Administration Hospital and other programs and agencies serving service members, veterans and their families.

10.10.2. The MCO shall report on the number of referrals for social services and community care provided to members by member type.

10.11. Long Term Services and Supports (LTSS)

10.11.1. Navigators. The MCO shall create an organizational structure to function as navigators for members in need of LTSS to:

10.11.1.1. Reduce any barriers to care encountered by members with long term care needs;

10.11.1.2. Ensure that each member with long term care needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists, as appropriate; and

10.11.1.3. Ensure that each member with long term care needs receives conflict free care coordination that facilitates the integration of physical health, behavioral health, psychosocial needs, and LTSS through person-centered care planning to identify a member's needs and the appropriate services to meet those needs; arranging, coordinating, and providing services; facilitating and advocating to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

10.11.2. Integrated Care. The MCO shall ensure that LTSS are delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation, based on the member's preferences and pursuant with 28 C.F.R. Pt. 35, App. A (2010), the Americans with Disabilities Act (ADA) [42 USC 126.12101] and Olmstead v. L.C., 527 U.S. 581 (1999).

10.11.2.1. The MCO shall support accessing all covered services appropriate to the medical, behavioral, psychosocial, and/or LTSS condition or circumstance.

10.11.2.2. The MCO shall identify members with long term care needs based on the member's physical, developmental, psychosocial, or behavioral conditions including but not limited to:

10.11.2.2.1. Children with DCYF involvement;

10.11.2.2.2. Children with special needs other than DCYF;

10.11.2.2.3.Children with Waiver, NF or CMHC services;

10.11.2.2.4.Adults with Special Needs with Waiver, NF or CMHC services;

10.11.2.2.5.Adults with Waiver, NF or CMHC services;

10.11.2.2.6.Older Adults with Waiver or CMHC services; or

10.11.2.2.7.Older adults with NF services.

10.11.2.3. The MCO shall reach out to members identified with long term care needs and their PCP to:

10.11.2.3.1. Assess them and identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring; and

10.11.2.3.2.Inform them of additional services and supports available to them through the MCO; and

10.11.2.3.3.Identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

10.11.2.4. For enrollees with long term care needs determined through an assessment or through regular care monitoring to need services, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.11.2.5.For enrollees with long term care needs determined through an assessment or regular care monitoring, the MCO must have a mechanism in place to assist enrollees to access medically necessary services.

11. EPSDT

11.1. Compliance

11.1.1. The MCO shall provide Early Periodic Screening Diagnostic Treatment (EPSDT) services to members less than twenty-one (21) years of age in compliance with all requirements found below:

11.1.1.1. The MCO shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the SSA and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The MCO shall comply with all EPSDT requirements pursuant to the New Hampshire Medicaid Rules.

11.1.1.2. The MCO shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through Health Check screens and exams and follow-up on any abnormal screening exams. The EPSDT Plan shall also include procedures for referral, tracking, and follow up for annual dental examinations and visits, upon receipt of dental claims information from DHHS. The EPSDT Plan shall consider and be consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists to the extent that such policy statements relate to the role of the primary care provider in coordinating care for infants, children and adolescents. The MCO shall submit its EPSDT Plan to DHHS for review and approval ninety (90) days prior to program start and annually sixty (60) calendar days prior to the first day of each Agreement year.

11.1.1.3. The MCO shall ensure providers perform a full EPSDT visit according to the periodic schedule approved by DHHS and the American Academy of Pediatrics periodicity schedule. The visit shall include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements §1902(a)(43) of the SSA, §1905(a)(4)(B) of the SSA and 42 CFR 441.50-.62, and health education/anticipatory guidance. All five (5) components shall be performed for the visit to be considered an EPSDT visit.

12. Behavioral Health

12.1. Behavioral Health - General Provisions

12.1.1. This section applies to individuals who have been determined to be eligible for community mental health services based on diagnosis, level of impairment and the requirements outlined in N.H. Code of Administrative Rules, chapter He-M 401.

12.1.2. Community mental health services, as set forth in Section 8.2, shall be provided in accordance with the NH Medicaid State Plan, He-M 426, He-M 408 and all other applicable state and federal regulations.

12.1.3. All clinicians providing community mental health services are subject to the requirements of He-M 426 and any other applicable state and federal regulations.

12.1.4. All individuals approved to provide community mental health services through a waiver granted by NH DHHS shall be recognized as qualified providers under the MCO plan subject to NCQA credentialing requirements.

12.1.5. All other behavioral health services shall be provided to all NH Medicaid-eligible recipients in accordance with the NH Medicaid State Plan.

12.1.6. The MCO shall pay for all NH Medicaid State Plan Services for its members as ordered to be provided by the Mental Health Court.

12.1.7. The MCO shall continue to support and ensure that culturally and linguistically competent community mental health services currently provided for people who are deaf continue to be made available. These services shall be similar to services currently provided through the Deaf Services Team at Greater Nashua Mental Health Center.

12.2. Community Mental Health Services

12.2.1. The MCO shall ensure, through review of individual service plans and quarterly reviews, that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall inform DHHS of their findings on a monthly basis.

12.2.2. The MCO shall employ a trauma informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan, pursuant to He-M 401, that will effectively address the individual's trauma history.

12.2.3. The MCO shall make Community Mental Health Services available to all members who have a severe mental disability. DHHS encourages agreement between the MCO and CMHCs to develop a capitated payment program with the intent to establish payment mechanisms to meet the goals of DHHS to strengthen the State's outpatient community health service system and the requirements of the Community Mental Health Agreement, and to further payment reform. In the event that any CMHC fails to sign a contract with the MCO within thirty (30) days before the current contract end date, the MCO shall notify DHHS of the failure to reach agreement with a CMHC and DHHS shall implement action steps to designate a community mental health program to provide services in the designated community mental health services region.

12.2.3.1. The MCO shall submit to DHHS a plan to assure continuity of care for all members accessing a community mental health agency.

12.2.4. In the event that an alternative community mental health program is approved and designated by DHHS, a transition plan shall be submitted for approval by DHHS including implementation strategy and timeframes. State Administrative Rule He-M 426, Community Mental Health Services, details the services available to adults with a severe mental illness and children with serious emotional disturbance. The MCO shall, at a minimum, make these services available to all members determined eligible for community mental health services under State Administrative Rule He-M 401.

12.2.4.1. The MCO shall be required to continue the implementation of evidence based practices across the entire service delivery system.

12.2.4.2. Behavioral Health Services shall be recovery and resiliency oriented, based on SAMHSA's definition of recovery and resiliency.

12.2.4.3. The MCO shall ensure that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans.

12.2.4.4. The MCO shall ensure that community mental health services to individuals who are homeless continue to be prioritized and made available to those individuals.

12.2.4.5. The MCO shall maintain or increase the ratio of community based to office based services for each region in the State, as specified in He-M 425, to be greater than or equal to the regional current percentage or 50%, whichever is greater.

12.2.4.6. The MCO shall monitor the ratio of community based to office based services for each region in the State, as specified in He-M 425.

12.2.4.7. The Department of Health and Human Services (DHHS) will issue a list of covered office and community based services annually, by procedure code, that are used to determine the ratio outlined in 12.2.4.5.

12.2.4.8. The MCO shall submit a written report to the Department of Health and Human Services DHHS every six (6) months, by region, of the ratio of community based services to office based services.

12.2.5. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

12.2.5.1. Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web-based training and certification system.

12.2.5.1.1. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member eligibility renewal following clinician certification to utilize the CANS and the ANSA and upon eligibility determination for newly evaluated consumers effective July 1, 2015.

12.2.5.1.2. The community mental health long term care eligibility tool, specified in He-M 401, and in effect on January 1, 2012 shall continue to be utilized by a clinician until such time as the Department of Health and Human Services implements web-based access to the CANS and the ANSA, the clinician is certified in the use of the CANS and the ANSA, and the member annual review date has passed.

12.2.6. The MCO shall ensure that community mental health service providers operate in a manner that enables the State to meet its obligations under Title II of the Americans with Disabilities Act, with particular attention to the "integration mandate" contained in 28 CFR 35.130(d).

12.2.7. The MCO shall continue the implementation of New Hampshire's 10-year Olmstead Plan, as updated from time to time, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration."

12.2.7.1. The MCO shall include in its written Program Management Plan:

12.2.7.1.1. Screening criteria for Assertive Community Treatment Teams for all persons with serious mental disabilities.

12.2.7.1.2. A needs assessment, capacity analysis and access plan for Community Residential and Supported Housing.

12.2.7.1.3. New and innovative interventions that will reduce admissions and readmissions to New Hampshire Hospital and increase community tenure for adults with a severe mental illness and children with a serious emotional disturbance.

12.2.8. The MCO shall work collaboratively to support the implementation of the Medicaid-funded services described in the Class Action Settlement Agreement in the case of Amanda D. et al. v. Hassan, et al., US v. State of New Hampshire, Civ. No. 1:12-cv-53-SM in conjunction with DHHS and the Community Mental Health Centers.

12.2.8.1. Adult Assertive Community Treatment Teams (ACT). The MCO shall ensure that ACT teams are available twenty-four (24) hours per day, seven (7) days per week, with on-call availability from midnight to 8:00 am. At a minimum, ACT teams shall deliver comprehensive, individualized, and flexible services, supports, treatment, and rehabilitation in a timely manner as needed, onsite in the individuals homes and in other natural environments and community settings, or alternatively, via telephone where appropriate to meet the needs of the individual. Each ACT team shall be composed of a multi-disciplinary group of between seven (7) and ten (10) professionals, including, at a minimum, a psychiatrist, a nurse, a Masters-level clinician (or functional equivalent therapist), functional support worker and a peer specialist. The team also will have members who have been trained and are competent to provide substance abuse support services, housing assistance and supported employment. Caseloads for ACT teams serve no more than ten (10) to twelve (12) individuals per ACT team member (excluding the psychiatrist who will have no more than seventy (70) people served per 0.5 FTE psychiatrist).

12.2.8.2. Evidence-based Supported Employment (EBSE). The MCO shall ensure that EBSE is provided to eligible consumers in accordance with the Dartmouth model. The MCO shall ensure that the penetration rate of individuals receiving EBSE increases to 18.6 percent by June 30, 2017. The penetration rate is determined by dividing the number of adults with severe mental illness (SMI) receiving EBSE by the number of adults who have SMI being served.

12.2.9. The Department of Health and Human Services will lead regional planning activities in each community mental health region to develop and refine community mental health services in New Hampshire. The MCO shall support and actively participate in these activities.

12.2.9.1. The focus of the regional planning process will be on reducing the need for inpatient care and emergency department utilization, and on increasing community tenure.

12.2.10. The MCO shall develop a Training Plan each year of the Agreement for how it will support the New Hampshire community mental health service system's effort to hire and train qualified staff. The MCO shall submit this Training Plan to DHHS sixty (60) calendar days prior to program start and annually ninety (90) calendar days prior to beginning of each Agreement year.

12.2.10.1. The MCO shall submit a report summarizing what training was provided, a copy of the agenda for each training, a participant registration list for each contracted CMHC and a summary, for each training provided, of the evaluations done by program participants, within ninety (90) calendar days of the conclusion of each Agreement year.

12.2.10.2. As part of that Training Plan, the MCO shall promote provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

12.2.10.3. The MCO Training Plan outlined in 12.2.10.1 shall be designed to sustain and expand the use of the Evidence Based Practices of Illness Management and Recovery (IMR), Evidence Based Supported Employment (EBSE), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Treatment (DBT) and Assertive Community Treatment (ACT), and to improve NH's penetration rates for Illness Management and Recovery (IMR) and Supported Employment, by 2% each year of the Agreement. The baseline measure for penetration rates shall be the NH submission to the SAMHSA Uniform Reporting System for 2011.

12.2.10.4. The MCO shall offer a minimum of 2 hours of training each contract year to all contracted community mental health center staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the State's objective of reducing the number of suicides in New Hampshire.

12.2.10.5. The MCO shall submit an annual report no later than ninety (90) calendar days following the close of each Agreement year with a summary of the trainings provided, a list of attendees from each contracted community mental health program, and the proposed training for the next fiscal year.

12.3. Emergency Services

12.3.1. The MCO shall ensure, through its contracts with local providers, that regionally based crisis lines and Emergency Services as defined in He-M 403 and He-M 426 are in place 24 hours a day/ 7 days a week for individuals in crisis. These crisis lines and Emergency Services Teams shall employ clinicians who are trained in managing crisis intervention calls and who have access to a clinician available to evaluate the member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

12.3.2. The MCO shall submit for review to the DHHS MCM Account Manager and the Director of the Bureau of Mental Health an annual report identifying innovative and cost effective models of providing crisis and emergency response services that will provide the maximum clinical benefit to the consumer while also meeting the State's objectives in reducing admissions and increasing community tenure.

12.4. Care Coordination

12.4.1. The MCO shall develop policies governing the coordination of care with primary care providers and community mental health programs. These policies shall be submitted to DHHS for review and approval ninety (90) calendar days prior to the beginning of each Agreement year, including Year 1.

12.4.2. The MCO shall ensure that there is coordination between the primary care provider and the community mental health program.

12.4.3. The MCO shall ensure that both the primary care provider and community mental health program request written consent from the member to release information to coordinate care regarding mental health services, primary care, and in the case of alcohol and drug abuse services written consent from the member and a notice to the recipient of the records stating 42 CFR Part 2 prohibits unauthorized disclosure of records regarding or substance abuse services.

12.4.4. The MCO shall monitor instances in which consent was not given, and if possible the reason why, and submit this report to DHHS no later than sixty (60) calendar days following the end of the fiscal year.

12.4.5. The MCO shall review with DHHS the approved policy, progress toward goals, barriers and plans to address identified barriers.

12.4.6. The MCO shall ensure integrated care coordination by requiring that providers accept all referrals for its members from the MCO that result from a court order or a request from DHHS.

12.5. New Hampshire Hospital

12.5.1. The MCO shall maintain a collaborative agreement with New Hampshire Hospital, the State of New Hampshire's state operated inpatient psychiatric facility. This collaborative agreement subject to the approval of DHHS shall at a minimum address the Americans with Disabilities Act requirement that individuals be served in the most integrated setting appropriate to their needs, include the responsibilities of the community mental health program in order to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.

12.5.2. It is the policy of the State to decrease discharges from inpatient care at New Hampshire Hospital to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning from New Hampshire Hospital. The MCO shall utilize the collaborative agreement to track any discharges that the MCO, through its provider network, was unable to place into the community and who instead were discharged to a shelter or into homelessness. The MCO shall submit a report to the Department of Health and Human Services DHHS, quarterly, detailing the reasons why members were placed into homelessness and include efforts made by the MCO to arrange appropriate placements.

12.5.3. The MCO shall designate a liaison with privileges, as required by New Hampshire Hospital, to continue members' care coordination activities, and assist in facilitating a coordinated discharge planning process for adults and children admitted to New Hampshire Hospital. Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital treatment team meetings and discharge planning meetings to ensure that individuals receive treatment in the least restrictive environment complying with the Americans with Disabilities Act and other applicable federal and State regulations.

12.5.3.1. The liaison shall actively participate, and assist New Hampshire Hospital staff in the development of a written discharge plan within twenty-four (24) hours of admission.

12.5.3.2. The MCO shall ensure that the final NHH Discharge Instruction Sheet shall be provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of members discharged. The MCO shall ensure that the discharge progress note shall be provided to the aftercare provider within 7 calendar days of member discharge for at least ninety percent (90%) of members discharged.

12.5.3.3. The MCO shall make at least three (3) attempts to contact members for whom the MCO has record of a telephone number within three (3) business days of discharge from New Hampshire Hospital in order to review the discharge plan, support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the member may have. The performance metric shall be that at least ninety-five percent (95%) of members discharged shall have been attempted to be contacted within three (3) business days.

12.5.3.4. The MCO shall ensure an appointment with a community mental health program or other appropriate mental health clinician for the member is scheduled prior to discharge. Such appointment shall occur within seven (7) calendar days after discharge.

12.5.3.4.1. Persons discharged from psychiatric hospitalization and new to a CMHC must have an intake appointment within seven (7) days.

12.5.3.5. The MCO shall work with DHHS to review cases of members that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

12.5.3.6. The MCO shall establish a reduction in readmissions plan, subject to approval by DHHS, to monitor the 30-day and 180-day readmission rates to New Hampshire Hospital, review member specific data with each of the community mental health programs, and implement measurable strategies within 90 days of the execution of this Agreement to reduce 30-day and 180-day readmission. The MCO shall include benchmarks and reduction goals in the Program Management Plan.

12.5.4. The MCO shall perform in-reach activities to New Hampshire Hospital designed to accomplish transitions to the community.

12.6. In Shape Program

12.6.1. The MCOs shall promote community mental health service recipients' whole health goals. Functional support services may be utilized to enable recipients to pursue and achieve whole health goals within an In Shape program or other program designed to improve health.

12.7. Parity

12.7.1. The MCO and its subcontractors must comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which requires the MCOs

to not discriminate based upon an enrollee's health status of having a mental health or substance use disorder.

12.7.1.1. The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.

12.7.1.2. The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

12.7.1.3. The MCO shall not impose Non- Quantitative Treatment Limits for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

12.7.1.4. Annual Certification with Federal Mental Health Parity Law: The MCOs must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the Federal Mental Health Parity Law, regulations and guidance issued by state and federal entities.

12.7.1.4.1. The MCO must submit a certification signed by the chief executive officer and chief medical officer stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.2. If the MCO determines that all administrative, clinical, and utilization practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will affirmatively state, that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.3. If the MCO determines that any administrative, clinical, and utilization practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law or guidance issued by state and federal entities during the calendar year, the certification will state that not all practices were in compliance with Federal Mental Health Parity Law or any guidance issued by state or federal entities and will include a list of the practices not in compliance and the steps the managed care entity has taken to bring these practices into compliance.

12.7.1.5. The MCO shall complete the DHHS Parity Compliance Report annually and shall include:

12.7.1.5.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCOs pursuant to DHHS criteria;

12.7.1.5.2. All member grievances and appeals regarding a parity violation and resolutions;

12.7.1.5.3. The processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification; and

12.7.1.5.4. Any other requirements identified by DHHS.

12.7.1.6. A member enrolled in any MCO may file a complaint with the New Hampshire Insurance Department at **https://www.nh.gov/insurance/consumers/complaints.htm** if services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance.

13. Substance Use Disorder

13.1. Substance Use Disorder - General Provisions

13.1.1. The MCO will offer contracts to Medicaid enrolled SUD providers who meet the MCO's credentialing standards. The MCO will reimburse those SUD providers in accordance with Section 21.2.10.

13.1.2. The MCO will submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of SUD service providers so that services are accessible without reasonable delays.

13.1.2.1. If the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours this provider is required to provide interim substance use disorder counselors services until such a time that the clients starts receiving the identified level of care. If the type of service is not provided by this agency they are then responsible for making an active referral to a provider of that type of service (for the identified level of care) within fourteen (14) days from initial contact and to provider interim substance use disorder counselors services until such a time that the member is accepted and starts receiving services by the receiving agency.

13.1.3. The MCO shall provide data, reports and plans in accordance with Exhibit O.

13.2. Compliance Metrics for Access to SUD Services

13.2.1. Agencies under contract with MCOs to provide SUD services shall respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The SUD provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face to face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but not later than two (2) business days following the date of first contact.

13.2.2. Members who have screened positive for SUD services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation (as identified in the He-W 513 administrative rules) as soon as possible following the ASAM Level of Care Assessment and no later than (3) days after admission.

13.2.3. Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed. Members identified for Partial

Hospitalization (PH) or Rehabilitative Residential (RR) Services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

13.2.3.1. Pregnant women shall be admitted to the identified level of care within 24 hours of the ASAM Level of Care Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor shall:

13.2.3.1.1. Assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance must include actively reaching out to identify providers on the behalf of the client; and

13.2.3.1.2. Provide interim services until the appropriate level of care becomes available at either the contractor agency or an alternative provider. Interim services shall include:

a. At least one 60 minute individual or group outpatient session per week;

b. Recovery support services as needed by the client; and

c. Daily calls to the client to assess and respond to any emergent needs.

13.2.4. If the type of service identified in the ASAM Level of Care Assessment will not be available from the provider that conducted the initial assessment within the fourteen (14) business day period, or if the type of service is not provided by the agency that conducts the ASAM Level of Care Assessment, this agency is responsible for making an active referral to a provider of that type of services (for the identified level of care) within fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

14. Pharmacy Management

14.1. Pharmacy Management – General Provisions

14.1.1. The MCO's, including any pharmacy subcontractors, shall create: formulary and pharmacy prior authorization criteria and other point of service edits (i.e. prospective drug utilization review edits and dosage limits), pharmacy policies and pharmacy programs subject to DHHS approval, and in compliance with §1927 of the SSA [42 CFR 438.3(s)]. The MCO shall not include drugs by manufacturers not enrolled in the OBRA 90 Medicaid rebate program on its formulary without DHHS consent.

14.1.2. The MCO shall adhere to New Hampshire law with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, law 2004, SB 383-FN, Sect. IVa. Specifically, a MCO member shall continue to be treated, or, if newly diagnosed, may be treated with a non-preferred drug based on any one of the following criteria:

14.1.2.1. Allergy to all medications within the same class on the preferred drug list;

14.1.2.2. Contraindication to or drug-to-drug interaction with all medications within the same class on the preferred drug list;

14.1.2.3. History of unacceptable or toxic side effects to all medications within the same class on the preferred drug list;

14.1.2.4. Therapeutic failure of all medications within the same class on the preferred drug list;

14.1.2.5. An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal Food and Drug Administration-approved indication;

14.1.2.6. Age specific indication;

14.1.2.7. Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or

14.1.2.8. Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

14.1.3. The MCO shall submit all of its policies, prior authorizations, point-of-sale and drug utilization review edits and pharmacy services procedures related to its maintenance drug policy, specialty pharmacy programs, and any new pharmacy service program proposed by the MCO to DHHS for its approval at least 60 calendar days prior to implementation.

14.1.4. The MCO shall submit the items described in 14.1.1 and 14.1.3 to DHHS for approval sixty (60) calendar days prior to the program start date of Step 1.

14.1.5. Any modifications to items listed in 14.1.1 and 14.1.3 shall be submitted for approval at least sixty (60) calendar days prior to the proposed effective date of the modification.

14.1.6. The MCO shall notify members and providers of any modifications to items listed in 14.1.1 and 14.1.3 thirty (30) calendar days prior to the modification effective date.

14.1.7. Implementation of a modification shall not commence prior to DHHS approval.

14.1.8. At the time a member with currently prescribed medications transitions to an MCO: upon MCO's receipt of (written or verbal) notification validating such prescribed medications from a treating provider, or a request or verification from a pharmacy that has previously dispensed the medication, or via direct data from DHHS, the MCO shall continue to cover such medications through the earlier of sixty (60) calendar days from the member's enrollment date, or until completion of a medical necessity review. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

14.1.9. The MCO shall adjudicate pharmacy claims for its members utilizing a point of service (POS) system where appropriate. System modifications, including but not limited to systems maintenance, software upgrades, implementation of International Classification of Diseases- 10 (ICD-10) code sets, and NDC code sets or migrations to new versions of National Council for Prescription Drug Programs (NCPDP) transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

14.1.10. In accordance with Section 1927 (d)(5)(A and B) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization and reimburse for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation when prior authorization cannot be obtained.

14.1.11. The MCO shall develop or participate in other State of New Hampshire pharmacy related quality improvement initiatives. At minimum, the MCO shall routinely monitor and address:

14.1.11.1. Polypharmacy (physical health and behavioral health medications);

14.1.11.2. Adherence to the appropriate use of maintenance medications, such as the elimination of gaps in refills;

14.1.11.3. The appropriate use of behavioral health medications in children by encouraging the use of and reimbursing for consultations with child psychiatrists;

14.1.11.4. For those beneficiaries with a diagnosis for substance use disorder (SUD) and all infants with a diagnosis of neonatal abstinence syndrome (NAS), or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall evaluate these patients needs for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment;

14.1.11.5. For those beneficiaries who enter the MCO lock-in program, the MCO shall evaluate the need for SUD treatment.

14.1.11.6. The MCO shall require prior authorization documenting the rationale for the prescription of more than 200 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective April 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescription of more than 120 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective October 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescriptions of more than 100 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries effective upon NH Board Administrative Rule MED 502 Opioid Prescribing;

14.1.12. In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 (CMS) rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process, in accordance with section 1927(b) of the SSA, and the MCO shall submit the encounter data file within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment.

14.1.13. The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for members for medications covered by other payers.

14.1.14.Specialty Drugs. The MCO shall pay for all specialty drugs consistent with the MCO's formulary and pharmacy edits and criteria.

14.1.15. DHHS will be directly responsible for the pharmacy benefit for Carbaglu and Ravicti, and those Hepatitis C and Hemophilia drugs specifically excluded from the actuarial rate calculations.

14.1.16.Other specialty and orphan drugs.

14.1.16.1. Other currently FDA approved specialty and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

14.1.16.2. When medically necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

14.1.17.Polypharmacy medication review. The MCO shall provide an offer for medication review and counseling to address polypharmacy.

14.1.17.1. MCO shall offer a medication review and counseling no less than annually by a pharmacist or other health care professional as follows:

14.1.17.1.1. To the primary care provider and care taker for children less than 19 years dispensed four (4) or more drugs per month (or prescriptions for 90 day supply covering each month); and

14.1.17.1.2.To adult beneficiaries dispensed more than 10 drugs each month (or prescriptions for 90 day supply covering each month).

14.1.18.The MCO shall adhere to federal regulation with respect to providing pharmacy data required to complete the Annual Drug Utilization Review Report to CMS:

14.1.18.1. The MCO must provide a detailed description of its drug utilization review program to DHHS on an annual basis in accordance with the Medicaid Drug Utilization Review Annual Report format and requirements; and

14.1.18.2. The MCO must operate a drug utilization review program in accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, which includes:

14.1.18.2.1. Prospective drug utilization review;

14.1.18.2.2.Retrospective drug utilization review; and

14.1.18.2.3. An educational program for providers including prescribers and dispensers.

14.2. Continuity of Care

14.2.1. The MCO shall provide continuity of care for current beneficiaries after the transition of the PDL to the MCO. For existing beneficiaries, the MCO shall provide coverage for all drugs for each current beneficiary for six months beginning September 1, 2015 for those drugs dispensed to the beneficiary within the six months prior to September 1, 2015.

14.3. Use of Psychotropic Medicines for Children in Foster Care – DCYF's SafeRx Program

14.3.1. The MCO shall assist in the oversight and management of the use of psychotropic medicines for children and youth in DCYF placement in accordance with PL (Public Law 112-34) and in accordance with DCYF policy 1653. Assistance includes:

14.3.1.1. Psychiatry review of Medications when requested by DCYF staff, with Peer To Peer discussion if warranted to include:

14.3.1.1.1. Pharmacy claims;

14.3.1.1.2. Provider progress notes;

14.3.1.1.3. Telephone contact with the providers, if necessary;

14.3.1.1.4. Current Diagnoses, DSM I-III;

14.3.1.1.5. Current Behavioral Functioning; and

14.3.1.1.6. Information from the placement provider, either foster care or residential re: behaviors and medication response.

14.3.1.2. Edits in pharmacy systems for outlying red flag criteria that would require further explanation and authorization including:

14.3.1.2.1. Children 5 and under being prescribed antipsychotics;

14.3.1.2.2. Children 3 and under on any psychotropic medicine; and

14.3.1.2.3. A child or youth being prescribed 4 or more psychotropic medicines, allowing for tapering schedules for ending one medicine and starting a new medicine.

15. Reserved.

16. Member Enrollment and Disenrollment

16.1. Eligibility

16.1.1. The State has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether he/she will be enrolled in the Care Management program. The State shall maintain its current responsibility for determining member eligibility. The MCO shall comply with eligibility decisions made by DHHS.

16.1.2. The MCO shall ensure that ninety-five percent (95%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. Data received Monday-Friday is to be uploaded Tuesday-Saturday between 12 AM EST and 8AM EST. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded by 10 AM EST. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond 10 AM EST.

16.1.3. The ASCX12 834 enrollment file will limit enrollment history to eligibility spans reflective of any assignment of the member with the MCO.

16.1.4. To ensure appropriate continuity of care, DHHS will provide up to two (2) years (as available) of all fee-for-service paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all fee-for-service Medicaid beneficiaries assigned to MCO. For members transitioning from another MCO, DHHS will also provide such claims data as well as available encounter information regarding the member supplied by other MCOs.

16.2. Relationship with Enrollment Services

16.2.1. DHHS or its designee shall be responsible for member enrollment and passing that information along to the MCO for plan enrollment [42 CFR 438.3(d)(2)].

16.2.2. The MCO shall accept individuals into its plan from DHHS or its designee in the order in which they apply without restriction, (unless authorized by the regional administrator), up to the limits set in this Agreement [42 CFR 438.3(d)(1)].

16.2.3. The MCO will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll [42 CFR 438.3(d)(3)].

16.2.4. The MCO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has a discriminatory effect [42 CFR 438.3(d)(4].

16.2.5. The MCO shall furnish information to DHHS or its designee so that it may comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the recipient receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; State Medicaid Manual (SMM) 2090.1; SMM 2101].

16.2.6. The MCO shall provide information, within five (5) business days, to DHHS or its designee that allows for a determination of a possible change in eligibility of members (for example, those who have died, been incarcerated, or moved out-of-state).

16.3. Enrollment

16.3.1. The MCO shall accept members who choose to enroll in the MCO:

16.3.1.1. During the initial enrollment period;

16.3.1.2. During an annual enrollment period;

16.3.1.3. During a renegotiation or reprocurement enrollment period;

16.3.1.4. If the member requests to be assigned to the same plan in which another family member is currently enrolled; or

16.3.1.5. Who have disenrolled with another MCO at the time described in 16.5.3.1.

16.3.2. The MCO shall accept that enrollee enrollment is voluntary, except as described in 42 CFR 438.50.

16.3.3. The MCO shall accept for automatic re-enrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less.

16.3.4. The MCO shall accept members who have been auto-assigned by DHHS to the MCO.

16.3.5. The MCO shall accept members who are auto-assigned to another MCO but have an established relationship with a primary care provider that is not in the network of the auto-assigned MCO. The member can request enrollment any time during the first twelve (12) months of auto-assignment.

16.4. Auto-Assignment

16.4.1. DHHS will use the following auto-assignment methodology:

16.4.1.1. Preference to an MCO with which there is already a family affiliation;

16.4.1.2. Equal assignment among the MCOs.

16.4.2. DHHS reserves the right to change the auto assignment process at its discretion.

16.4.3. DHHS may also revise its auto-assignment methodology during the Contract Period for new Medicaid members who do not select an MCO (Default Members). The new assignment methodology would reward those MCOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. DHHS will also consider other appropriate factors.

16.4.4. DHHS may revise its auto-assignment methodology when exercising renegotiation and reprocurement rights under section 3.9.1 of this Agreement.

16.5. Disenrollment

16.5.1. Disenrollment provisions of 42 CFR 438.56(d)(2) apply to all members, regardless of whether the member is mandatory or voluntary [42 CFR 438.56(a); SMD letter 01/21/98].

16.5.2. A member may request disenrollment with cause at any time when:

16.5.2.1. The member moves out of state;

16.5.2.2. The member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the member to unnecessary risk; or

16.5.2.3. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to providers experienced in dealing with the member's health care needs [42 CFR 438.56(d)(2)]

16.5.3. A member may request disenrollment without cause, at the following times:

16.5.3.1. During the ninety (90) calendar days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later;

16.5.3.2. For members who are auto-assigned to a MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO, the member can request disenrollment during the first twelve (12) months of enrollment at any time;

16.5.3.3. Any time for members who enroll on a voluntary basis;

16.5.3.4. During open enrollment every twelve (12) months;

16.5.3.5. During open enrollment related to renegotiation and reprocurement under Section 3.9.

16.5.3.6. For sixty (60) calendar days following an automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual enrollment/disenrollment opportunity (This provision applies to re-determinations only and does not apply when a member is completing a new application for Medicaid eligibility); and

16.5.3.7. When DHHS imposes the intermediate sanction on the MCO specified in 42 CFR 438.702(a)(3) [§1932(a)(4)(A) of the SSA; §1932(e)(2)(C) of the SSA; 42 CFR 438.56(c)(1); 438.56(c)(2)(i), (ii), (iii), and (iv); 42 CFR 438.702(a)(3); SMD letter 02/20/98; SMD letter 01/21/98]

16.5.4. The MCO shall provide members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period.

16.5.5. If a member is requesting disenrollment, the member (or his or her representative) shall submit an oral or written request to DHHS or its agent.

16.5.6. The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS' request for information.

16.5.7. The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons [42 CFR 438.56(b)(1); SMM 2090.12]:

16.5.7.1. Member has established out of state residence;

16.5.7.2. Member death;

16.5.7.3. Determination that the member is ineligible for enrollment based on the criteria specified in this Agreement regarding excluded populations; or

16.5.7.4. Fraudulent use of the member ID card.

16.5.8. The MCO shall not request disenrollment of a member for any reason not permitted in this Agreement [42 CFR 438.56(b)(3)].

16.5.9. The MCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular

member or other members) or abuse of substances, prescribed or illicit, and any legal consequences resulting from substance abuse. [42 CFR 438.56(b)(2)].

16.5.10. The MCO may request disenrollment in the event of threatening or abusive behavior that jeopardizes the health or safety of members, staff, or providers.

16.5.11. If an MCO is requesting disenrollment of a member, the MCO shall:

16.5.11.1. Specify the reasons for the requested disenrollment of the member; and

16.5.11.2. Submit a request for involuntary disenrollment to DHHS (or its agent) along with documentation and justification, for review and approval

16.5.12. Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member or the MCO files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); SMM 2090.6; SMM 2090.11].

16.5.13. DHHS (or its agent) shall provide for automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less [42 CFR 438.56(g)].

17. Member Services

17.1. Member Information

17.1.1. The MCO shall maintain a Member Services Department to assist members and their family members, guardians or other authorized individuals in obtaining covered services under the Care Management program.

17.1.2. The MCO shall have a 'No Wrong Door' approach, consistent with the DHHS Balancing Incentive Program, to member calls and inquiries, and shall have one toll-free number for members to contact.

17.1.3. The MCO shall have in place a mechanism to help members and potential members understand the requirement and benefits of the plan [42 CFR 438.10(c)(7)].

17.1.4. The MCO shall make a welcome call to each new member within thirty (30) days of the member's enrollment in the MCO. A minimum of three (3) attempts should be made at various times of the day, on different days, for at least ninety-five percent (95%) of new members. The welcome call shall at a minimum:

17.1.4.1. Assist the member to select a Primary Care Provider (PCP) or confirm selection of a PCP;

17.1.4.2. Include a brief Health Needs Assessment;

17.1.4.3. Screen for special needs and /or services of the member; and

17.1.4.4. Answer any other member questions about the MCO and ensure that members can access information in their preferred language.

17.1.5. Welcome calls shall not be required for members residing in a nursing facility longer than 120 days. The MCO shall:

17.1.5.1. Meet with each nursing facility no less than annually to provide an orientation to the MCM program and instructions regarding completion of the Health Needs Assessment for each member residing in a nursing facility longer than 120 days; and

17.1.5.2. Send letters to members residing in nursing facilities longer than 120 days or their authorized representatives describing welcome calls and how a member or their authorized representative can request a welcome call.

17.1.6. The MCO shall send a letter to a member upon initial enrollment, and anytime the member requests a new Primary Care Provider (PCP), confirming the member's PCP and providing the PCP's name address and telephone number.

17.1.7. The MCO shall issue an Identification Card (ID Card) to all new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. The ID Card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the ID card:

17.1.7.1. The member's name;

17.1.7.2. The member's date of birth;

17.1.7.3. The member's Medicaid ID number assigned by DHHS at the time of eligibility determination;

17.1.7.4. The name of the MCO; and

17.1.7.5. The name of MCO's NHHPP product;

17.1.7.6. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

17.1.7.7. How to file an appeal or grievance.

17.1.8. The MCO shall reissue a Member ID card if:

17.1.8.1. A member reports a lost card;

17.1.8.2. A member has a name change; or

17.1.8.3. Any other reason that results in a change to the information disclosed on the ID card.

17.1.9. The MCO shall publish member information in the form of a member handbook available at the time of member enrollment in the plan for benefits effective January 1, 2018. The member handbook shall be based upon the model enrollee handbook developed by DHHS.

17.1.9.1. Two weeks in advance of open enrollment, the MCOs shall inform all members by mail of their right to receive at no cost to any member a written copy of the member handbook effective for the new benefit year.

17.1.10. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives.

17.1.11. The MCO shall submit the member handbook to DHHS for approval at the time it is developed and after any substantive revisions, prior to publication and distribution.

17.1.12. Pursuant to the requirements set forth in 42 CFR 438.10, the Member Handbook shall include, in easily understood language, but not be limited to:

17.1.12.1. A table of contents;

17.1.12.2. DHHS developed definitions so that enrollees can understand the following terminology: appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, grievance, habilitation services and devices, home health care, hospice services, hospitalization, hospital, outpatient care, physician services, prescription drug coverage, prescription drugs, primary care physician, PCP, rehabilitation services and devices, skilled nursing care, and specialist.

17.1.12.3. Information about the role of the primary care provider (PCP);

17.1.12.4. Information about choosing and changing a PCP;

17.1.12.5. Appointment procedures;

17.1.12.6. [Intentionally left blank.]

17.1.12.7. Description of all available benefits and services, including information on out-of-network providers;Information on how to access services, including EPSDT services, non-emergency transportation services, and maternity and family planning services. The handbook should also explain that the MCO cannot require a member to receive prior approval prior to choosing a family planning provider;

17.1.12.8. An explanation of any service limitations or exclusions from coverage;

17.1.12.9. A notice stating that the MCO shall be liable only for those services authorized by or required of the health plan;

17.1.12.10. Information on where and how members may access benefits not available from or not covered by the MCO;

17.1.12.11. The Necessity definitions used in determining whether services will be covered;

17.1.12.12. Detailed information regarding the amount, duration, and scope of benefits so that enrollees understand the benefits to which they are entitled.

17.1.12.13.A description of all pre-certification, prior authorization, or other requirements for treatments and services;

17.1.12.14.Information regarding prior authorization in the event the member chooses to transfer to another MCO and the member's right to continue to utilize a provider specified in a prior authorization regardless of whether the provider is participating in the MCO network;

17.1.12.15.The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;

17.1.12.16.Information on how to obtain services when the member is out of the State and for after-hours coverage;

17.1.12.17.Cost-sharing requirements;

17.1.12.18.Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including an inclusion of the MCO's toll-free telephone line and website;

17.1.12.19.A description of Utilization Review policies and procedures used by the MCO;

17.1.12.20.A description of those member rights and responsibilities, described in 17.3 of this Agreement, but also including but not limited to notification that:

17.1.12.20.1.Oral interpretation is available for any language, and information as to how to access those services;

17.1.12.20.2.Written translation is available in prevalent languages, and information as to how to access those services;

17.1.12.20.3.Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and information as to how to access those services;

17.1.12.21.The policies and procedures for disenrollment;

17.1.12.22.Information on Advance Directives;

17.1.12.23.A statement that additional information, including information on the structure and operation of the MCO plan and provider incentive plans, shall be made available upon request;

17.1.12.24.Member rights and protections;

17.1.12.25.Information on the Grievance, Appeal, and Fair Hearing procedures and timeframes in a DHHS-approved description, including:

17.1.12.25.1.The right to file grievances and appeals;

17.1.12.25.2.The requirements and timeframes for filing a grievance or appeal;

17.1.12.25.3.The availability of assistance in the filing process;

17.1.12.25.4.The right to request a State fair hearing after the MCO has made a determination on an enrollee's appeal which is adverse to the enrollee; and

17.1.12.25.5.An enrollee's right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however if the enrollee receives an adverse decision then the enrollee may be required to pay for the cost of service furnished while the appeal or State fair hearing is pending as specified in 42 CFR 438.10(g)(2);

17.1.12.26.Member's right to a second opinion from a qualified health care professional within the network, or one outside the network arranged by the MCO at no cost to the member. [42 CFR 438.206(b)(3)].

17.1.12.27.The extent to which, and how, after hours and emergency coverage are provided including:

17.1.12.27.1.What constitutes an emergency and emergency medical care; and

17.1.12.27.2.The fact that prior authorization is not required for emergency services; and

17.1.12.27.3.The enrollee's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)];

17.1.12.28.Information on how to access the New Hampshire Office of the Long Term Care Ombudsman;

17.1.12.29. Information on how to access auxiliary aids and services, including additional information in alternative formats or languages;

17.1.12.30. Information and guidance as to how the enrollee can effectively use the managed care program as described in 42 CFR 438.10(g)(2);

17.1.12.31. Information on how to report suspected fraud or abuse;

17.1.12.32. Information on how to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center who can provide all enrollees and potential enrollees choice counseling and information on managed care; and

17.1.12.33. Disenrollment information.

17.1.13. The MCO shall produce a revised member handbook, or an insert informing members of changes to covered services, upon DHHS notification of any change in covered services, and at least thirty (30) calendar days prior to the effective date of such change. In addition to changes to documentation, the MCO shall notify all existing members of the covered services changes at least thirty (30) calendar days prior to the effective date of such changes.

17.1.14. The MCO shall mail the handbook to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment [42 CFR 438.10(g)(1)].

17.1.15. The MCO shall notify all enrollees of their disenrollment rights, at a minimum, annually [42 CFR 438.10 (f)].

17.1.16. [Intentionally left blank.]

17.1.17. The MCO shall notify all enrollees, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the plan's website. The member information appearing on the website shall include the following, at a minimum:

17.1.17.1. Information contained in the Member Handbook

17.1.17.2. The following information on the MCO's provider network:

17.1.17.2.1. Names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English languages (including American Sign Language) spoken by current contracted providers, including identification of providers that are not accepting new patients. This shall include, at a minimum: information on PCPs, specialists, Family Planning Providers, pharmacies, Federally

Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals;

17.1.17.2.2. Any restrictions on the member's freedom of choice among network providers; and

17.1.17.2.3. How to file an appeal and/or a grievance.

17.1.18. For any change that affects member rights, filing requirements, time frames for grievances, appeals, and State fair hearing, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each member written notice of the change at least thirty (30) days before the intended effective date of the change.

17.1.19. Should the MCO not cover a covered service because of moral/ethical or religious reasons, the MCO shall provide a list of these services to the Department. This list shall be used by the Department to provide information to members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

17.1.20. Should the MCO contract with providers and/or subcontractors to deliver services to members pursuant to the MCO's obligations under this Contract and the providers or subcontractors cannot provide a covered service because of moral/ethical or religious reasons, the MCO shall provide a list of these services to the Department. This list shall be used by the MCO and Department to provide information to members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

17.1.21.

17.1.22. The MCO shall submit a copy of all information intended for members to DHHS for approval ten (10) business days prior to distribution.

17.2. Language and Format of Member Information

17.2.1. The MCO shall develop all member materials at or below a sixth (6th) grade reading level, as measured by the appropriate score on the Flesch reading ease test.

17.2.2. The MCO shall use the DHHS developed definitions consistently throughout its user manual, notices, and in any other form of client communication.

17.2.3. The MCO shall develop enrollee notices in accordance with the DHHS model notices.

17.2.4. The MCO shall provide all enrollment notices, information materials, and instructional materials relating to members and potential members in a manner and

format that may be easily understood in a font size no smaller than 12 point [42 CFR 438.10(d) / SMD Letter 2/20/98].

17.2.5. The MCO's written materials shall be developed to meet all applicable Cultural Considerations requirements in Section 18 so that they are communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The MCO shall inform members that information is available in alternative formats and how to access those formats [42 CFR 438.10(d)(6)].

17.2.6. The MCO shall make all written member information available in English, Spanish, and the commonly encountered languages of New Hampshire. All written member information shall include at the bottom a tagline explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the MCO's Customer Service Center. The MCO shall also provide all written member information in large print with a font size no smaller than 18 point upon request [42 CFR 438.10(d)(3)].

17.2.6.1. Written member information shall include at a minimum provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.

17.2.7. The MCO shall also make oral interpretation services available free of charge to each member or potential member for MCO covered services. This applies to all non-English languages, not just those that DHHS identifies as languages of other Major Population Groups. The beneficiary shall not to be charged for interpretation services. The MCO shall notify members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services [42 CFR 438.10(d)].The MCO shall provide auxiliary aids such as TTY/TDY and American Sign Language interpreters available free of charge to each member or potential member who requires these services [42 CFR 438.10(d)].

17.3. Member Rights

17.3.1. The MCO shall have written policies which shall be included in the member handbook and posted on the MCO website regarding member rights [42 CFR 438.100] including:

17.3.1.1. Each managed care member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;

17.3.1.2. Each managed care member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

17.3.1.3. Each managed care member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment;

17.3.1.4. Each managed care member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

17.3.1.5. Each managed care member is guaranteed the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 42 CFR 438.100; and

17.3.1.6. Each managed care member has a right to a second opinion. [42 CFR 438.206].

17.3.2. Each member is free to exercise his/her rights, and that the MCO shall assure that the exercise of those rights shall not adversely affect the way the MCO and its providers or DHHS treat the member [42 CFR 438.100(c)].

17.3.3. Each managed care member has the right to request and receive any MCO's written physician incentive plans.

17.4. Member Call Center

17.4.1. The MCO shall operate a NH specific call center Monday through Friday, except for state approved holidays. The call center shall be staffed with personnel who are knowledgeable about the MCOs plan in NH to answer member inquiries.

17.4.2. At a minimum, the call center shall be operational:

17.4.2.1. Two days per week: 8:00 am EST to 5:00 pm EST;

17.4.2.2. Three days per week: 8:00 am EST to 8:00 pm EST; and

17.4.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

17.4.3. The member call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

17.4.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

17.4.3.2. Average Speed of Answer: Ninety percent (90%) of calls will be answered with live voice within thirty (30) seconds; and

17.4.3.3. Voicemail messages shall be responded to no later than the next business day.

17.4.4. The MCO shall develop a means of coordinating its call center with the DHHS Customer Service Center.

17.4.5. The MCO shall develop a warm transfer protocol for members who may call the incorrect call center to speak to the correct representative and provide monthly reports to DHHS on the number of warm transfers made and the program to which the member was transferred.

17.5. Member Information Line

17.5.1. The MCO shall establish a member hotline that shall be an automated system that operates outside of the call center standard hours, Monday through Friday, and at all hours on weekends and holidays.

17.5.2. The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for callers to leave messages.

17.5.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages.

17.5.4. A representative of the MCO shall return messages no later than the next business day.

17.6. Marketing

17.6.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing to potential members [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.2. The MCO shall submit all MCO marketing material to DHHS for approval before distribution [§1932(d)(2)(A)(1) of the SSA; 42 CFR 438.104(b)(1)(i); SMD letter 12/30/97]. DHHS will identify any required changes to the marketing materials within fifteen (15) business days. If DHHS has not responded to a request for review by the fifteenth (15th) business day, the MCO may proceed to use the submitted materials.

17.6.3. The MCO shall comply with federal requirements for provision of information that ensures the potential member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

17.6.4. The MCO marketing materials shall not contain false or materially misleading information.

17.6.5. The MCO shall not offer other insurance products as inducement to enroll.

17.6.6. The MCO shall ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients of DHHS [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.7. The MCO's marketing materials shall not contain any written or oral assertions or statements that:

17.6.7.1. The recipient must enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

17.6.7.2. That the MCO is endorsed by CMS, the Federal or State government, or similar entity [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101]

17.6.8. The MCO shall distribute marketing materials to the entire state in accordance with §1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1 and SMM 2101. The MCO's marketing materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.7. Member Engagement Strategy

17.7.1. The MCO shall develop and facilitate an active member advisory board that is composed of members who represent its member population. At least twenty-five percent (25%) of the members of the advisory board should be receiving an LTSS service or be a support person, who is not a paid service provider or employed as an advocate, to a member receiving an LTSS service. Representation on the consumer advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. The advisory board shall meet at least quarterly. The advisory board shall meet in-person or through interactive technology including but not limited to a conference call or webinar and provide a member perspective to influence the MCO's quality improvement program, program changes and decisions. All costs related to the member advisory board shall be the responsibility of the MCO.

17.7.2. The MCO shall hold in-person regional member meetings for two-way communication where members can provide input and ask questions and the MCO can ask questions and obtain feedback from members. Regional meetings shall be held at least twice each Agreement year. The MCO shall make efforts to provide video conferencing opportunities for members to attend the regional meetings. If video conferencing is not available then, the MCO shall use alternate technologies as available for all meetings.

17.7.3. The MCO shall report on the activities of the meetings required in Sections 17.7.1 and 17.7.2 including meeting dates, board members, topics discussed and actions taken in response to Board contributions to DHHS in the Medicaid Care Management Program Comprehensive Annual Report.

17.7.4. The MCO shall conduct a member satisfaction survey at least annually in accordance with National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) requirements to gain a broader perspective of member opinions. The MCO survey instrument is subject to DHHS approval. The results of these surveys shall be made available to DHHS to be measured against criteria established by DHHS, and to the MCO's membership [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.10(f)(6); 42 CFR 438.10(g); 42 CFR 438.6(h)].

17.7.5. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

17.8. Provider Directory

17.8.1. The MCO shall publish a Provider Directory that shall be approved by DHHS prior to publication and distribution. The MCO shall submit the draft directory and all substantive changes to DHHS for approval.

17.8.2. The Provider Directory shall include names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English language (including American Sign Language) spoken by, current contracted providers. This shall include, at a minimum; information on PCPs, specialists, Family Planning Providers, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals.

17.8.3. The Provider Directory shall provide all information according to the requirements of 42 CFR 438.10(h).

17.8.4. The MCO shall send a letter to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7)

calendar days after the effective date of enrollment directing the member to the Provider Directory on the MCO's website and informing the member of the right to a printed version of provider directory information upon request [42 CFR 438.10(h)].

17.8.5. The MCO shall notify all members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the plan's website in a machine readable file and format as specified by the Secretary. The MCO shall update the paper copy of the Provider Directory at least monthly and shall update no later than thirty (30) calendar days after the MCO receives updated information. [42 CFR 438.10(h)(4)].

17.8.6. The MCO shall post on its website a searchable list of all contracted providers. At a minimum, this list shall be searchable by provider name, specialty, and location.

17.8.7. Thirty (30) calendar days after contract effective date or ninety (90) calendar days prior to the Program start date, whichever is later, the MCO shall develop and submit the draft Provider Directory template to DHHS for approval and thirty (30) calendar days prior to each Program Start Date the MCO shall submit the final provider directory.

17.8.8. Upon the termination of a contracted provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify enrollees who received their primary care from, or was seen on a regular basis by, the terminated provider.

17.9. Program Website

17.9.1. The MCO shall develop and maintain, consistent with DHHS standards and other applicable Federal and State laws, a website to provide general information about the MCO's program, its provider network, the member handbook, its member services, and its grievance and appeals process.

17.9.2. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes.

17.9.3. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory. The Provider Directory shall identify all providers, including primary care, specialty care, behavioral health, substance abuse, home health, home care, rehabilitation, hospital, and other providers, and include the following information for each provider:

17.9.3.1. Address of all practice/facility locations;

17.9.3.2. Gender;

17.9.3.3. Office hours;

17.9.3.4. Telephone numbers;

17.9.3.5. Website (if applicable);

17.9.3.6. Accommodations provided for people with disabilities;

17.9.3.7. Whether the provider has completed cultural competence training;

17.9.3.8. Hospital affiliations, if applicable;

17.9.3.9. Open/close status for MCO members;

17.9.3.10. Languages spoken (including American Sign Language) in each provider location;

17.9.3.11. Medical Specialty; and

17.9.3.12. Board certification, when applicable.

17.9.3.13. The MCO program content included on the website shall be:

17.9.3.14. Written in English, Spanish, and any other of the commonly encountered languages in the State;

17.9.3.15. Culturally appropriate;

17.9.3.16. Written for understanding at the 6th grade reading level; and

17.9.3.17. Geared to the health needs of the enrolled MCO program population.

17.9.4. The MCO shall maintain an updated list of formulary drug lists on its website. Such information shall include:

17.9.4.1. Which medications are covered (both generic and name brand); and

17.9.4.2. Which tier each medication is on.

17.9.5. The MCO's NH Medicaid Care Management website shall be compliant with the Federal Department of Justice "Accessibility of State and Local Government Websites to people with disabilities".

18. Culturally and Linguistically Competent Services

18.1. Cultural Competency Plan

18.1.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how the MCO shall ensure that services are provided in a culturally and linguistically competent manner to all Medicaid members, including those with Limited English Proficiency (LEP). The Cultural Competency Plan shall describe how the providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. The MCO shall work with DHHS Office of Minority Heath & Refugee Affairs and the New Hampshire Medical Society to address cultural and linguistic considerations as defined in the section.

18.2. General Provisions

18.2.1. The MCO shall participate in efforts to promote the delivery of services in a culturally and linguistically competent manner to all members and their families, including those with LEP and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)].

18.2.2. The MCO shall develop appropriate methods of communicating and working with its members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

18.2.3. The MCO shall develop appropriate methods for identifying and tracking members' needs for communication assistance for health encounters including preferred spoken language for health encounters, need for interpreter, and preferred language for written health information.

18.2.4. The MCO shall collect data regarding member's race, ethnicity, and spoken language in accordance with the current best practice standards from the Office of Management and Budget and/or the 2011 final standards for data collection as required by Section 4302 of the Affordable Care Act from the federal Department of Health and Human Services.

18.2.5. The MCO shall not use children or minors to provide interpretation services.

18.2.6. If the member declines offered free interpretation services, there must be a process in place for informing the member of the potential consequences of declination with the assistance of a competent interpreter to assure the member's understanding, as well as a process to document the member's declination. Interpreter services must be re-offered at every new contact. Every declination requires new documentation of the offer and decline.

18.2.7. The MCO shall respect members whose lifestyle or customs may differ from those of the majority of members.

18.2.8. The MCO shall ensure interpreter services are available to any member who requests them, regardless of the prevalence of the member's language within the overall program for all health plan and MCO services exclusive of inpatient services. The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e., will provide meaningful access) for all members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and will be based upon the unique needs and circumstances of each individual. Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the provider of the encounter service.

18.2.9. The MCO shall bear the cost of interpretive services, including American Sign Language (ASL) interpreters and translation into Braille materials available to hearing- and vision-impaired members.

18.2.10. The Member Handbook shall include information on the availability of oral and interpretive services.

18.2.11. The MCO shall communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care.

18.2.12. As a condition of receipt of Federal financial assistance, the MCO acknowledges and agrees that it must comply with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin (42 U.S.C. 2000d et seq.).

18.2.13. As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of Limited English Proficiency (LEP). To ensure compliance with Title VI, the MCO must take reasonable steps to ensure that LEP persons have meaningful access to the MCO's programs. The MCO shall provide the following assistance, including, but not limited to:

18.2.13.1. Offer language assistance to individuals who have LEP and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

18.2.13.2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

18.2.13.3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

18.2.13.4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

18.2.14. Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. MCOs are encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. For assistance and information regarding MCO LEP obligations, go to **http://www.lep.gov**.

19. Grievances and Appeals

19.1. General Requirements

19.1.1. The MCO shall develop, implement and maintain a Grievance System under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance and which includes a grievance process, an appeal process, and access to the State's fair hearing system. The MCO shall ensure that the Grievance System is in compliance with 42 CFR 438 Subpart F, and N.H. Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

19.1.2. The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS' review and approval prior to the first readiness review. Any proposed changes to the Grievance System must be approved by DHHS prior to implementation.

19.1.3. The Grievance System shall be responsive to any grievance or appeal of dual- eligible members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accord with this Agreement. In the event the MCO, after review, determines that the dual-eligible member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the member to the State's SHIP program, which is currently administered by Service Link Aging and Disability Resource Center.

19.1.4. The MCO shall be responsible for ensuring that the Grievance System (grievance process, appeal process, and access to the State's fair hearing system) complies with the following general requirements. The MCO must:

19.1.4.1. Give members any reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the member in providing written consent for appeals;

19.1.4.2. Acknowledge receipt of each grievance and appeal (including oral appeals), unless the enrollee or authorized provider requests expedited resolution;

19.1.4.3. Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making;

19.1.4.4. Ensure that decision makers take into account all comments, documents, records, and other information submitted by the enrollee of their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination; and

19.1.4.4.1. If deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the member's condition or disease:

a. An appeal of a denial based on lack of medical necessity;

b. A grievance regarding denial of expedited resolutions of an appeal; or

c. A grievance or appeal that involves clinical issues.

19.1.5. The MCO shall send written notice to members and providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

19.1.6. The MCO shall provide information as specified in 42 CFR § 438.10(g) about the Grievance System to providers and subcontractors at the time they enter into a contact or subcontract. The information shall include, but is not limited to:

19.1.6.1. The member's right (or provider acting on their behalf) to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

19.1.6.2. The member's right to file grievances and appeals and their requirements and timeframes for filing;

19.1.6.3. The availability of assistance with filing;

19.1.6.4. The toll-free numbers to file oral grievances and appeals;

19.1.6.5. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

19.1.6.6. Any State-determined provider appeal rights to challenge the failure of the MCO to cover a service.

19.1.7. The MCO shall make available training to providers in supporting and assisting members in the Grievance System.

19.1.8. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the member, the dates received, the dates of each review, the dates of the grievance or appeal, and the date of resolution.

19.1.9. The MCO shall provide a report of all actions, grievances, and appeals, including all matters handled by delegated entities, to DHHS on a monthly basis.

19.1.10. The MCO shall review Grievance System information as part of the State quality strategy and in accord with this Agreement and 42 CFR 438.402. The MCO shall make such information accessible to the State and available upon request to CMS.

19.1.11. The MCO shall provide any and all provider complaint and appeal logs to DHHS.

19.2. Grievance Process

19.2.1. The MCO shall develop, implement, and maintain a grievance process that establishes the procedure for addressing member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.2.2. The grievance process shall address member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. An enrollee or the enrollee's authorized representative with written consent may file a grievance at any time.

19.2.3. Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated, may file a complaint with the MCO in accordance with He-M 204.

19.2.4. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR part 438, subpart K may file a grievance.

19.2.5. The MCO shall have policies and procedures addressing the grievance process, which comply with the requirements of this Agreement. The MCO shall submit in advance to DHHS for its review and approval, all grievance process policies and procedures and related notices to members regarding the grievance process. Any proposed changes to the grievance process must be approved by DHHS prior to implementation.

19.2.6. The MCO shall allow a member, or the member's authorized representative with the member's written consent to file a grievance with the MCO either orally or in writing [42 CFR 438.402(c)].

19.2.7. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance for one hundred percent (100%) of members filing a grievance. If the enrollee requests disenrollment, then the MCO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment.

19.2.8. The MCO shall notify members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues must be in writing.

19.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

19.3. Appeal Process

19.3.1. The MCO shall develop, implement, and maintain an appeal process that establishes the procedure for addressing member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.3.2. The MCO shall allow a member, or the member's authorized representative, or a provider acting on behalf of the member and with the member's written consent, to request an appeal orally or in writing of any MCO action [42 CFR 438.402(c)].

19.3.3. The MCO shall include as parties to the appeal, the member and the member's authorized representative, or the legal representative of the deceased member's estate.

19.3.4. For appeals of standard service authorization decisions, the MCO shall allow a member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. This shall also apply to a member's request for an expedited appeal. An oral appeal must be followed by a written, signed appeal.

19.3.5. The MCO shall ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the member or the authorized provider requests expedited resolution. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution.

19.3.6. If DHHS receives a request to appeal an action of the MCO, DHHS will forward relevant information to the MCO and the MCO will contact the member and acknowledge receipt of the appeal.

19.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

19.3.8. The MCO shall allow the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO shall inform the member of the limited time available for this in the case of expedited resolution.

19.3.9. The MCO shall provide the member and the member's representative opportunity, to receive the member's case file, including medical records, and any other documents and records considered during the appeal process free of charge prior to the hearing.

19.3.10. The MCO shall resolve one hundred percent (100%) of standard member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. The date of filing shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest. Or, in the case of a provider filing an appeal on behalf of the member, the date of filing shall be considered the date upon which the MCO receives authorization from the member for the provider to file an appeal on the member's behalf.

19.3.11. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the enrollee is deemed to have exhausted the MCO's appeals process, and the enrollee may initiate a state fair hearing.

19.3.12. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR 42 CFR part 438, subpart K may file an appeal.

19.4. Actions

19.4.1. The MCO shall allow for the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

19.4.1.1. Denial or limited authorization of a requested service, including the type or level of service;

19.4.1.2. Reduction, suspension, or termination of a previously authorized service;

19.4.1.3. Denial, in whole or in part, of payment for a service;

19.4.1.4. Failure to provide services in a timely manner, as defined by the State;

19.4.1.5. Untimely service authorizations;

19.4.1.6. Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

19.4.1.7. At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one MCO, the denial of a member's request to obtain services outside the network, in accord with 42 CFR 438.52(b)(2)(ii).

19.5. Expedited Appeal

19.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the member, or a provider request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

19.5.1.1. The MCO must inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals.

19.5.1.2. The MCO shall make a decision on the member's request for expedited appeal and provide notice, as expeditiously as the member's health condition requires, within 72 hours after the MCO receives the appeal. The MCO may extend the 72 hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest. The MCO shall also make reasonable efforts to provide oral notice. The first date shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest.

19.5.1.3. If the MCO extends the timeframes not at the request of the enrollee, it must:

19.5.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.5.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision;

19.5.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.5.1.4. The MCO shall meet the timeframes in 19.5.1.2 for one hundred percent (100%) of requests for expedited appeals.

19.5.1.5. The MCO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

19.5.1.6. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

19.5.1.7. The member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the member of his/her right and the procedures to file a grievance in the notice of denial.

19.6. Content of Notices

19.6.1. The MCO shall notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing.

19.6.2. Each notice of adverse action shall conform with 42 CFR 431.210, contain and explain:

19.6.2.1. The action the MCO or its subcontractor has taken or intends to take;

19.6.2.2. The reasons for the action;

19.6.2.3. The member's or the provider's right to file an appeal;

19.6.2.4. Procedures for exercising member's rights to appeal or grieve;

19.6.2.5. Circumstances under which expedited resolution is available and how to request it; and

19.6.2.6. The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits.

19.6.3. The MCO shall ensure that all notices of adverse action be in writing and must meet the following language and format requirements:

19.6.3.1. Written notice must be translated for the individuals who speak one of the commonly encountered languages spoken in New Hampshire (as defined by the State per 42 CFR 438.10(d));

19.6.3.2. Notice must include language clarifying that oral interpretation is available for all languages and how to access it; and

19.6.3.3. Notices must use easily understood language and format, and must be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All members and potential members must be informed that information is available in alternative formats and how to access those formats.

19.6.4. The MCO shall mail the notice of adverse benefit determination by the date of the action when any of the following occur:

19.6.4.1 The enrollee has died;

19.6.4.2 The enrollee submits a signed written statement requesting service termination;

19.6.4.3 The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction will result;

19.6.4.4 The enrollee has been admitted to an institution where he or she is ineligible under the state plan for further services;

19.6.4.5 The enrollee's address is determined unknown based on returned mail with no forwarding address;

19.6.4.6 The enrollee is accepted for Medicaid services by another state, territory, or commonwealth;

19.6.4.7 A change in the level of medical care is prescribed by the enrollee's physician;

19.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act;

19.6.4.9 The transfer or discharge from a facility will occur in an expedited fashion.

19.7. Timing of Notices

19.7.1. Termination, suspension or reduction of services - The MCO shall provide members written notice at least ten (10) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services, except the period of advance notice shall be five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the member.

19.7.2. Denial of payment - The MCO shall provide members written notice on the date of action when the action is a denial of payment or reimbursement.

19.7.3. Standard service authorization denial or partial denial- The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

19.7.3.1. The member or the provider requests the extension; or

19.7.3.2. The MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.3.3. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

19.7.4. Expedited process - For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

19.7.4.1. The MCO may extend the three (3) business days' time period by up to seven (7) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.5. Untimely service authorizations - The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations.

19.8. Continuation of Benefits

19.8.1. The MCO shall continue the member's benefits if:

19.8.1.1. The appeal is filed timely, meaning on or before the later of the following:

19.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action; or

19.8.1.1.2. The intended effective date of the MCO's proposed action.

19.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

19.8.1.3. The services was ordered by an authorized provider;

19.8.1.4. The authorization period has not expired; and

19.8.1.5. The member requests extension of benefits, orally or in writing.

19.8.2. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

19.8.2.1. The member withdraws the appeal, in writing;

19.8.2.2. The member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision;

19.8.2.3. A State fair hearing decision adverse to the member is made; or

19.8.2.4. The authorization expires or authorization service limits are met.

19.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the member the amount paid for the services provided to the member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

19.9. Resolution of Appeals

19.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within the following timeframes:

19.9.1.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within thirty (30) calendar days after receipt of the appeal, unless the MCO notifies the member that an extension is necessary to complete the appeal.

19.9.1.2. The MCO may extend the timeframes up to fourteen (14) calendar days if:

19.9.1.2.1. The member requests an extension, orally or in writing; or

19.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the member's best interest.

19.9.1.3. If the MCO extends the timeframes not at the request of the enrollee then it must:

19.9.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.9.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

19.9.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.9.1.4. Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request.

19.9.2. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

19.9.3. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting provider or member may obtain the Utilization Management clinical review or decision-making criteria.

19.9.4. For notice of an expedited resolution, the MCO shall make reasonable efforts to provide oral notice.

19.9.5. For appeals not resolved wholly in favor of the member, the notice shall:

19.9.5.1. Include information on the member's right to request a State fair hearing;

19.9.5.2. How to request a State fair hearing;

19.9.5.3. Include information on the member's right to receive services while the hearing is pending and how to make the request; and

19.9.5.4. Inform the member that the member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action.

19.10. State Fair Hearing

19.10.1. The MCO shall inform members and providers regarding the State fair hearing process, including but not limited to, members right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F. The Parties to the State fair hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

19.10.2. The MCO shall ensure that members are informed, at a minimum, of the following:

19.10.2.1. That members must exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

19.10.2.2. That if a member does not agree with the MCO's resolution of the appeal, the member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date on the MCO's notice of the resolution of the appeal.

19.10.3. If the member requests a fair hearing, the MCO shall provide to DHHS and the member, upon request, and within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

19.10.4. The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit. The MCO shall consult with DHHS regarding the State fair hearing process In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate and at no additional cost. In the event the State fair hearing decision is appealed by the member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost. The Office of the Attorney General or designee shall represent the State on an appeal from a fair hearing decision by a member.

19.10.5. DHHS shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

19.11. Effect of Adverse Decisions of Appeals and Hearings

19.11.1. If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

19.11.2. If the MCO or DHHS reverses a decision to deny authorization of services, and the member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services.

19.12. Survival

19.12.1. The obligations of the MCO pursuant to Section 19 to fully resolve all grievances and appeals including, but not limited to, providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

20. Access

20.1. Network

20.1.1. The MCO shall provide documentation to DHHS showing that it is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 20 and 21.

20.1.2. The MCO's network shall have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the geographic standards in Section 20.2, the timely provision of services requirements in Section 20.4, Equal Access, and reasonable choice by members to meet their needs.

20.1.3. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the readiness review for the enrollment of NHHPP members.

20.1.4. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the first readiness review for each phase of Step 2.

20.1.5. The MCO shall submit documentation to DHHS to demonstrate that it offers an appropriate range of preventive, primary care, and specialty services and maintains an adequate network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)]:

20.1.5.1. At the second readiness review prior to the Program start date;

20.1.5.2. Forty-five (45) calendar days following the end of the semi-annual period; and

20.1.5.3. At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to:

20.1.5.3.1. Changes in services, benefits, geographic service area, or payments

20.1.5.3.2. Enrollment of a new population in the MCO [42 CFR 438.207(c)]

20.1.6. The MCO shall submit documentation quarterly to DHHS to demonstrate Equal Access to services for Step 1, 2 and NHHPP populations.

20.1.7. The MCO shall be subject to annual, external independent reviews of the timeliness of, and access to the services covered under this Agreement [42 CFR 438.204].

20.1.8. For Step 1 Implementation, the anticipated number of members in Sections 20.1.1 and 20.1.2 shall be based on the "NH Medicaid Care Management Fifty Percent Population Estimate by Zip code" report provided by DHHS.

20.2. Geographic Distance

20.2.1. The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and Equal Access to its members.

Provider/Service	Statewide
PCPs (adult & pediatric)	Two (2) within forty (40) minutes or fifteen (15) miles
Adult Specialists	One (1) within sixty (60) minutes or forty-five (45) miles
Pediatric Specialists	One within one hundred twenty (120) minutes or eighty (80) miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) miles
Mental Health Providers (adult & pediatric)	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
SUD Councilors (MLDAC) (adult & pediatric)	One (1) within forty-five (45) minutes or fifteen (15) miles
SUD Programs (Comprehensive, Outpatient, Methadone Clinics) (adult & pediatric)	One (1) within sixty (60) minutes or forty-five (45) miles.

20.3. Network Adequacy Exception Process

20.3.1. The MCO may request exceptions from the network adequacy standards [42 CFR 438.68] after demonstrating its efforts to create a sufficient network of providers to meet these standards. DHHS shall grant the MCO an exception where:

20.3.1.1. The MCO demonstrates that an insufficient number of qualified providers or facilities willing to contract with the MCO are available to meet the network adequacy standards in 20.2 and 20.4;

20.3.1.2. The MCO demonstrates to the Department's satisfaction that the MCO's failure to develop a provider network that meets the requirements of 20.2 and 20.4 is due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

20.3.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from an in-network physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist licensed by the NH Board of Medicine. RSA 167:4-d.

20.3.2. At any time the provisions of this section may apply, the MCO will work with DHHS to ensure that members have access to needed services.

20.3.3. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the provider network to ensure that necessary admissions can be made.

20.4. Timely Access to Service Delivery

20.4.1. The MCO shall make services available for members twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR 438.206(c)(1)(iii)].

20.4.2. The MCO shall require that all network providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial, and FFS patients. [42 CFR 438.206(c)(1)(ii)].

20.4.3. The MCO shall encourage its PCPs to offer after-hours office care in the evenings and on weekends.

20.4.4. The MCO's network shall meet the following minimum timely access to service delivery standards [42 CFR 438.206(c)(1)(i)]

20.4.4.1. Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

20.4.4.2. The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

20.4.4.2.1. Transitional healthcare by a provider shall be available from a primary or specialty provider for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

20.4.4.2.2. Transitional home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the member's primary care or specialty care provider or as part of the discharge plan.

20.4.4.2.3. Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

20.4.4.2.4. Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

20.4.4.2.5. Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and don't meet the definition of Emergency Medical Condition.

20.4.4.2.6. Emergency medical, SUD and psychiatric care shall be available twenty-four (24) hours per day, seven (7) days per week.

20.4.4.2.7. Behavioral health care shall be available as follows:

a. care within six (6) hours for a non-life threatening emergency;

b. care within forty-eight (48) hours for urgent care; or

c. an appointment within ten (10) business days for a routine office visit.

20.4.4.2.8. For members receiving Step 2 covered services, transitional care shall be readily available and delivered, after discharge from a nursing facility, inpatient or institutional care, in accordance with the member's discharge plan or as ordered by the member's primary care or specialty care provider. Transfers and discharges shall be done in accordance with RSA 151:21 and RSA 151:26.

20.4.5. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide a semi-annual report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v).

20.4.6. The MCO shall develop a Corrective Action Plan if there is a failure to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

20.4.7. The MCO shall monitor waiting times for appointments at approved community mental health providers and report case details on a semi-annual basis.

20.5. Women's Health

20.5.1. The MCO shall provide female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

20.5.2. The MCO shall provide access to family planning services to members without the need for a referral or prior-authorization. Additionally, members shall be able to access these services by providers whether they are in or out of the MCO's network.

20.5.2.1. Family Planning Services shall include, but not be limited to, the following:

20.5.2.1.1. Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

20.5.2.1.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

20.5.2.1.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

20.5.2.1.4. Referral of members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

20.5.2.1.5. Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and HPV vaccine

20.5.2.2. Enrollment in the MCO shall not restrict the choice of the provider from whom the member may receive family planning services and supplies [42 CFR 431.51(b)(2)].

20.5.2.3. The MCO shall only provide for abortions in the following situations:

20.5.2.3.1. If the pregnancy is the result of an act of rape or incest; or

20.5.2.3.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed [42 CFR 441.202].

20.5.3. The MCO shall not provide abortions as a benefit, regardless or funding, for any reasons other than those identified in this Agreement [42 CFR 441.202].

20.6. Indian Health

20.6.1. The term Indian for purposes of this section shall include those individuals defined in 42 CFR 438.14(a).

20.6.2. The MCO shall allow all members that are an Indian to receive covered services from an out-of-state IHCP regardless of whether it is an out-of-network provider. The MCO shall pay for covered services provided at such IHCPs as if it was an approved out-of-network service pursuant to Section 20.8.

20.6.3. Any out-of-state IHCP that serves an Indian member of the MCO may refer the member to a network provider.

20.6.4. The MCO shall pay any out-of-state IHCP who provides covered services to an Indian pursuant to this section the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's fee for service methodology.

20.6.5. The MCO shall pay any out-of-state IHCP that is also a FQHC the encounter rate as if it was an in-network FQHC. If the encounter rate is less than the published encounter rate in the Federal Register than the State will make a supplemental payment to make up the difference between the amount the MCO entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

20.6.6. The MCO shall make payment to any such IHCP in a timely manner as required under 42 CFR 447.45 and 42 CFR 447.46.

20.7. Access to Special Services

20.7.1. The MCO shall ensure members have access to DHHS-designated Level I and Level II trauma centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.

20.7.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, hospice programs, and licensed long term care facilities with Medicare-certified skilled nursing beds. To the extent that the above specialty services are available within New Hampshire, the plan shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable.

20.7.3. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude New Hampshire providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

20.8. Out-of-Network Providers

20.8.1. If the MCO's network is unable to provide necessary medical, behavioral, and SUD services covered under the Agreement to a particular member, the MCO shall adequately and in a timely manner cover these services for the member through out-of-network sources [42 CFR 438.206(b)(4)]. The MCO shall inform the out-of-network provider that the member cannot be balance billed.

20.8.2. The MCO shall coordinate with out-of-network providers regarding payment. For payment to out-of-network, or non-participating providers, the following requirements apply:

20.8.2.1. If the MCO offers the service through an in-network provider(s), and the member chooses to access non-emergent services from an out-of-network provider, the MCO is not responsible for payment.

20.8.2.2. If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the MCO and the out-of-network provider.

20.8.3. The MCO shall ensure that cost to the member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

20.9. Second Opinion

20.9.1. The MCO shall provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no greater cost to the member than allowed by DHHS [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a second opinion in its Member Handbook.

20.10.Provider Choice

20.10.1.The MCO shall allow each member to choose his or her health professional to the extent possible and appropriate [42 CFR 438.3(l)].

21. Network Management

21.1. Provider Network

21.1.1. The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered medical, behavioral health, SUD, and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

21.1.1.1. Current and anticipated New Hampshire Medicaid enrollment;

21.1.1.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the covered New Hampshire population;

21.1.1.3. The number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services;

21.1.1.4. The number of network providers not accepting new or any New Hampshire Medicaid patients;

21.1.1.5. The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by New Hampshire members;

21.1.1.6. Accessibility of provider practices for members with disabilities [42 CFR 438.206(b)(1)];

21.1.1.7. Adequacy of the primary care network to offer each member a choice of at least two appropriate primary care providers that are accepting new Medicaid patients; and

21.1.1.8. Required access standards identified in this Agreement

21.1.2. In developing its network, the MCO's provider selection policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

21.1.3. The MCO shall not employ or contract with providers excluded from participation in federal health care programs.

21.1.4. The MCO shall not employ or contract with providers who fail to provide Equal Access to services.

21.1.5. The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of all members including those with LEP and those with unique cultural needs.

21.1.6. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory, as specified in Section 17.9 of this Agreement.

21.2. Network Requirements

21.2.1. The MCO shall ensure its providers and subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement.

21.2.2. All providers shall be licensed and or certified in accordance with the laws of the state in which they provide the covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program. All provider types that may obtain a National Provider Identifier (NPI) shall have an NPI in accordance with 45 CFR Part 162, Subpart D.

21.2.3. All providers in the MCO's network are required to be enrolled as New Hampshire Medicaid providers. DHHS may waive this requirement for good cause on a case-by-case basis.

21.2.4. In all contracts with health care professionals, the MCO shall comply with requirements in 42 CFR 438.214, NCQA standards, and RSA 420-J:4, which includes selection and retention of providers, credentialing and re-credentialing requirements, and non-discrimination (42 CFR 438.12(a)(2); 42 CFR 438.214].

21.2.5. The MCO shall not require a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

21.2.6. The MCO's Agreement with health care providers shall be in writing, shall be in compliance with applicable federal and state laws and regulations, and shall include the requirements in this Agreement.

21.2.7. The MCO shall submit all model provider contracts to DHHS for review during the Readiness Review process. The MCO shall resubmit the model provider contracts any time it makes substantive modifications to such Agreements. DHHS retains the right to reject or require changes to any provider Agreement.

21.2.8. The MCO shall negotiate rates with providers in accordance with Section 9 of this Agreement, unless otherwise specified in this Agreement.

21.2.9. The MCO shall reimburse private duty nursing agencies for private duty nursing services provided on or after April 1, 2016 at the fee-for-for service rate established by DHHS. The MCO shall provide the following information to determine if access to private duty nursing services is increasing:

21.2.10. The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

21.2.11. The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

21.2.12. The MCO shall submit model provider contracts related to the implementation of NHHPP to DHHS prior to the beginning of enrollment in NHHPP. The contract will provide for:

21.2.12.1. An in-state provider of services included in Step 1 must provide services to both the MCO's Step 1 and NHHPP members, except for SUD providers and chiropractors; provided, however, that exceptions to this requirement may be made upon a request by the MCO and approved by DHHS for providers that only want to provide coverage for Step 1 Services.

21.2.12.2. The provider shall provide equal availability of services and access to both Step 1 and NHHPP members unless an exception to the requirement in section 21.2.10.1 was approved for the provider and the provider is not required to provide coverage for NHHPP Services.

21.2.12.3. The MCO shall pay the provider for services at a rate not more than nor less than the amounts established according to Section 21.2.10.4.

21.2.12.4. The MCO shall reimburse providers for NHHPP services according to the NHHPP Provider Fee Schedule posted at **https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms** as of August 15, 2017 and incorporated herein. DHHS shall provide the MCO sixty (60) days notice prior to any change to the Schedule. Services falling outside the published NHHPP Provider Fee Schedule shall be paid at a rate determined by the Department and enforced in the sixty (60) calendar day notification period.

21.2.12.5. The MCO shall allow a participating provider thirty (30) days to review contract modifications to an existing contract relating to the implementation of the NHHPP.

21.2.13. The MCO provider Agreement shall require providers in the MCO network to accept the member's Medicaid ID Card as proof of enrollment in the MCO until the member receives his/her MCO ID Card.

21.2.14. The MCO shall maintain a provider relations presence in New Hampshire as approved by DHHS.

21.2.15. The MCO shall prepare and issue Provider Manual(s) upon request to all Network Providers, including any necessary specialty manuals (e.g., behavioral health). For newly contracted and credentialed providers, the MCO shall issue copies of the Provider Manual(s) no later than seven (7) calendar days after inclusion in the network. The provider manual shall be available on the web and updated no less than annually.

21.2.16. The MCO shall provide training to all providers and their staff regarding the requirements of this Agreement including the grievance and appeal system. The MCO's provider training shall be completed within thirty (30) calendar days of entering into a contract with a provider. The MCO shall provide ongoing training to new and existing providers as required by the MCO, or as required by DHHS.

21.2.17. Provider materials shall comply with state and federal laws and DHHS and NHID requirements. The MCO shall submit any Provider Manual(s) and provider training materials to DHHS for review and approval sixty (60) calendar days prior to any substantive revisions. Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

21.2.18. The MCO shall operate a toll-free telephone line for provider inquiries from 8 a.m. to 5 p.m. EST, Monday through Friday, except for State-approved holidays. The provider toll free line shall be staffed with personnel who are knowledgeable about the MCO's plan in New Hampshire. The provider call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

21.2.18.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

21.2.18.2. Average Speed of Answer: Eighty percent (80%) of calls will be answered with live voice within thirty (30) seconds; and

21.2.18.3. Ninety percent (90%) of voicemail messages shall be responded to no later than the next business day.

21.2.19. The MCO shall maintain a Transition Plan providing for continuity of care in the event of Agreement termination, or modification limiting service to members, between the MCO and any of its contracted providers, or in the event of site closing(s) involving a primary care provider with more than one location of service.

The Transition Plan shall describe how members will be identified by the MCO and how continuity of care will be provided.

21.2.20. The MCO shall ensure that after regular business hours the provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a member. The MCO shall have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent medical, behavioral health or LTSS related condition or an emergency medical or behavioral health condition.

21.2.21. The MCO shall notify DHHS and affected current members in writing of a provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. Within three (3) calendar days following the effective date of the termination the MCO shall have a Transition Plan in place for all affected members.

21.2.22. If a member is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the MCO shall notify the member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a Transition Plan for the affected members.

21.2.23. The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the provider network. As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued member access to needed service and how the MCO will maintain compliance with its contractual obligations for member access to needed services. A significant change is defined as:

21.2.23.1. A decrease in the total number of PCPs by more than five percent (5%);

21.2.23.2. A loss of all providers in a specific specialty where another provider in that specialty is not available within sixty (60) minutes or forty-five (45) miles;

21.2.23.3. A loss of a hospital in an area where another contracted hospital of equal service ability is not available within forty-five (45) miles or sixty (60) minutes; or

21.2.23.4. Other adverse changes to the composition of the network, which impair or deny the members' adequate access to in-network providers.

21.2.24. The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its network, the MCO shall give the affected providers written notice of the reason for its decision. [42 CFR 438.12(a)(1) ; 42 CFR 438.214(c); SMD letter 02/20/98)].

21.2.25. The requirements in 42 CFR 438.12 (a) may not be construed to:

21.2.25.1. Require the MCO to contract with providers beyond the number necessary to meet the needs of its member;

21.2.25.2. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

21.2.25.3. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)].

21.3. Screening and Enrollment

21.3.1. No later than January 1, 2018, the MCO shall ensure that all of its network providers are enrolled with DHHS Medicaid.

21.3.2. No later than November 1, 2017, the MCO shall provide to DHHS all identifying information for its enrolled network providers including:

21.3.2.1. Name;

21.3.2.2. Specialty;

21.3.2.3. Date of Birth;

21.3.2.4. Social Security number;

21.3.2.5. National Provider identifier;

21.3.2.6. Federal taxpayer identification number; and

21.3.2.7. State license or certification number of the provider.

21.4. Provider Credentialing and Re-Credentialing

21.4.1. The MCO shall demonstrate to DHHS that its providers are credentialed according to the requirements of 42 CFR 438.206(b)(6), current NCQA standards, Code of Administrative Rules He-M 403, and RSA 420-J:4.

21.4.2. The MCO shall submit to DHHS its credentialing standards relating to the implementation of Choices for Independence waiver services.

21.4.3. The MCO shall have written policies and procedures to review, approve and at least every three (3) years recertify the credentials of all participating physician and all other licensed providers who participate in the MCO's network [42 CFR 438.214(a); 42 CFR 438.214(b) (1&2); RSA 420-J:4]. At a minimum, the scope and structure of a MCO's credentialing and re-credentialing processes shall be consistent NCQA standards and NHID, and relevant state and federal regulations relating to provider credentialing and notice. The MCO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with NCQA delegated credentialing requirements and any comparable requirements defined by DHHS.

21.4.4. The MCO shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: within thirty (30) calendar days for primary care providers; within forty-five (45) calendar days for specialists, SUD providers, chiropractors, Nursing Facilities and CFI service providers. [RSA 420-J:4). The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying the provider of the MCO's decision.

21.4.5. The re-credentialing process shall occur in accordance with NCQA guidelines. The re-credentialing process shall take into consideration provider performance data including, but not be limited to: member complaints and appeals, quality of care, and appropriate utilization of services.

21.4.6. The MCO shall maintain a policy that mandates board certification levels that, at a minimum, meets the ninety (90) percentile rates indicated in NCQA standards (HEDIS Medicaid All Lines of Business National Board Certification Measures as published by NCQA in Quality Compass) for PCPs and specialty physicians in the provider network. The MCO shall make information on the percentage of board-certified PCPs in the provider network and the percentage of board-certified specialty physicians, by specialty, available to DHHS upon request.

21.4.7. The MCO shall provide that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number [42 CFR 493.1 and 42 CFR 493.3].

21.4.8. The MCO shall not employ or contract with providers, business managers, owners or others excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or 42 CFR 1000.

21.4.9. The MCO shall ensure that providers whose Medicare certification is a precondition of participation in the Medicaid program obtain certification within one year of enrollment in MCO's provider network.

21.4.10. The MCO shall notify DHHS when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

21.5. Provider Engagement

21.5.1. The MCO shall, at a minimum, develop and facilitate an active provider advisory board that is composed of a broad spectrum of provider types. Representation on the provider advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. This advisory board shall include representation from CFI service providers. This advisory board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the meetings shall be provided to DHHS within thirty (30) calendar days of the meeting.

21.5.2. The MCO shall conduct a provider satisfaction survey, approved by DHHS and administered by a third party, on a statistically valid sample of each major provider type; PCP, specialists, hospitals, pharmacies, DME and Home Health providers, Nursing Facilities and CFI service providers. DHHS shall have input to the development of the survey. The survey shall be conducted semi-annually the first year after the program start date and at least once an Agreement year thereafter to gain a broader perspective of provider opinions. The results of these surveys shall be made available to DHHS and published on the DHHS website.

21.5.3. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

21.6. Anti-Gag Clause for Providers

21.6.1. The MCO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

21.6.1.1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

21.6.1.2. For any information the member needs in order to decide among all relevant treatment options;

21.6.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

21.6.1.4. For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [§1923(b)(3)(D) of the SSA; 42 CFR 438.102(a)(1)(i), (ii), (iii), and (iv); SMD letter 2/20/98].

21.7. Reporting

21.7.1. Provider Participation Report: Provide provider participation reports on an annual basis by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of member access to health care.

21.7.2. Provider Quality Report Card: Ability to provide dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc.

22. Quality Management

22.1. General Provisions

22.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO shall work in collaboration with members and providers to actively improve the quality of care provided to members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate into the MCO's quality improvement activities.

22.1.2. The MCO shall support and comply with the most current version of the Quality Strategy for the New Hampshire Medicaid Care Management Program.

22.1.3. The MCO shall have an ongoing quality assessment and performance improvement program for the operations and the services it furnishes for members [42 CFR 438.330(b); and SMM 2091.7].

22.1.4. The MCO shall approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and shall:

22.1.4.1. Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

22.1.4.2. Foster data-driven decision-making;

22.1.4.3. Solicit member and provider input on the prioritization and strategies for QAPI activities;

22.1.4.4. Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and member and provider satisfaction;

22.1.4.5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements;

22.1.4.6. Support re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions as appropriate; and

22.1.4.7. The MCO shall undertake a member experience of care survey;

22.1.4.7.1. The MCO shall deploy the CMS Home and Community Based Care Service Experience of Care Survey, Testing Experience and Functional Tools (TEFT) as early as 6 months but not later than 9 months from Step 2 Phase 2 start date, if ready for deployment.

22.1.4.7.2. The MCO shall deploy an in-person patient experience survey (PES) if the CMS Home and Community Based Care Service Experience of Care Survey is not ready for deployment with this same timeframe.

22.1.4.7.3. The MCO shall use a DHHS approved, external vendor and statistically sound methodology to conduct the member experience of care survey.

22.1.5. The MCO shall have mechanisms that detect both underutilization and overutilization of services.

The MCO shall develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the requirements of this Agreement. The MCOs shall also meet the requirements of for the QAPI Program [42 CFR 438.330; SMM 2091.7].

22.1.6. The MCO shall submit a QAPI Program Annual Summary in a format and timeframe specified by DHHS or its designee for its approval. The MCO shall keep participating physicians and other Network Providers informed and engaged in the QAPI Program and related activities. The MCO shall include in provider contracts a requirement securing cooperation with the QAPI.

22.1.7. The MCO shall maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO shall designate a senior executive responsible for the QAPI Program and the Medical Director shall have substantial involvement in QAPI Program activities. At a minimum, the MCO shall ensure that the QAPI Program structure:

22.1.7.1. Is organization-wide, with clear lines of accountability within the organization;

22.1.7.2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;

22.1.7.3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

22.1.7.4. Evaluates the effectiveness of clinical and non-clinical initiatives.

22.1.8. If the MCO sub-contracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO shall maintain detailed files documenting work performed by the sub-contractor. The file shall be available for review by DHHS or its designee upon request.

22.1.9.

22.1.10. The MCO shall integrate behavioral health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services provided to members. The MCO shall collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, and psycho-social outcomes, resulting from the integration and coordination of physical and behavioral health services. The MCO shall conduct any performance improvement projects required by CMS and a minimum of four (4) performance improvement projects, subject to DHHS approval, per year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one (1) of these projects shall have a behavioral health focus. At least one (1) of these projects shall have a home and community based waiver focus. The MCO shall report the status and results of each project to DHHS as requested and shall report on the status results of the CMS performance improvement projects described in 42 CFR 438.330.

22.1.11. The performance improvement projects shall involve the following:

22.1.11.1. Measurement of performance using statistically valid, national recognized objective quality indicators;

22.1.11.2. Implementation of system interventions to achieve improvement in the access to and quality of care;

22.1.11.3. Evaluation of the effectiveness of the interventions based on any performance measures required by CMS as outlined in 42 CFR 438.330(c); and

22.1.11.4. Planning and initiation of activities for increasing or sustaining improvement; and

22.1.11.5. Reporting on the status and results to DHHS on an annual basis.

22.1.12. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

22.1.13. The MCO shall have a plan to assess and report the quality and appropriateness of care furnished to members with special needs in order to identify any ongoing special conditions of a member that require a course of treatment or regular care monitoring The plan must be submitted to DHHS for review and approval. The assessment mechanisms must use appropriate health care professionals.[42 CFR 438.208(c)(2); 42 CFR 438.330].

22.1.14. The MCO's Medical Director and Quality Improvement Director will participate in quarterly Quality Improvement meetings with DHHS and the other MCOs contracted with DHHS to discuss quality related initiatives and how those initiatives could be coordinated across the MCOs.

22.1.15. The MCOs shall be required to be accredited by NCQA, including all applicable Medicaid Standards and Guidelines and the MCOs must authorize NCQA to provide DHHS a copy of its most recent accreditation review, including:

22.1.15.1. Accreditation status, survey type, and level (as applicable);

22.1.15.2. Accreditation results, including recommended actions or improvements, corrective actions plans, and summaries of findings; and

22.1.15.3. Expiration date of the accreditation.

22.2. Practice Guidelines and Standards

22.2.1. The MCO shall adopt evidence-based clinical practice guidelines built upon high quality data and strong evidence. Such practice guidelines shall consider the needs of the MCO's members, be adopted in consultation with Network Providers, and be reviewed and updated periodically, as appropriate.

22.2.2. The MCO shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

22.2.3. The MCO shall make practice guidelines available, including, but not limited to, the web, to all affected providers and, upon request, to members and potential members.

22.2.4. The MCO's decisions regarding utilization management, member education, and coverage of services shall be consistent with the MCO's clinical practice guidelines [42 CFR 438.236(d)].

22.3. External Quality Review Organization

22.3.1. The MCO shall collaborate with DHHS's External Quality Review Organization (EQRO) as outlined in 42 CFR 438.358 to assess the quality of care and services provided to members and to identify opportunities for MCO improvement. To

facilitate this process, the MCO shall supply data, including but not limited to claims data and medical records, to the EQRO.

22.4. Evaluation

22.4.1. The MCO shall prepare a written report within ninety (90) calendar days at the end of each Agreement year on the QAPI that describes:

22.4.1.1. Completed and ongoing Quality management activities, including all delegated functions;

22.4.1.2. Performance trends on QAPI measures to assess performance in quality of care and quality of service;

22.4.1.3. An analysis of whether there have been any demonstrated improvements in the quality of care or service; and

22.4.1.4. An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement

22.4.2. The annual evaluation report shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

22.4.3. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, members, and appropriate MCO staff, as well as posted on the web. The MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

22.5. Quality Measures

22.5.1. MCO shall report annually, according to the then current industry/regulatory standard definitions, the following quality measure sets:

22.5.1.1. CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP;

22.5.1.2. CMS Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid;

22.5.1.3. NCQA Medicaid Accreditation HEDIS/CAHPS Measures, which shall be validated by submission to NCQA; and

22.5.1.4. All available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment; and

22.5.1.5. Any CMS mandated measures outlined in 42 CFR 438.330(c)(1)(i).

22.5.2. If additional measures are added to the NCQA or CMS measure sets, MCO shall include those new measures. For measures that are no longer part of the measures sets, DHHS may at its option continue to require those measures.

22.5.3. In addition MCO shall submit other quality measures as specified by DHHS in Exhibit O in a format to be specified by DHHS.

22.5.4. DHHS shall provide the MCO with ninety (90) calendar days notice of any additions or modifications to the quality measures as specified by DHHS in Exhibit O.

22.5.5. Each Data Year as defined by NCQA HEDIS specifications, or other twelve (12) month period determined by DHHS, at DHHS discretion, DHHS may select four (4) measures to be included in the Quality Incentive Program (QIP). DHHS shall notify the MCO of the four (4) measures to be included in the QIP no later than three (3) months prior to the start of the period for which data will be collected to evaluate the program.

22.5.6. For each measure selected by DHHS for the QIP, DHHS will monitor MCO performance to determine baseline measures and levels of improvement.

22.5.7. Should DHHS choose QIPs and implement withholds for QIP performance, in the event of changes to the Medicaid Care Management program or material circumstances beyond DHHS or the MCOs' control, which DHHS determines would unduly limit all MCOs' ability to reasonably perform and achieve the withhold return threshold, DHHS will evaluate the impact of the circumstances and make such changes as required, at the discretion of DHHS.

22.5.8. At such time DHHS provides access to Medicare data sets to the MCOs, the MCO shall integrate expanded Medicare data sets into its Care Coordination and Quality Programs and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual members. The MCO shall:

22.5.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from care coordination of the dual members;

22.5.8.2. Include Medicare data in DHHS quality reporting; and

22.5.8.3. Sign data use agreements and submit data management plans as required by CMS.

23. Utilization Management

23.1. Policies & Procedures

23.1.1. The MCO's policies and procedures related to the authorization of services shall be in compliance with 42 CFR 438.210 and NH RSA Chapter 420-E:2.

23.1.2. The MCO shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services [42 CFR 438.210(b)(1)].

23.1.3. The MCO shall submit its written utilization management policies, procedures, and criteria to DHHS for approval as part of the first readiness review. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.4. The MCO shall submit its written utilization management policies, procedures, and criteria specific to each phase of Step 2 Phase I to DHHS for approval as part of the first readiness review. Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs and a subsequent person-centered planning process. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.5. The MCO's written utilization management policies, procedures, and criteria shall, at a minimum, conform to the standards of NCQA.

23.1.6. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)].

23.1.7. The MCO's written utilization management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Further such policies, procedures and criteria shall address, at a minimum, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information.

23.1.8. The MCO's written utilization management policies, procedures, and criteria shall be:

23.1.8.1. Developed with input from appropriate actively practicing practitioners in the MCO's service area;

23.1.8.2. Updated at least biennially and as new treatments, applications, and technologies emerge;

23.1.8.3. Developed in accordance with the standards of national accreditation entities;

23.1.8.4. Based on current, nationally accepted standards of medical practice;

23.1.8.5. If practicable, evidence-based; and

23.1.8.6. Be made available upon request to DHHS, providers and members.

23.1.9. The MCOs shall work in good faith with DHHS develop prior authorization forms with consistent information and documentation requirements from providers wherever feasible. Providers shall be able to submit the prior authorizations forms electronically, by mail, or fax. The MCOs shall submit a proposed plan for the development of common prior authorization processes within ninety (90) calendar days of the NHHPP Program Start Date.

23.1.10. The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including, but not limited to, interrater reliability monitoring, and consult with the requesting provider when appropriate and at the request of the provider submitting the authorization [42 CFR 438.210(b)(2)].

23.1.11. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)(3)].

23.1.12. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member [42 CFR 438.210(e)].

23.1.13. Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

23.1.14. The MCOs shall follow the transition of care policy developed by DHHS, which is consistent with 42 CFR 438.62.

23.1.15. When a member receiving State Plan Home Health Services and Step 1 services chooses to change to another MCO, the new MCO shall be responsible for the member's claims as of the effective date of the member's enrollment in the new MCO except as specified in Section 31.2.17. Upon receipt of prior authorization information from DHHS, the new MCO shall honor prior authorizations in place by the former MCO for fifteen (15) calendar days or until the expiration of previously issued prior authorizations, whichever comes first. The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 23.4.2.1.

23.1.16. Prior authorizations in place for long term services and supports at the time a member transitions to an MCO will be honored until the earliest of (a) the authorization's expiration date, (b) the member's needs changes, (c) the provider loses its Medicaid status or (d) otherwise approved by DHHS. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO. In the event that the prior authorization specifies a specific provider, that MCO will continue to utilize that provider regardless of whether the provider is participating in the MCO network until such time as services are available in the MCO's network. The MCO will ensure that the member's needs are met continuously and will continue to cover services under the previously issued prior authorization until the MCO issues new authorizations that address the member's needs.

23.1.17. Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire.

23.2. Medical Necessity Determination

23.2.1. The MCO shall specify what constitutes "medically necessary services" in a manner that:

23.2.1.1. Is no more restrictive than the State Medicaid program; and

23.2.1.2. Addresses the extent to which the MCO is responsible for covering services related to the following [42 CFR 438.210(a)]:

23.2.1.2.1. The prevention, diagnosis, and treatment of health impairments;

23.2.1.2.2. The ability to achieve age-appropriate growth and development; and

23.2.1.2.3. The ability to attain, maintain, or regain functional capacity.

23.2.2. For members twenty-one (21) years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are [He-W 530.01(f)]:

23.2.2.1. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

23.2.2.2. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

23.2.2.3. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

23.2.2.4. Not experimental, investigative, cosmetic, or duplicative in nature.

23.2.3. For EPSDT services the following definition of medical necessity shall be used: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service He-W546.01(f).

23.2.4. The MCO must provide the criteria for medical necessity determinations for mental health or substance use disorder benefits to any enrollee, potential enrollee, or contracting provider upon request.

23.3. Necessity Determination

23.3.1. For long term services and supports the following definition of necessity shall be used: "Necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term services and supports within the limits of current waivers, statutes, administrative rules, and/or Medicaid State Plan amendments.

23.4. Notices of Coverage Determinations

23.4.1. The MCO shall provide the requesting provider and the member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

23.4.2. The MCO shall make utilization management decisions in a timely manner. The following minimum standards shall apply:

23.4.2.1. Urgent determinations: The determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for ninety-eight percent (98%) of requests, unless the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the MCO shall notify the member or member's representative within twenty-four (24) hours of receipt of the request and shall advise the member or member's representative of the specific information necessary to make a determination. The member or member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information.

23.4.2.2. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

23.4.2.3. Routine determinations: The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but in no event exceed the following timeframes for ninety-five percent (95%) of requests:

23.4.2.3.1. Fourteen (14) calendar days after the receipt of a request:

a. An extension of up to fourteen (14) calendar days is permissible if:

i. the member or the provider requests the extension; or

ii. the MCO justifies a need for additional information and that the extension is in the member's interest;

23.4.2.3.2. Two (2) calendar days for diagnostic radiology.

23.4.2.4. The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

23.4.2.5. The member or the provider requests the extension; or

23.4.2.6. The MCO justifies a need for additional information and how the extension is in the member's interest.

23.4.2.7. If such an extension is necessary due to a failure of the member or member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the member or member's representative shall be given at least forty- five (45) calendar days from receipt of the notice within which to provide the specified information. Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

23.4.2.8. Determination for Services that have been delivered: The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the member fails to provide sufficient information to determine the request, the MCO shall notify the member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the member shall be given at least forty-five (45) calendar days to provide the required information. The thirty (30) calendar day period for determination shall be tolled until such time as the member submits the required information.

23.4.3. Whenever there is an adverse determination, the MCO shall notify the ordering provider and the member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

23.5. Advance Directives

23.5.1. The MCO shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489.

23.5.2. The MCO shall adhere to the definition of advance directives as defined in 42 CFR 489.100.

23.5.3. The MCO shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCO [42 CFR 422.128].

23.5.4. The MCO shall not condition the provision of care or otherwise discriminate against an enrollee or potential enrollee based on whether or not the individual has executed an advance directive.

23.5.5. The MCO shall provide information in the member handbook with respect to the following:

23.5.5.1. The member's rights under the state law. The information provided by the MCO shall reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change [42 CFR 438.3(j)(3) and (4)].

23.5.5.2. The MCO's policies respecting the implementation of those rights including a statement of any limitation regarding the implementation of advance directives as a matter of conscience

23.5.5.3. That complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State Agency [42 CFR 438.3(;)(1); 42 CFR 438.10(g)(2); 42 CFR 422.128; 42 CFR 489 (subpart I); 42 CFR 489.100].

24. MCIS

24.1. System Functionality

24.1.1. The MCO Managed Care Information System (MCIS) shall include, but not be limited to:

24.1.1.1. Management of Recipient Demographic Eligibility and Enrollment and History

24.1.1.2. Management of Provider Enrollment and Credentialing

24.1.1.3. Benefit Plan Coverage Management, History and Reporting

24.1.1.4. Eligibility Verification

24.1.1.5. Encounter Data

24.1.1.6. Weekly Reference File Updates

24.1.1.7. Service Authorization Tracking, Support and Management

24.1.1.8. Third Party Coverage and Cost Avoidance Management

24.1.1.9. Financial Transactions Management and Reporting

24.1.1.10. Payment Management (Checks, EFT, Remittance Advices, Banking)

24.1.1.11. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)

24.1.1.12. Call Center Management

24.1.1.13. Claims Adjudication

24.1.1.14. Claims Payments

24.1.1.15. Quality of Services (QOS) metrics

24.2. Information System Data Transfer

24.2.1. Effective communication between the MCO and DHHS will require secure, accurate, complete and auditable transfer of data to/from the MCO and DHHS management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

24.2.1.1. DHHS read access to all NH Medicaid Care Management data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

24.2.1.2. Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

24.2.1.3. Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state.

24.2.1.4. Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

24.2.1.5. MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

24.2.1.6. Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and provide for source to target or source to specification mappings;

24.2.1.7. Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

24.2.1.8. A given day's data transmissions, as specified in 24.5.9, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions will be included in the next batch transmission.

24.2.2. The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

24.2.3. The State shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.

24.3. Ownership and Access to Systems and Data

24.3.1. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data will be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

24.4. Records Retention

24.4.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than seven (7) years from the date of termination of this Agreement. Records involving matters that are the subject of litigation shall be retained for a period of not less than seven (7) years following the termination of litigation. Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

24.4.2. Upon expiration of the seven (7) year retention period and upon request, the subject records must be transferred to DHHS' possession. No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

24.5. MCIS Requirements

24.5.1. The MCO shall have a comprehensive, automated, and integrated Managed Care Information System (MCIS) that is capable of meeting the requirements listed below and throughout this Agreement and for providing all of the data and information necessary for DHHS to meet federal Medicaid reporting and information regulations.

24.5.2. All subcontractors shall meet the same standards, as described in this Section 24, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a subcontractor with respect to its provided functions.

24.5.3. Specific functionality related to the above shall include, but is not limited to, the following :

24.5.3.1. The MCIS membership management system must have the capability to receive, update, and maintain New Hampshire's membership files consistent with information provided by DHHS.

24.5.3.2. The MCIS shall have the capability to provide daily updates of membership information to sub-contractors or providers with responsibility for processing claims or authorizing services based on membership information.

24.5.3.3. The MCIS' provider file must be maintained with detailed information on each provider sufficient to support provider enrollment and payment and also meet DHHS' reporting and encounter data requirements.

24.5.3.4. The MCIS' claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system.

24.5.3.5. The MCIS' Services Authorization system shall be integrated with the claims processing system.

24.5.3.6. The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements.

24.5.3.7. The MCIS' credentialing system shall have the capability to store and report on provider specific data sufficient to meet the provider credentialing requirements, Quality Management, and Utilization Management Program Requirements.

24.5.3.8. The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in member, provider, claims and authorization files, and in order to enable encounter data to be utilized for member profiling, provider profiling, claims validation, fraud, waste and abuse monitoring activities, and any other research and reporting purposes defined by DHHS.

24.5.3.9. The encounter data system shall have a mechanism in place to receive, process, and store the required data.

24.5.3.10. The MCO system shall be compliant with the requirements of HIPAA, including privacy, security, National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format. This also includes IRS Pub 1075 where applicable.

24.5.4. MCIS capability shall include, but not be limited to the following:

24.5.4.1. Provider network connectivity to Electronic Data Interchange (EDI) and provider portal systems;

24.5.4.2. Documented scheduled down time and maintenance windows as agreed upon with DHHS for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

24.5.4.3. DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes, and procedures (approved by the State) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

24.5.4.4. DHHS access to user acceptance test environment for externally accessible systems including websites and secure portals;

24.5.4.5. Documented instructions and user manuals for each component; and

24.5.4.6. Secure access.

24.5.5. MCIS Up-time

24.5.5.1. Externally accessible systems, including telephony, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours per day, seven (7) days per week, three-hundred-sixty-five (365) days per year, except for scheduled maintenance upon notification of and pre-approval by DHHS. Maintenance period cannot exceed four (4) consecutive hours without prior DHHS approval.

24.5.5.2. MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions will result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

24.5.6. Systems operations and support shall include, but not be limited to the following:

24.5.6.1. On-call procedures and contacts

24.5.6.2. Job scheduling and failure notification documentation

24.5.6.3. Secure (encrypted) data transmission and storage methodology

24.5.6.4. Interface acknowledgements and error reporting

24.5.6.5. Technical issue escalation procedures

24.5.6.6. Business and member notification

24.5.6.7. Change control management

24.5.6.8. Assistance with User Acceptance Testing (UAT) and implementation coordination

24.5.6.9. Documented data interface specifications – data imported and extracts exported including database mapping specifications.

24.5.6.10. Disaster Recovery and Business Continuity Plan

24.5.6.11. Journaling and internal backup procedures. Facility for storage MUST be class 3 compliant.

24.5.6.12. Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

24.5.7. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

24.5.7.1. Network diagram that fully defines the topology of the MCO's network.

24.5.7.2. State/MCO connectivity

24.5.7.3. Any MCO/subcontractor locations requiring MCIS access/support

24.5.7.4. Web access for DHHS staff, providers and recipients

24.5.8. Data transmissions from DHHS to the MCO will include, but not be limited to the following:

24.5.8.1. Provider Extract (Daily)

24.5.8.2. Recipient Eligibility Extract (Daily)

24.5.8.3. Recipient Eligibility Audit/Roster (Monthly)

24.5.8.4. Medical and Pharmacy Service Authorizations (Daily)

24.5.8.5. Commercial and Medical Third Party Coverage (Daily)

24.5.8.6. Claims History (Bi-Weekly)

24.5.8.7. Capitation payment data

24.5.9. Data transmissions from the MCO to DHHS shall include but not be limited to:

24.5.9.1. Member Demographic changes (Daily)

24.5.9.2. MCO Provider Network Data (Daily)

24.5.9.3. Medical and Pharmacy Service Authorizations (Daily)

24.5.9.4. Beneficiary Encounter Data including paid, denied, adjustment transactions by pay period (Weekly)

24.5.9.5. Financial Transaction Data

24.5.9.6. Updates to Third Party Coverage Data (Weekly)

24.5.9.7. Behavioral Health Certification Data (Monthly)

24.5.10.The MCO shall provide DHHS staff with access to timely and complete data:

24.5.10.1. All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS.

24.5.10.2. The MCO shall work collaboratively with DHHS, DHHS' MMIS fiscal agent, the New Hampshire Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement.

24.5.10.3. The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/subcontractor locations supporting the New Hampshire program.

24.5.10.4. The MCO shall utilize data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

24.5.10.5. The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including encounter data

24.5.10.6. The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this document (24.2.1.8).

24.5.10.7. Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable state and federal law.

24.5.10.8. Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

24.5.11.The MCIS shall include web access for use by and support to enrolled providers and members. The services shall be provided at no cost to the provider or members. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

24.5.11.1. The MCO shall create secure web access for Medicaid providers and members and authorized DHHS staff to access case-specific information.

24.5.11.2. The MCO shall manage provider and member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist providers and members with gaining access and utilizing the web portal.

24.5.11.3. Providers will have the ability to electronically submit service authorization requests and access and utilize other utilization management tools.

24.5.11.4. Providers and members shall have the ability to download and print any needed Medicaid MCO program forms and other information.

24.5.11.5. Providers shall have an option to e-prescribe as an option without electronic medical records or hand held devices.

24.5.11.6. MCO shall support provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es).

24.5.11.7. Providers shall have access to drug information.

24.5.11.8. The website shall provide an e-mail link to the MCO to allow providers and members or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website.

24.5.11.9. The website shall be secure and HIPAA compliant in order to ensure the protection of Protected Health Information and Medicaid recipient confidentiality. Access shall be limited to verified users via passwords and any other available industry standards. Audit logs must be maintained reflecting access to the system and random audits will be conducted.

24.5.11.10.The MCO shall have this system available no later than the Program Start Date.

24.5.11.11.Support Performance Standards shall include:

24.5.11.11.1.Email inquiries – one (1) business day response

24.5.11.11.2.New information posted within one (1) business day of receipt

24.5.11.11.3.Routine maintenance

24.5.11.11.4.Standard reports regarding portal usage such as hits per month by providers/members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports.

24.5.11.11.5.Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO must redirect user to site to install appropriate browser.

24.5.12.Critical systems within the MCIS support the delivery of critical medical services to members and reimbursement to providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

24.5.12.1. The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to New Hampshire within twenty-four (24) hours of incident onset.

24.5.12.2. The MCO shall ensure that the New Hampshire PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements as defined in Section 24.5.13.

24.5.12.3. The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction. Archiving processes shall not modify the data composition of DHHS' records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

24.5.12.4. The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between providers, provider billing agents/clearing houses, or DHHS and the MCO. Audit logs of activities will be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

24.5.12.5. Thirty (30) calendar days prior to the beginning of each State Fiscal Year, the MCO shall submit the following documents and corresponding checklists for DHHS' review and approval:

24.5.12.5.1.Disaster Recovery Plan

24.5.12.5.2.Business Continuity Plan

24.5.12.5.3.Security Plan

24.5.12.5.4. The MCO shall provide the following documents. If after the original documents are submitted the MCO modifies any of them, the revised documents and corresponding checklists shall be submitted to DHHS for review and approval:

a. Risk Management Plan

b. Systems Quality Assurance Plan

c. Confirmation of 5010 compliance and Companion Guides

d. Confirmation of compliance with IRS Publication 1075

e. Approach to implementation of ICD-10 and ultimate compliance

24.5.13. Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements shall be part of the change management process:

24.5.13.1. The complete system shall have proper configuration management/change management in place (to be reviewed and approved by DHHS). The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

24.5.13.2. The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent. DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

24.5.13.3. The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day. The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

24.5.13.4. A New Hampshire program centralized electronic repository shall be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

retrievable for review and or reporting by DHHS in the timeframe set forth by DHHS.

24.5.16. The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute ad-hoc queries to support DHHS data and information needs. DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

24.5.17. Quality of Service (QOS) Metrics:

24.5.17.1. System Integrity: The system shall ensure that both user and provider portal design, and implementation is in accordance with Federal, standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

24.5.17.2. The security of the care management processing system must minimally provide the following three types of controls to maintain data integrity that directly impacts QOS . These controls shall be in place at all appropriate points of processing:

24.5.17.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

24.5.17.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

24.5.17.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

24.5.17.2.4. System Administration: Ability to comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with Agreement terms and conditions. Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions at no additional cost.

24.5.13.5. The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any member.

24.5.13.6. The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

24.5.14. DHHS, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

24.5.14.1. The System Readiness Review may include a desk review and/or an onsite review.

24.5.14.2. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

24.5.14.3. If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency.

24.5.15. Systems enhancements developed specifically, and data accumulated, as part of the New Hampshire Care Management program remain the property of the State of New Hampshire.

24.5.15.1. Source code developed for this program shall remain the property of the vendor but will be held in escrow.

24.5.15.2. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

24.5.15.3. The MCO shall not destroy or purge DHHS' data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be

25. Data Reporting

25.1. General Provisions

25.1.1. The MCO shall make all collected data available to DHHS upon request and upon the request of CMS [42 CFR 438.242(b)(4)].

25.1.2. The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility [42 CFR 438.242(a)].

25.1.3. The MCO shall collect data on member and provider characteristics as specified by DHHS and on services furnished to members through a MCIS system or other methods as may be specified by DHHS [42 CFR 438.242(b)(2)].

25.1.4. The MCO shall ensure that data received from providers are accurate and complete by:

25.1.4.1. Verifying the accuracy and timeliness of reported data;

25.1.4.2. Screening the data for completeness, logic, and consistency; and

25.1.4.3. Collecting service information in standardized formats to the extent feasible and appropriate [42 CFR 438.242(b)(3)].

25.2. Encounter Data

25.2.1. The MCO shall submit encounter data in the format and content, timeliness, completeness, and accuracy as specified by the DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS.

25.2.2. All encounter data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

25.2.2.1. The MCO shall provide support to DHHS to substantiate the validity, integrity and reconciliation of DHHS reports that utilize the MCO encounter data.

25.2.3. Submission of encounter data to DHHS does not eliminate the MCO's responsibility under state statute to submit member and claims data to the Comprehensive Healthcare Information System [NH RSA 420-G:1,1 II. (a)]

25.2.4. The MCO shall ensure that encounter records are consistent with the DHHS requirements and all applicable state and federal laws.

25.2.5. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

25.2.6. The MCO shall use appropriate member identifiers as defined by DHHS.

25.2.7. The MCO shall maintain a record of both servicing and billing information in its encounter records.

25.2.8. The MCO shall also use appropriate provider identifiers for encounter records as directed by DHHS.

25.2.9. The MCO shall have a computer and data processing system sufficient to accurately produce the data, reports, and encounter record set in formats and timelines prescribed by DHHS as defined in this Agreement.

25.2.10. The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

25.2.11. The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS. The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

25.2.12. The MCO's systems that are required to use or otherwise contain the applicable data type shall conform with current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards:

25.2.12.1. Health Care Common Procedure Coding System (HCPCS)

25.2.12.2. CPT codes

25.2.12.3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the U.S. Department of Health and Human Services (HHS).

25.2.12.4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

25.2.12.5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.

25.2.12.6. National Drug Codes (NDC): The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

25.2.12.7. Code on Dental Procedures and Nomenclature (CDT): The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

25.2.12.8. Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains point of service (POS) codes used throughout the health care industry.

25.2.12.9. Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

25.2.12.10. Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the Medicaid Management Information System (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

25.2.13. All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format.

25.2.14. All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and as applicable the Medicare paid amount, other insurance paid amount and expected member co-payment amount.

25.2.15. The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

25.2.16.The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

25.2.17.The MCO shall collect, and submit to the State's fiscal agent, member service level encounter data for all covered services. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

25.2.18.The MCO shall conform to all current and future HIPAA-compliant standards for information exchange. Batch and Online Transaction Types are as follows:

25.2.18.1. Batch transaction types

25.2.18.1.1.ASC X12N 820 Premium Payment Transaction

25.2.18.1.2.ASC X12N 834 Enrollment and Audit Transaction

25.2.18.1.3.ASC X12N 835 Claims Payment Remittance Advice Transaction

25.2.18.1.4.ASC X12N 837I Institutional Claim/Encounter Transaction

25.2.18.1.5.ASC X12N 837P Professional Claim/Encounter Transaction

25.2.18.1.6.ASC X12N 837D Dental Claim/Encounter Transaction

25.2.18.1.7.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.18.2. Online transaction types

25.2.18.2.1.ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

25.2.18.2.2.ASC X12N 276 Claims Status Inquiry

25.2.18.2.3.ASC X12N 277 Claims Status Response

25.2.18.2.4.ASC X12N 278/279 Utilization Review Inquiry/Response

25.2.18.2.5.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.19.Submitted encounter data shall include all elements specified by DHHS including, but not limited to, those specified in Exhibit N and detailed in the Medicaid Encounter Submission Guidelines.

25.2.20.The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims. Any exceptions will be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception. The MCO shall also use the provider identifiers as directed by DHHS for both Encounter and fee-for-service claims submissions, as applicable.

25.2.21. The MCO shall provide as a supplement to the encounter data submission a member file, which shall contain appropriate member identification numbers, the primary care provider assignment of each member, and the group affiliation of the primary care provider.

25.2.22. The MCO shall submit complete encounter data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

25.2.23. The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

25.2.24. The MCO shall provide complete and accurate encounters to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards:

25.2.24.1. Completeness

25.2.24.1.1. The MCO shall submit encounters that represent at least ninety-nine percent (99%) of the covered services provided by the MCO's network and non-network providers. All data submitted by the providers to the MCO shall be included in the encounter submissions.

25.2.24.2. Accuracy

25.2.24.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits.

25.2.24.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

25.2.24.2.3. One-hundred percent (100%) of member identification numbers shall be accurate and valid.

25.2.24.2.4. Ninety-eight percent (98%) of servicing provider information will be accurate and valid.

25.2.24.2.5. Ninety-eight percent (98%) of member address information shall be accurate and valid.

25.2.24.3. Timeliness

25.2.24.3.1. Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment. All encounters shall be submitted, both paid and denied claims. The paid claims shall include the MCO paid amount.

25.2.24.3.2. The MCO shall be subject to remedies as specified in Section 34 for failure to timely submit encounter data, in accordance with the accuracy standards established in this Agreement.

25.2.24.4. Error Resolution

25.2.24.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice. For all ongoing claim encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fifteen (15) calendar days after such notice. If the MCO fails to do so, DHHS will require a Corrective Action Plan and assess liquidated damages as described in Section 34. MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

25.2.24.4.2. All sub-contracts with providers or other vendors of service shall have provisions requiring that encounter records are reported or submitted in an accurate and timely fashion.

25.2.24.5. Survival

25.2.24.5.1. All encounter data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

25.3. Data Certification

25.3.1. All data submitted to DHHS by the MCO shall be certified by one of the following:

25.3.1.1. The MCO's Chief Executive Officer;

25.3.1.2. The MCO's Chief Financial Officer; or

25.3.1.3. An individual who has delegated authority to sign for, and who reports directly to, the MCO's Chief Executive Officer or Chief Financial Officer.

25.3.2. The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, encounter data, and other information contained in contracts, proposals. The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data. The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

25.4. Data System Support for QAPI

25.4.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI requirements described in Section 21. The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of MCO providers, member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

26. Fraud Waste and Abuse

26.1. Program Integrity Plan

26.1.1. The MCO shall have a Program Integrity Plan in place that has been approved by DHHS and that shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse. The MCO is expected to be familiar with, comply with, and require compliance with, all state and federal regulations related to Medicaid Program Integrity, whether or not those regulations are listed herein, and as required in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008, and Section 1902(a)(68) of the Social Security Act.

26.1.1.1. The MCO shall retain all data, information, and documentation described in 42 CFR 438.604, 438.606, 438.608, and 438.610 for period no less than ten (10) years.

26.1.1.2. Fraud, waste and abuse investigations are targeted reviews of a provider or member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services. Cases which would be considered investigations are as follows, but not limited to:

26.1.1.2.1. review of instances which may range from outliers identified through data mining;

26.1.1.2.2. pervasive or persistent findings of routine audits to specific allegations that involve or appear to involve intentional misrepresentation in an effort to receive an improper payment;

26.1.1.2.3. notification of potential fraud, waste, and abuse through member verification of services, or complaint filed; and.

26.1.1.2.4. any reviews as defined by CMS as fraud, waste, and abuse investigation.

26.1.1.3. Routine claims audits are random reviews conducted for the purpose of verifying provider compliance with contractual requirements including, but not limited to, quality standards, reimbursement guidelines, and/or medical policies.

26.2. Fraud, Waste and Abuse Prevention Procedures

26.2.1. The MCO shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud, waste and abuse. The MCO procedures shall include, at a minimum, the following:

26.2.1.1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;

26.2.1.2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

26.2.1.3. Effective training and education for the compliance officer and the MCO's employees;

26.2.1.4. Effective lines of communication between the compliance officer and the MCO's employees;

26.2.1.5. Enforcement of standards through well-publicized disciplinary guidelines;

26.2.1.6. Provisions for internal monitoring and auditing;

26.2.1.7. Provisions for the MCO's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23; and

26.2.1.8. Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's Agreement [42 CFR 438.608(a) and (b)]

26.2.2. The MCO shall establish a Program Integrity Unit within the MCO comprised of:

26.2.2.1. Experienced Fraud, Waste and Abuse reviewers who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein; and

26.2.2.2. An experienced Fraud, Waste, and Abuse Coordinator who is qualified by having appropriate background, training, education, and experience in health care provider fraud, waste and abuse.

26.2.3. .This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud, Waste and Abuse that may be committed by providers that are paid by the MCO and/or their subcontractors. The MCO Program Integrity Plan shall also include the prevention, detection, investigation and reporting of suspected fraud by the MCO, the MCO's employees, subcontractors, subcontractor's employees, or any other third parties with whom the MCO contracts. The MCO shall refer all suspected provider fraud to the DHHS Program Integrity Unit upon discovery. The MCO shall refer all suspected member fraud to DHHS Special Investigations Unit.

26.3. Reporting

26.3.1. The MCO shall promptly report provider fraud, waste and abuse information to DHHS' Program Integrity Unit, which is responsible for such reporting to federal oversight agencies pursuant to [42 CFR 455.1(a)(1) and 42 CFR438.608].

26.3.1.1. The MCO shall perform a preliminary investigation of all incidents of suspected fraud, waste and abuse internally. The MCO shall not take any of the following actions as they specifically relate to claims involved with the investigation unless prior written approval is obtained from DHHS' Program Integrity Unit, utilizing the MCO Request to Open Investigation form:

26.3.1.1.1. Contact the subject of the investigation about any matters related to the investigation, either in person, verbally or in writing, hardcopy, or electronic;

26.3.1.1.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

26.3.1.1.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

26.3.2. The MCO shall promptly report to DHHS' Division of Client Services all information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including but not limited to:

26.3.2.1. Changes in the enrollee's residence; and

26.3.2.2. Death of an enrollee.

26.3.3. The MCO shall promptly report to DHHS' Office of Medicaid Services and the Program Integrity Unit all changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

26.3.4. The MCO shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (five (5) percent or greater) in the MCO, or any sub-contractor in which the MCO has a five percent (5%) or greater ownership interest [42 CFR 438.608(c)(2)].

26.3.5. [Intentionally left blank.]

26.3.6. The MCO shall provide written disclosure of any prohibited affiliation under §438.610 and as described in subparagraph 4.3.2 of this Agreement [42 CFR 438.608(c)(1)].The MCO shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State.

26.3.7. As an integral part of the Program Integrity function, and in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438, the MCO shall provide DHHS or its designee real time access to all of the MCO electronic encounter and claims data from the MCO's current claims reporting system. The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in section 24.5.16.

26.3.7.1. MCOs shall provide any additional data access upon written request from DHHS for any potential fraud, waste, or abuse investigation or for MCO oversight review. The additional access shall be provider within 3 business days of the request.

26.3.8. The MCO shall make claims and encounter data available to DHHS (and other State staff) using a reporting system that is compatible with DHHS' system(s).

26.3.9. The MCO, their subcontractors, their contracted providers, their subcontractor's providers, and any subcontractor's subcontractor's providers shall cooperate fully with Federal and State agencies and contractors in any program integrity related investigations and subsequent legal actions. The MCO, their subcontractors and their contracted providers, subcontractor's providers, and any subcontractor's subcontractor's providers shall, upon written request and as required by this Agreement or state and/or federal law, make available any and all administrative, financial and medical records relating to the delivery of items or services for which MCO monies are expended. In addition, and as required by this Agreement or state and/or federal law, such agencies shall, also be allowed access to the place of business and to all MCO records of any contractor, their subcontractor or their contracted provider, subcontractor's providers, and any subcontractor's subcontractor's providers.

26.3.9.1. The MCO is responsible for program integrity oversight of its subcontractors. In accordance with federal regulations, CMS requires MCO contracts to contain provisions giving states' Program Integrity Units audit and access authority over MCOs and their subcontractors to include direct on site access to ordinal policies and procedures, claims processing, and provider credentialing for validation purposes at the expense of the MCO.

26.3.10. The MCO shall have a written process approved by DHHS for Recipient Explanation of Medicaid Benefits, which shall include tracking of actions taken on responses, as a means of determining and verifying that services billed by providers were actually provided to members. The MCO shall provide DHHS with a quarterly EOB activity report, including, but not limited to, tracking of all responses received, action taken by the MCO, and the outcome of the activity. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the MCO.

26.3.11. The MCO shall maintain an effective fraud, waste and abuse-related provider overpayment identification, recovery and tracking process. This process shall include

a methodology for a means of estimating overpayment, a formal process for documenting communication with providers, and a system for managing and tracking of investigation findings, recoveries, and underpayments related to fraud, waste and abuse investigations. DHHS and the AG Medicaid Fraud Unit shall have unrestricted access to information and documentation related to the NH Medicaid program for use during annual MCO Program Integrity audits and on other occasions as needed as a means of verifying and validating MCO compliance with the established policies, procedures, methodologies, and investigational activity regarding provider fraud, waste and abuse.

26.3.12. The MCO shall provide DHHS with a monthly report of all Program Integrity, in process and completed during the month, including fraud, waste and abuse by the MCO, the MCO's employees, subcontractors, subcontractor's employees, and contracted providers. [42 CFR 455.17]. The MCO will supply at a minimum:

26.3.12.1. provider name/ID number,

26.3.12.2. source of complaint,

26.3.12.3. type of provider,

26.3.12.4. nature of complaint,

26.3.12.5. review activity, and

26.3.12.6. approximate dollars involved,

26.3.12.7. Provider Enrollment Safeguards related to Program Integrity;

26.3.12.8. Overpayments, Recoveries, and Claim Adjustments;

26.3.12.9. Audits/Investigations Activity;

26.3.12.10. MFCU Referrals;

26.3.12.11. Involuntary Provider Terminations; and

26.3.12.12. Provider Appeal/Hearings Activity resulting from, or related to, Program Integrity.

26.3.13. All fraud, waste and abuse reports submitted to DHHS shall be mutually developed and agreed upon between DHHS and the MCO. The reports will be submitted to DHHS in a format and mode of delivery, mutually agreed upon between DHHS and the MCO.

26.3.14. In the event DHHS is unable to produce a desired Ad Hoc report through its access to the MCO's data as provided herein, DHHS shall request in writing such Ad hoc report from the MCO and, within three (3) business days of receipt of such request, the MCO shall notify DHHS of the time required by the MCO to produce and deliver the Ad hoc report to DHHS, at no additional cost to DHHS.

26.3.15. The MCO shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the MCO discovers wasteful and or abusive incorrect billing trends with a particular provider/provider type, specific billing issue trends, or quality trends, it is the MCO's responsibility, as part of the provider audit/investigative process, to recover any inappropriately paid funds, and as part of the resolution and outcome, for the MCO to determine the appropriate remediation, such as reaching out to the provider to provide individualized or group training/education regarding the issues at hand. Within sixty (60) days of discovery, the MCO shall report overpayments identified during investigations to DHHS Program Integrity and shall include them on the monthly investigation activity report. The MCO shall still notify Program Integrity unit to request approval to proceed with a suspected fraud or abuse investigation.

26.3.16. [Intentionally left blank.]

26.3.17. Annually, the MCO shall submit to DHHS a report of the overpayments it recovered and certify by its Chief Financial Officer that this information is accurate to the best of his or her information, knowledge, and belief [42 CFR 438.606].DHHS reserves the right to conduct peer reviews of final program integrity investigations completed by the MCO.

26.3.18. DHHS will perform an annual program integrity audit, conducted on-site at the MCO (at the expense of the MCO) to verify and validate the MCO's compliance. The review will include, but not limited to, the plan's established policies and methodologies, credentialing, provider and staff education/training, provider contracts, and case record reviews to ensure that the MCO is making proper payments to providers for services under their agreements, and pursuant to 42 CFR 438 6(g). The review will include direct access to MCO system while on site and hard copy of documentation while on site as requested. Any documentation request at the end of the on site shall be delivered to Program Integrity within 3 business days of request. The MCO shall provide DHHS staff with access to appropriate on-site private work space to conduct DHHS's program integrity contract management reviews.

26.3.19. The MCO shall meet with DHHS monthly, or as determined by DHHS, to discuss audit and investigation results and make recommendations for program improvements. DHHS shall meet with both MCOs together quarterly, or as determined by DHHS, to discuss areas of interest for past, current and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities, and to discuss and share provider audit information and results.

26.3.20. The MCO shall provide DHHS with an annual report of all investigations in process and completed during the Agreement year within thirty (30) calendar days of the end of the Agreement year. The report shall consist of, at a minimum, an aggregate of the monthly reports, as well as any recommendations by the MCO for future reviews, changes in the review process and reporting process, and any other findings related to the review of claims for fraud, waste and abuse.

26.3.21. The MCO shall provide DHHS with a final report within thirty (30) calendar days following the termination of this Agreement. The final report format shall be developed jointly by DHHS and the MCO, and shall consist of an aggregate compilation of the data received in the monthly reports.

26.3.22. The MCO shall refer all suspected provider Medicaid fraud cases to DHHS upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.

26.3.23. The MCO shall institute a Pharmacy Lock-In Program for members which has been reviewed and approved by DHHS.

26.3.23.1. If the MCO determines that a member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to members regarding the Pharmacy Lock-In determination.

26.3.24. MCOs may, with prior approval from DHHS, implement Lock-In Programs for other medical services.

26.3.25. The MCO shall provide DHHS with a monthly report regarding the Pharmacy Lock-In Program. Report format, content, design, and mode of transmission shall be mutually agreed upon between DHHS and the MCO.

26.3.26. DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit or DHHS Special Investigations Unit.

26.3.27. Subject to applicable state and federal confidentiality/privacy laws, upon written request, the MCO will allow access to all NH Medicaid medical records and claims information to State and Federal agencies or contractors such as, but not limited to Medicaid Fraud Control Unit, Recovery Audit Contractors (RAC) the Medicaid Integrity Contractors (MIC), or DHHS Special Investigations Unit.

26.3.27.1. The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency (State and Federal) or their contractors, whether administrative, civil, or criminal. Such cooperation shall include providing, upon written request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in

medical or pharmaceutical questions or in any matter related to an investigation.

26.3.28. The MCO's MCIS system shall have specific processes and internal controls relating to fraud, waste and abuse in place, including, but not limited to the following areas:

26.3.28.1. Prospective claims editing;

26.3.28.2. NCCI edits;

26.3.28.3. Post-processing review of claims; and

26.3.28.4. Ability to pend any provider's claims for pre-payment review if the provider has shown evidence of credible fraud [42 CFR 455.21] in the Medicaid Program.

26.3.29. The MCO and their subcontractors shall post and maintain DHHS approved information related to Fraud, Waste and Abuse on its website, including but not limited to provider notices, updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

26.3.30. The MCO and their subcontractors shall be subject to on-site reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests as a result of an annual or targeted on-site review (at the expense of the MCO).

26.3.31. DHHS shall conduct investigations related to suspected provider fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for any and all types of claims older than six months for which the MCO does not have an active investigation.

26.3.32. DHHS shall validate the MCO and their subcontractors' performance on the program integrity scope of services to ensure the MCO and their subcontractors are taking appropriate actions to identify, prevent, and discourage improper payments made to providers, as set forth in 42 CFR 455 – Program Integrity.

26.3.33. DHHS shall establish performance measures to monitor the MCO compliance with the Program Integrity requirements set forth in this Agreement.

26.3.34. DHHS shall notify the MCO of any policy changes that impact the function and responsibilities required under this section of the Agreement.

26.3.35. DHHS shall notify the MCO of any changes within its agreement with its fiscal agent that may impact this section of this Agreement as soon as reasonably possible.

26.3.36.The MCO(s) shall report to DHHS all identified providers prior to being investigated, to avoid duplication of on-going reviews with the RAC, MIC, MFCU and, using the MCO Request to Open Investigation Form. DHHS will either approve the MCO to proceed with the investigation, or deny the request due to potential interference with an existing investigation.

26.3.37.The MCO(s) shall maintain appropriate record systems for services to members pursuant to 42 CFR 434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff, or its designee, to MCO(s) NH Medicaid related data files. Such information shall include, but not be limited to:

26.3.37.1. Recipient – First Name, Last Name, DOB, gender, and identifying number;

26.3.37.2. Provider Name and number (rendering, billing and Referring);

26.3.37.3. Date of Service(s) Begin/End;

26.3.37.4. Place Of Service;

26.3.37.5. Billed amount/Paid amount;

26.3.37.6. Paid date;

26.3.37.7. Standard diagnosis codes (ICD-9-CM and ICD-10-CM), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim);

26.3.37.8. Paid, denied, and adjusted claims;

26.3.37.9. Recouped claims and reason for recoupment;

26.3.37.10.Discharge status;

26.3.37.11.Present on Admission (POA);

26.3.37.12.Length of Stay;

26.3.37.13.Claim Type;

26.3.37.14.Prior Authorization Information;

26.3.37.15.Detail claim information;

26.3.37.16.Provider type;

26.3.37.17.Category of Service;

26.3.37.18.Admit time and discharge date;

26.3.37.19.Admit code;

26.3.37.20.Admit source;

26.3.37.21.Covered days;

26.3.37.22.TPL information;

26.3.37.23.Units of service;

26.3.37.24.EOB;

26.3.37.25.MCO ID#;

26.3.37.26.Member MCO enrollment date;

26.3.37.27.If available, provider time in and time out for the specific service(s) provided;

26.3.37.28.Data shall be clean, not scrubbed; and

26.3.37.29.And any other data deemed necessary by DHHS

26.3.38.The MCO shall provide DHHS with the following monthly reports as required by CMS:

26.3.38.1. Date of Death.

26.3.39.The MCO shall provide DHHS with any new reports as identified and required by state and federal regulation. The timing, format, content and mode of transmission will be mutually agreed upon between DHHS and the MCO.

27. Third Party Liability

DHHS and the MCO will cooperate in implementing cost avoidance and cost recovery activities. The rights and responsibilities of the parties relating to members and Third Party Payors are as follows:

27.1. MCO Cost Avoidance Activities

27.1.1. The MCO shall have primary responsibility for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans, and workers compensation. The MCO must attempt to avoid initial payment of claims, whenever possible, when federal or private health insurance resources are available. To support that responsibility, the MCO must implement a file transfer protocol between the DHHS MMIS and the MCO's MCIS to receive Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138. MCO shall require its subcontractors to promptly and consistently report COB daily information to the MCO.

27.1.2. The MCO shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

27.1.3. The number of claims cost avoided by the MCO's claims system, including the amount of funds, the amounts billed, the amounts not collected, and the amounts denied, must be reported weekly to DHHS in delimited text format.

27.1.4. The MCO shall maintain records of all COB collection efforts and results and report such information either through monthly electronic data transfers or access rights for DHHS to the MCO's data files. The data extract shall be in the delimited text format. Data elements may be subject to change during the course of the Agreement. The MCO shall accommodate changes required by DHHS and DHHS shall have access to all billing histories and other COB related data.

27.1.5. The MCO shall provide DHHS with a detailed claim history of all claims for a member, including adjusted claims, on a monthly basis based on a specific service date parameter requested for accident and trauma cases. This shall be a full replacement file each month for those members requested. These data shall be in the delimited text format. The claim history shall have, at a minimum, the following data elements:

27.1.5.1. Member name;

27.1.5.2. Member ID;

27.1.5.3. Dates of service;

27.1.5.4. Claim unique identifier (transaction code number);

27.1.5.5. Claim line number;

27.1.5.6. National Diagnosis Code;

27.1.5.7. Diagnosis code description;

27.1.5.8. National Drug Code;

27.1.5.9. Drug code description;

27.1.5.10. Amount billed by the provider;

27.1.5.11. Amount paid by the MCO;

27.1.5.12. Amount of other insurance recovery, name or Carrier ID;

27.1.5.13. Date claim paid;

27.1.5.14. Billing provider name; and

27.1.5.15. Billing provider NPI.

27.1.6. The MCO shall provide DHHS with a monthly file of COB collection effort and results. These data shall be in a delimited text format. The file should contain the following data elements:

27.1.6.1. Medicaid member name;

27.1.6.2. Medicaid member ID;

27.1.6.3. Insurance Carrier, other public payer, PBM, or benefit administrator ID;

27.1.6.4. Insurance Carrier, other public payer, PBM, or benefit administrator name;

27.1.6.5. Date of Service;

27.1.6.6. Claim unique identifier (transaction code number);

27.1.6.7. Date billed to the insurance carrier, other public payer, PBM, or benefit administrator;

27.1.6.8. Amount billed;

27.1.6.9. Amount recovered;

27.1.6.10. Denial reason code;

27.1.6.11. Denial reason description; and

27.1.6.12. Performing provider.

27.1.7. The MCO and its subcontractors shall not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations nor bill or pursue collection from a member for services. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third Party Liability is established at the time the claim is adjudicated.

27.2. DHHS Cost Avoidance and Recovery Activities

27.2.1. DHHS shall be responsible for:

27.2.1.1. Medicare and newly eligible members' initial insurance verification and submitting this information to the MCO;

27.2.1.2. Cost avoidance and pay and chase of those services that are excluded from the MCO;

27.2.1.3. Accident and trauma recoveries;

27.2.1.4. Lien, Adjustments and Recoveries and Transfer of Assets pursuant to § 1917 of the SSA;

27.2.1.5. Mail order co-pay deductible pharmacy program for Fee for Service and HIPP (Health Insurance Premium Payment) program;

27.2.1.6. Veterans Administration benefit determination;

27.2.1.7. Health Insurance Premium Payment Program; and

27.2.1.8. Audits of MCO collection efforts and recovery.

27.3. Post-Payment Recovery Activities

27.3.1. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources.

27.3.2. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts.

27.3.3. Other resources with regard to Third Party Liability include but are not limited to: recoveries from personal injury claims, liability insurance, first party automobile medical insurance, and accident indemnity insurance.

27.4. MCO Post Payment Activities

27.4.1. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources, including a claim involving Workers' Compensation or where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible or collection through either legal action or traditional subrogation and collection procedures.

27.4.2. The MCO shall be responsible for Reviewing claims for accident and trauma codes as required under 42 C.F.R. §433.138 (e). The MCO shall specify the guideline used in determining accident and trauma claims and establish a procedure to send the DHHS Accident Questionnaire to Medicaid members, postage pre-paid, when such potential claim is identified. The MCO shall instruct members to return the Accident Questionnaire to DHHS. The MCO shall provide the guidelines and procedures to DHHS for review and approval. Any changes to procedures must be submitted to DHHS at least thirty days for approval prior to implementation.

27.4.3. Due to potential time constraints involving accident and trauma cases and due to the large dollar value of many claims which are potentially recoverable by DHHS, the MCO must identify these cases before a settlement has been negotiated. Should DHHS fail to identify and establish a claim prior to settlement due to the MCO's untimely submission of notice of legal involvement where the MCO has received such notice, the amount of the actual loss of recovery shall be assessed against the MCO. The actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by DHHS.

27.4.4. The MCO has the latter of eighteen (18) months from the date of service or twelve (12) months from the date of payment of health-related insurance resources to initiate recovery and may keep any funds that it collects. The MCO must indicate its intent to recover on health-related insurance by providing to DHHS an electronic file of those cases that will be pursued. The cases must be identified and a file provided to DHHS by the MCO within thirty (30) days of the date of discovery of the resource.

27.4.5. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a Medically Necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

27.5. DHHS Post Payment Recovery Activity

27.5.1. DHHS retains the sole and exclusive right to investigate, pursue, collect and retain all Other Resources, including accident and trauma. DHHS is assigned the MCO's subrogation rights to collect the "Other Resources" covered by this provision. Any correspondence or Inquiry forwarded to the MCO (by an attorney, provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forward to DHHS.

27.5.2. The MCO may neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by DHHS under the scope of these "Other Resources" shall be retained by DHHS.

27.5.3. DHHS may pursue, collect and retain recoveries of all health-related insurance cases; provided, however, that if the MCO has not notified DHHS of its intent to pursue a case identified for recovery before the latter of eighteen (18) months after the date of service or twelve (12) months after the date of payment, such cases not identified for recovery by the MCO will become the sole and exclusive right of DHHS to pursue, collect and retain. The MCO must notify DHHS through the prescribed electronic file process of all outcomes for those cases identified for pursuit by the MCO.

27.5.4. Should DHHS lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in billing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable Claim shall be assessed against the MCO.

28. Compliance with State and Federal Laws

28.1. General

28.1.1. The MCO, its subcontractors, and the providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

28.1.2. The MCO 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].

28.1.3. The MCO shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

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

28.1.3.2. Related rules: Title 42 Chapter IV;

28.1.3.3. 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);

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

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

28.1.3.6. Regulations promulgated thereunder: 42 CFR 457;

28.1.3.7. Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

28.1.3.8. Patient Protection and Affordable Care Act of 2010;

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

28.1.3.10. State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

28.1.3.11. American Recovery and Reinvestment Act; and

28.1.3.12. Any waivers approved by the Centers for Medicare & Medicaid Services.

28.1.4. The MCO will not release and make public statements or press releases concerning the program without the prior consent of DHHS.

28.1.5. The MCO shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and the MCO, 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.

28.2. Non-Discrimination

28.2.1. The MCO shall require its providers and 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 or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

28.2.2. ADA Compliance

28.2.2.1. The MCO shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA.

28.2.2.1.1. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

28.2.2.2. The MCO shall submit to DHHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the MCO's knowledge. The MCO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by the MCO and shall be available for inspection by the DHHS. The MCO warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA. Where applicable, the MCO shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

28.2.2.3. The MCO shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all members who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

28.2.2.4. The MCO shall forward to DHHS copies of all grievances alleging discrimination against members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability for review and appropriate action within three (3) business days of receipt by the MCO.

28.2.3. Non-Discrimination in employment:

28.2.3.1. The MCO shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. The MCO 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. The MCO 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.

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

28.2.3.3. The MCO 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 the MCO'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.

28.2.3.4. The MCO 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.

28.2.3.5. The MCO 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.

28.2.3.6. In the event of the MCO'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 the MCO 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.

28.2.3.7. The MCO 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. The MCO 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 the MCO

becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

28.2.4. Non-Discrimination in Enrollment

28.2.4.1. The MCO shall and shall require its providers and subcontractors to accept assignment of an member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

28.2.4.2. The MCO shall and shall require its providers and subcontractors to not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

28.2.5. Non-Discrimination with Respect to Providers

28.2.5.1. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's members, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the MCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

28.3. Changes in Law

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

29. Administrative Quality Assurance Standards

29.1. Claims Payment Standards

29.1.1. The MCO shall pay or deny ninety-five percent (95%) of clean claims within thirty (30) days of receipt, or receipt of additional information [42 CFR 447.46; 42 CFR 447.45(d)(2), (d)(3), (d)(5), and (d)(6)].

29.1.2. The MCO shall pay interest on any clean claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

29.1.3. The MCO shall pay or deny all claims within sixty (60) calendar days of receipt.

29.1.4. Additional information necessary to process incomplete claims shall be requested from the provider within thirty (30) days from the date of original claim receipt.

29.1.5. For purposes of this requirement, New Hampshire DHHS has adopted the claims definitions established by CMS under the Medicare program, which are as follows:

29.1.5.1. "clean" claim: a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and

29.1.5.2. "incomplete" claim: a claim that is denied for the purpose of obtaining additional information from the provider.

29.1.6. Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or electronic funds transfer is issued to the service provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

29.2. Quality Assurance Program

29.2.1. The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS on a monthly basis.

29.2.2. Monthly reporting shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

29.2.3. The MCO shall implement Corrective Action Plans to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

29.3. Claims Financial Accuracy

29.3.1. Claims financial accuracy measures the accuracy of dollars paid to providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

29.4. Claims Payment Accuracy

29.4.1. Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay ninety-seven percent (97%) of claims accurately.

29.5. Claims Processing Accuracy

29.5.1. Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process ninety-five percent (95%) of all claims correctly.

30. Privacy and Security of Members

30.1. General Provisions

30.1.1. The MCO shall be in compliance with privacy policies established by governmental agencies or by State or federal law.

30.1.2. The MCO shall provide sufficient security to protect the State and DHHS data in network, transit, storage, and cache.

30.1.3. In addition to adhering to privacy and security requirements contained in other applicable laws and statutes, the MCO shall execute as part of this Agreement a Business Associates Agreement governing the permitted uses and disclosure and security of Protected Health Information.

30.1.4. The MCO shall ensure that it uses and discloses individually identifiable health information in accordance with HIPAA privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable [42 CFR 438.224]; complies with federal statutes and regulations governing the privacy of drug and alcohol abuse patient records (42 CFR, Part 2.33), and all applicable state statutes and regulations, including but not limited to: R.S.A. 167:30: protects the confidentiality of all DHHS records with identifying medical information in them.

30.1.5. With the exception of submission to the Comprehensive Healthcare Information System or other requirements of State or federal law, claims and member data on New Hampshire Medicaid members may not be released to any party without the express written consent of DHHS.

30.1.6. The MCO shall ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information [42 CFR 438.208(b)].

31. Finance

31.1. Financial Standards

31.1.1. In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with New Hampshire Insurance Department regulations, and any other relevant laws and regulations.

31.1.2. The MCO shall maintain a risk-based capital (RBC) ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

31.1.3. With the exception of payment of a claim for a medical product or service that was provided to a member, and that is in accordance with a written Agreement with the provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

31.1.3.1. RBC ratio was less than 2.0 for the most recent year filing, per R.S.A. 404-F:14 (III); and

31.1.3.2. MCO was not in compliance with the NHID solvency requirement.

31.1.4. The MCO shall notify DHHS within ten (10) calendar days when its Agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

31.1.5. The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

31.1.6. The MCO shall not be responsible for DSH/GME (IME/DME) payments to hospitals. DSH and GME amounts are not included in capitation payments.

31.1.7. The MCO shall submit data on the basis of which DHHS determines that the MCO has made adequate provision against the risk of insolvency.

31.2. Capitation Payments

31.2.1. Preliminary capitation rates for non NHHPP members for the agreement period through June 30, 2019 are shown in Exhibit B. For each of the subsequent years of the Agreement actuarially sound per member, per month capitated rates will be calculated and certified by the DHHS's actuary.

31.2.2. Capitation rates for NHHPP members are shown in Exhibit B and were determined as part of Agreement negotiations, any best and final offer process, and the DHHS actuary's soundness certification.

31.2.3. Capitation rate cell is determined as of the first day of the capitation month and does not change during the entire month regardless of member changes (e.g., age).

31.2.4. DHHS will make a monthly payment to the MCO for each member enrolled in the MCO's plan. Capitation payments shall only be made for Medicaid-eligible enrollees and be retained by the MCOs for those enrollees. The capitation rates, as set forth in Exhibit B, will be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis as follows:

31.2.4.1. The Chronic Illness and Disability Payment System and/or Medicaid Rx risk adjuster (CDPS + Rx, Medicaid Rx) will be used to risk adjust MCO capitation payments;

31.2.4.2. A risk score will be developed for members with six (6) months or more months of Medicaid eligibility (either FFS or managed care) inclusive of three (3) months of claims run out in the base experience period. For members with less than six (6) months of eligibility, a score equal to the average of those scored beneficiaries in each cohort will be used; and

31.2.4.3. The MCO risk score for a particular rate cell will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population enrolled in the Care Management program. For rate cells with an opt-out provision, the MCO risk score will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population that is eligible to enroll in the Care Management program (FFS eligibles + MCO members).

31.2.4.4. [Intentionally left blank.]

31.2.5. DHHS reserves the right to terminate or implement the use of a risk adjustment process for specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates.

31.2.6. The capitation payment for Medicaid Managed Care members will be made retrospectively with a two (2) month delay. For example, a payment will be made within five (5) business days of the first day in October 2012 for services provided in July 2012.

31.2.7. Section 31.2.6 notwithstanding, capitation payments for NHHPP members will be paid in the month of service.

31.2.8. Capitation payment settlements will be made at three (3) month intervals. DHHS will recover capitation payments made for deceased members, or members who were later determined to be ineligible for Medicaid and/or for Medicaid managed care or need rate cell or kick payment corrections. DHHS will pay MCO for retroactive member assignments, corrections to kick payments, behavioral health certification level correction or other rate assignment corrections.

31.2.9. Capitation payments for members who became ineligible for services in the middle of the month will be prorated based on the number of days eligible in the month.

31.2.10. The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement [42 CFR 438.608(c)(3)].

31.2.11. For each live birth, DHHS will make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all maternity expenses, including all delivery and postpartum care. In the event of a multiple birth DHHS will only make only one maternity kick payment. A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

31.2.12.For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2012 and August 2012 for a baby born any time in July 2012. Enrolled babies will be covered under the MCO capitated rates thereafter. For each live birth, for Fiscal Year 2019, the newborn kick payment will be made for both newborns with and without Neonatal Abstinence Syndrome. Each type of payment is distinct and only one payment is made per newborn.

31.2.13.The MCO shall submit information on maternity and newborn events to DHHS. The MCO shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

31.2.14.

31.2.15.DHHS will inform the MCO of any required program revisions or additions in a timely manner. DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

31.2.16. When requested by DHHS, the MCO shall submit base data to DHHS to ensure actuarial soundness in development of the capitated rates.

31.2.17. The MCO's Chief Financial Officer shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate [42 CFR 438.606].

31.2.18. In the event an enrolled Medicaid member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive full capitation payment for that member. The entity responsible for coverage of the member at the time of admission as an inpatient, i.e. either DHHS or another MCO, shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

31.2.19. Payment for behavioral health rate cells shall be determined based on a member's CMHC behavioral certification level and a member having had an encounter at a CMHC in the last 6 months. Changes in the certification level for a member shall be reflected as of the first of each month and does not change during the month.

31.2.20. The SFY 2019 MCM Capitation rates include directed payments of $5 million to the CMHCs across all programs and populations, pending approval by CMS, to ensure timely access to high-quality care. MCOs are required to pay these amounts directly to the Community Mental Health Centers (CMHCs) according to criteria defined by the Department and approved by CMS. The directed payments will be based on the utilization and delivery of services for Medicaid beneficiaries that receive Community Mental Health Program services delivered at CMHCs, regardless of the basis of their eligibility for Medicaid (i.e., services delivered to members identified as SPMI, SMI, low utilizer and SED children). These amounts are to be paid directly to the providers by the MCOs and do not include additional allowance for administrative expense or risk margin. The Department reserves the right to modify the Exhibit O to support any CMS required reporting related to directed payment.

31.2.21. Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the New Hampshire Insurance Administrative Fund (Fund) pursuant to R.S.A. 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NH Insurance Department.

31.2.22. For any member with claims exceeding five hundred thousand dollars ($500,000) for the fiscal year, after applying any third party insurance off set, DHHS will reimburse fifty percent (50%) of the amount over five hundred thousand dollars ($500,000) after all claims have been recalculated based on the DHHS fee schedule for the services. For a member whose services may be projected to exceed five hundred thousand dollars ($500,000) in MCO claims, the MCO shall advise DHHS. Prior approval from the Medicaid Director is required for subsequent services provided to the member.

31.3. Medicaid Loss Ratio

31.3.1. The MCO shall determine the Medicaid Loss Ratio ("MLR") experienced in accordance with 42 CFR 438.8.

31.3.2. The MCO shall submit MLR summary reports quarterly to DHHS, which shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year. Specifically, the MCO shall provide separate summary reports for NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program. The MCO must attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. Such summary reports shall be based on a template provided and developed by DHHS within sixty (60) days of the effective date of this Agreement.

31.3.3. The MCO and its subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

31.4. NHHPP Risk Protection Structure

31.4.1. DHHS will implement risk adjustment and risk corridors for the NHHPP Medically Frail and NHHPP Transitional populations.

31.4.1.1. Risk adjustment – (MCO Revenue Reallocation) – Similar to the risk adjustment process for the current Medicaid Step 1 population under the MCM program, risk adjustment will shift revenue from MCOs with lower acuity populations to MCOs with higher acuity populations. The risk adjustment component will only apply to the NHHPP Medically Frail population. The risk adjustment process is revenue neutral. The NHHPP Transitional population is expected to have very short enrollment duration and therefore will not be risk adjusted.

31.4.2. Risk adjustment – Methodology – Acuity will be measured using the CDPS+Rx, a diagnosis and pharmacy based risk adjuster that will also be used for the current Medicaid population. Key differences in the risk adjustment process for the NHHPP Medically Frail population include:

31.4.2.1. DHHS will use concurrent risk adjustment for the NHHPP Medically Frail population. DHHS will use SFY 2019 claims and the standard CDPS+Rx concurrent risk weights to estimate SFY 2019 acuity (as opposed to prospective models that use a prior year's claims to estimate current acuity).

31.4.2.2. Risk adjustment transfer payments will be made as part of the contract period settlement, not as prospective payments.

31.4.3. Risk corridors – DHHS will establish a target medical loss ratio (MLR) of 89.3% based on NHHPP pricing assumptions and perform a separate calculation for the NHHPP Medically Frail and NHHPP Transitional populations:

31.4.3.1. Administrative and margin allowance of 8.9% of the capitation rate prior to state premium tax.

31.4.3.2. New Hampshire state premium tax of 2%.

31.4.3.3. DHHS and each MCO will share the financial risk of actual results that are above or below the MLR target as shown in the table below:

New Hampshire Department of Health and Human Services New Hampshire Health Protection Program Population Risk Corridor Program		
Actual MLR Compared to Target MLR	**MCO Share**	**DHHS Share**
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

31.4.3.4. The NHHPP Medically Frail risk corridor calculation will be applied after the risk adjustment calculation.

31.4.4. For SFY 2019, risk protection settlement will occur after the SFY 2019 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.4.1. June 30, 2019: End of NHHPP contract period

31.4.4.2. December 31, 2019: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.4.3. January 31, 2020: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.4.4. April 30, 2020: DHHS releases settlement payment report to MCOs

31.4.4.5. May 31, 2020: DHHS makes / receives final settlement payments to / from MCOs

31.4.5. For SFY 2018, risk protection settlement will occur after the SFY 2018 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.5.1. June 30, 2018: End of NHHPP contract period

31.4.5.2. December 31, 2018: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.5.3. January 31, 2019: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.5.4. April 30, 2019: DHHS releases settlement payment report to MCOs

31.4.5.5. May 31, 2019: DHHS makes / receives final settlement payments to / from MCOs

31.4.6. For SFY 2017, risk protection settlement will occur after the SFY 2017 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.6.1. June 30, 2017: End of NHHPP contract period

31.4.6.2. December 31, 2017: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2017 dates of service paid through December 31, 2017)

31.4.6.3. January 31, 2018: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.6.4. April 30, 2018: DHHS releases settlement payment report to MCOs

31.4.6.5. May 31, 2018 DHHS makes / receives final settlement payments to / from MCOs

31.4.7. For SFY 2016, risk protection settlement will occur after the SFY 2016 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.7.1. June 30, 2016: End of NHHPP contract period

31.4.7.2. December 31, 2016: Cutoff date for encounter data to be used in the risk protection settlement calculations (January 2016 – June 2016 dates of service paid through December 31, 2016)

31.4.7.3. January 31, 2017: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.7.4. April 30, 2017: DHHS releases settlement payment report to MCOs

31.4.7.5. May 31, 2017: DHHS makes / receives final settlement payments to / from MCOs

31.4.8. For September 2014 – December 2015 risk protection settlement:

31.4.8.1.August 31, 2016: DHHS intends to release settlement payment report to MCOs

31.4.8.2.September 30, 2017: DHHS intends to make / receive final settlement payments to / from MCOs.

31.5. Financial Responsibility for Dual-Eligibles

31.5.1. The MCO shall pay any Medicare coinsurance and deductible amount up to what New Hampshire Medicaid would have paid for that service, whether or not the Medicare provider is included in the MCO's provider network. These payments are included in the calculated capitation payment.

31.6. Premium Payments

31.6.1. DHHS is responsible for collection of any premium payments from members. If the MCO inadvertently receives premium payments from members, it shall inform the member and forward the payment to DHHS.

31.7. Sanctions

31.7.1. If the MCO fails to comply with the financial requirements in Section 31, DHHS may take any or all of the following actions:

31.7.1.1. Require the MCO to submit and implement a Corrective Action Plan

31.7.1.2. Suspend enrollment of members to the MCO after the effective date of sanction

31.7.1.3. Terminate the Agreement upon forty-five (45) calendar days written notice

31.7.1.4. Apply liquidated damages according to Section 34

31.8. Medical Cost Accruals

31.8.1. The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims.

31.9. Audits

31.9.1. The MCO shall allow DHHS and/or the NHID to inspect and audit any of the financial records of the MCO and its subcontractors. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)].

31.9.2. The MCO shall file annual and interim financial statements in accordance with the standards set forth below. This Section 31.9.2 will supersede any conflicting requirements in Exhibit C of this Agreement.

31.9.3. Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners ("NAIC"), annual audited financial statements that have been audited by an independent Certified Public Accountant. Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

31.9.4. The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the Insurance Department.

31.9.5. The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

31.10.Member Liability

31.10.1.The MCO shall not hold its Medicaid members liable for:

31.10.1.1. The MCO's debts, in the event of the MCO's insolvency [42 CFR 438.116(a); SMM 2086.6];

31.10.1.2. The covered services provided to the member, for which the State does not pay the MCO;

31.10.1.3. The covered services provided to the member, for which the State, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or

31.10.1.4. Payments for covered services furnished under an Agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided those services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(a), (b) and (c); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.2. Subcontractors and referral providers may not bill members any amount greater than would be owed if the entity provided the services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.3. The MCO shall cover continuation of services to members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency [SMM 2086.6B].

31.11. Denial of Payment

31.11.1. Payments provided for under the Agreement will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in [§1903(m)(5)(B)(ii) of the SSA; 42 CFR 438.726(b); 42 CFR 438.730(e)].

31.12. Federal Matching Funds

31.12.1. Federal matching funds are not available for amounts expended for providers excluded by Medicare, Medicaid, or Children's Health Insurance Program (CHIP), except for emergency services [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and §1903(i)(2) of the SSA; SMD letter 12/30/97]. Payments made to such providers are subject to recoupment from the MCO by DHHS.

31.13. Health Insurance Providers Fee

31.13.1. Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposed an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

31.13.1.1. To the extent such fees exist:

31.13.1.1.1. The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement no later than 120 days following its review and acceptance of the Contractor's Adjusted Fee.

31.13.1.1.2. To claim reimbursement for the Contractor's Adjusted Fee, the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:

Attn: Medicaid Finance Director

New Hampshire Medicaid Managed Care Program

129 Pleasant Street

Concord, NH 03304

32. Termination

32.1. Transition Assistance

32.1.1. Upon receipt of notice of termination of this Agreement by DHHS, the MCO 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 vendor or to perform the work itself.

32.1.1.1. Transition Plan

32.1.1.1.1. MCO must prepare a Transition Plan which is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date.

32.1.1.2. Data

32.1.1.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, 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.

32.1.1.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO shall transmit the information and records required 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.

32.2. Service Authorization

32.2.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received. Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS.

32.2.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

32.3. Claims Responsibilities

32.3.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

32.3.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

32.4. Termination for Cause

32.4.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if the MCO [42 CFR 438.610(c)(3); 42 CFR 434.6(a)(6)]:

32.4.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any member, including significant marketing abuses;

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

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

32.4.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS' notice and written request for compliance;

32.4.1.5. Violates state or federal law or regulation;

32.4.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

32.4.1.7. Becomes insolvent;

32.4.1.8. Fails to meet applicable requirements in sections §1932, §1903 (m) and §1905(t) of the SSA [42 CFR 438.708]. In the event of a termination by DHHS pursuant to 42 CFR 438.708, DHHS shall provide the MCO with a pre-termination hearing in accordance with 42 CFR 438.710;

32.4.1.9. 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

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

32.4.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance.

32.4.2. If DHHS terminates this Agreement for cause, the MCO 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 MCO. 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 reasonable attributable to the MCO's failure to perform any service in accordance with the terms of this Agreement.

32.5. Termination for Other Reasons

32.5.1. Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for sixty (60) calendar days after written notice thereof by the other party.

32.5.2. In the event the MCO gives written notice that it does not accept the actuarially sound capitation rates established by DHHS for Year 2 or later of the program, the MCO and DHHS will have thirty (30) days from the date of such notice or thirty (30) calendar days from the expiration of the rates indicated in Exhibit B, whichever comes later, to attempt to resolve the matter without terminating the agreement. If no resolution is reached in the above thirty (30) calendar days period, then the contract will terminate ninety (90) calendar days thereafter, or at the time that all members have been disenrolled from the MCO's plan, whichever date is earlier. In the event of such termination, the MCO shall accept the lesser of the most recently agreed to capitation rates or the new annual capitation rate for each rating category as payment in full for Covered Services and all other services required under this Agreement delivered to Members until all Members have been disenrolled from the MCO's plan consistent with any mutually agreed upon transition plans to protect Members.

32.6. Final Obligations

32.6.1. DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Amounts due to MCO for unpaid premiums, risk settlement, ABA therapies, High Dollar Stop Loss, shall be paid to MCO within one year of date of termination.

32.7. Survival of Terms

32.7.1. 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:

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

32.7.1.2. 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.

32.8. Notice of Hearing

32.8.1. Except because of change in circumstances or in the event DHHS terminates this Agreement pursuant to subsections (1), (2), (3) or (10 of Section 32.3.1, DHHS shall give the MCO ninety (90) days advance, written notice of termination of this Agreement and shall provide the MCO with an opportunity to protest said termination and/or request an informal hearing in accordance with 42 CFR 438.710. This notice shall specify the applicable provisions of this Agreement and the effective date of termination, which shall not be less than will permit an orderly disenrollment of members to the Medicaid FFS program or transfer to another MCO.

33. Agreement Closeout

33.1. Period

33.1.1. A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day the MCO is responsible for coverage of specific beneficiary groups or operating under this Agreement. During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS. Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

33.2. Data

33.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new MCO and/or DHHS shall define the information required during this period and the time frames for submission.

33.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO 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.

33.2.3. The MCO shall be responsible for continued submission of data to the Comprehensive Healthcare Information System during and after the transition in accordance with NHID regulations.

33.3. Service Authorizations

33.3.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with the new MCO to process service authorization requests received. Disputes between the MCO and the new MCO regarding service authorizations shall be resolved by DHHS.

33.3.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

33.4. Claims Responsibilities

33.4.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

33.4.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

34. Remedies

34.1. Reservation of Rights and Remedies

34.1.1. 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 MCO 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.

34.2. Liquidated Damages

34.2.1. DHHS and the MCO agree that it will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards indicated below throughout the life of this Agreement. Any breach by the MCO will delay and disrupt DHHS's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable.

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

34.2.3. DHHS shall make all assessments of liquidated damages. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify the MCO as specified in Section 34.10 of this Agreement.

34.2.4. The MCO shall submit a written Corrective Action Plan to DHHS, within five business days of notification, for review and approval prior to implementation of corrective action.

34.2.5. The MCO agrees that as determined by DHHS, failure to provide services meeting the performance standards below will result in liquidated damages as specified. The MCO agrees to abide by the Performance Standards and Liquidated Damages specified, provided that DHHS has given the MCO data required to meet performance standards in a timely manner. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

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

34.2.7. Liquidated damages may be assessed for each day, incidence or occurrence, as applicable, of a violation or failure.

34.2.8. The amount of liquidated damages assessed by DHHS to the MCO shall not exceed three percent (3%) of total expected yearly capitated payments, based on average annual membership from start date, for the MCO.

34.2.9. Liquidated damages related to timely processing of membership, claims and or/encounters shall be waived until such time as DHHS's file transfer systems and processes are operational.

34.3. Category 1

34.3.1. Liquidated damages up to $100,000 per violation or failure may be imposed for Category 1 events. Category 1 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.3.1.1. Acts that discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll an enrollee, except as permitted under law or under this Agreement, or any practice that would reasonably be expected to discourage enrollment by an enrollee whose medical condition or history indicates probable need for substantial future medical services. [42 CFR 700(b)(3) and 42 CFR 704(b)(2)].

34.3.1.2. A determination by DHHS that a recipient was not enrolled because of a discriminatory practice; $15,000 for each recipient subject to the $100,000 overall limit in 42 CFR 704(b)(2).

34.3.1.3. A determination by DHHS that a member found eligible for CFI services was relocated to a Nursing Facility due to MCO's failure to arrange for adequate in-home services in compliance with this Agreement and He-E801.09.

34.3.1.4. Misrepresentations of actions or falsifications of information furnished to CMS or the State.

34.3.1.5. Failure to comply with material requirements in this Agreement.

34.3.1.6. [Intentionally left blank.]

34.3.1.7. Failure to meet the Administrative Quality Assurance Standards specified in Section 29 of this Agreement.

34.3.1.8. Failure of the MCO to assume full operation of its duties under this Agreement in accordance with the implementation and transition timeframes specified herein.

34.4. Category 2

34.4.1. Liquidated damages up to $25,000 per violation or failure may be imposed for Category 2 events. Category 2 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.4.1.1. Misrepresentation or falsification of information furnished to a member, potential member, or health care provider.

34.4.1.2. Distribution, directly, or indirectly, through any agent or independent MCO, marketing materials that have not been approved by the State or that contain false or materially misleading information.

34.4.1.3. Violation of any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

34.4.1.4. Imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program; a maximum of $25,000 or double the amount of the charges, whichever is greater. The State will deduct the amount of the overcharge and return it to the affected member.

34.4.1.5. Failure to resolve member Appeals and Grievances within the timeframes specified in Section 19 of this Agreement.

34.4.1.6. Failure to ensure client confidentiality in accordance with 42 CFR 166 and 45 CFR 164; an incident of non-compliance shall be assessed as per member and/or per HIPAA regulatory violation.

34.4.1.7. Violation of a subcontracting requirement in this Agreement.

34.4.1.8. Failure to provide medically necessary services that the MCO is required to provide under law, or under this Agreement, to a member covered under this Agreement.

34.5. Category 3

34.5.1. Liquidated damages up to $10,000 per violation or failure may be imposed for Category 3 events. Category 3 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.5.1.1. Late, inaccurate, or incomplete turnover or termination deliverables.

34.6. Category 4

34.6.1. Liquidated damages up to $5,000 per violation or failure may be imposed for Category 4 events. Category 4 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.6.1.1. Failure to meet staffing requirements as specified in Section 6.

34.6.1.2. Failure to submit reports not otherwise addressed in this Section within the required timeframes.

34.7. Category 5

34.7.1. Liquidated damages as specified below may be imposed for Category 5 events. Category 5 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.7.1.1. Failure to provide a sufficient number of providers in order to ensure member access to all covered services and to meet the geographic access standards and timely access to service delivery specified in this Agreement:

34.7.1.1.1. $1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan;

34.7.1.1.2. $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan.

34.7.1.2. Failure to submit readable, valid health care data derived from Claims, Pharmacy or Encounter data in the required form or format, and timeframes required by the terms of this Agreement:

34.7.1.2.1. $5,000 for each day the submission is late;

34.7.1.2.2. for submissions more than thirty (30) calendar days late, DHHS reserves the right to withhold five percent (5%) of the aggregate

capitation payments made to the MCO in that month until such time as the required submission is made.

34.7.1.3. Failure to implement the Disaster Recovery Plan (DRP):

34.7.1.3.1. Implementation of the DRP exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2.

34.7.1.3.2. Implementation of the DRP exceeds the proposed time by more than two (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per day beginning with day 3 and up to day 5.

34.7.1.3.3. Implementation of the DRP exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days: twenty five thousand dollars ($25,000) per day beginning with day 6 and up to day 10.

34.7.1.3.4. Implementation of the DRP exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per day beginning with day 11.

34.7.1.4. Unscheduled system unavailability occurring during a continuous five (5) business day period:

34.7.1.4.1. Greater than or equal to two (2) and less than twelve (12) hours cumulative; up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof.

34.7.1.4.2. Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative; up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof.

34.7.1.4.3. Greater than or equal to twenty-four (24) hours cumulative; up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

34.7.1.5. Failure to correct a system problem not resulting in system unavailability within the allowed timeframe:

34.7.1.5.1. One (1) to fifteen (15) calendar days late; two hundred and fifty dollars ($250) per calendar day for days 1 through 15.

34.7.1.5.2. Sixteen (16) to thirty (30) calendar days late; five hundred dollars ($500) per calendar day for days 16 through 30.

34.7.1.5.3. More than thirty (30) calendar days late; one thousand dollars ($1,000) per calendar day for days 31 and beyond.

34.7.1.6. Failure to meet telephone hotline performance standards:

34.7.1.6.1. One thousand dollars ($1,000) for each percentage point that is below the target answer rate of ninety percent (90%) in thirty (30) seconds.

34.7.1.6.2. One thousand dollars ($1,000) for each percentage point that is above the target of a one percent (1%) blocked call rate.

34.7.1.6.3. One thousand dollars ($1,000) for each percentage point that is above the target of a five percent (5%) abandoned call rate.

34.7.1.7. The MCO shall resolve one hundred percent (100%) of standard member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO

34.8. Suspension of Payment

34.8.1. Payment of capitation payments shall be suspended when:

34.8.1.1. The MCO fails to cure a default under this Agreement within thirty (30) days of notification;

34.8.1.2. Failing to act on identified Corrective Action Plan;

34.8.1.3. Failure to implement approved program management or implementation plans;

34.8.1.4. Failure to submit or act on any transition plan, or corrective action plan, as specified in this Agreement; or

34.8.1.5. Upon correction of the deficiency or omission, capitation payments shall be reinstated.

34.9. Administrative and Other Remedies

34.9.1. In addition to other liquidated damages described in Category 1-5 events, DHHS may impose the following other remedies:

34.9.1.1. Appointment of temporary management of the MCO, as provided in 42 CFR 438.706, if DHHS finds that the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

34.9.1.2. Suspending enrollment of new members and/or changing auto-assignment of new members to the MCO.

34.9.1.3. Granting members the right to terminate enrollment without cause and notifying affected members of their right to disenroll.

34.9.1.4. Suspension of payment to the MCO for members enrolled after the effective date of the remedies and until CMS or DHHS is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur.

34.9.1.5. Termination of the Agreement if the MCO 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.

34.9.1.6. Civil monetary fines in accordance with 42 CFR 438.704.

34.9.1.7. Additional remedies allowed under State statute or regulation that address area of non-compliance specified in 42 CFR 438.700.

34.10.Notice of Remedies

34.10.1.Prior to the imposition of either liquidated damages or any other remedies under this Agreement, including termination for breach, with the exception of requirements related to the Implementation Plan, DHHS will issue written notice of remedies that will include, as applicable, the following:

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

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

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

34.10.1.4. Request for a Corrective Action Plan;

34.10.1.5. The timeframe and procedure for the MCO to dispute DHHS's determination. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

34.10.1.6. If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor.

35. Dispute Resolution Process

35.1. Informal Dispute Process

35.1.1. In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) days following the action or decision, the MCO may protest such action or decision by the delivery of a notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. The MCO 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 of the time, format and location of the presentations. At the conclusion of the presentations, the Director will consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation. The Director may appoint a designee to hear and determine the matter. If the Director or designee affirms the action or decision and the action or decision relates to termination of this Agreement, DHHS shall give enrollees of the MCO notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

35.2. No Waiver

35.2.1. The MCO's exercise of its rights under Section 34.1 shall not limit, be deemed a waiver of, or otherwise impact the parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A or any applicable provisions of the N.H. Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

36. Confidentiality

36.1. Confidentiality of Records

36.1.1. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Agreement shall be confidential and shall not be disclosed by the MCO, provided however, that pursuant to state laws and the regulations and administrative rules 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 Agreement; 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 MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian. In the case of records protected by 42 CFR Part 2.33, the individual must provide consent and notice as specified by 42 CFR Part 2.33.

36.2. MCO Owned or Maintained Data or Information

36.2.1. 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 the MCO. Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. The MCO acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense. If the MCO fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2018 – June 30, 2019
Capitation Payment

Eligibility Category	Capitation Rates
Low Income Children and Adults - Age 2-11 Months	$223.43
Low Income Children and Adults - Age 1-18 Years	139.77
Low Income Children and Adults - Age 19+ Years	477.56
Foster Care / Adoption	364.07
Breast and Cervical Cancer Program	1,822.10
Severely Disabled Children	1,055.54
Elderly and Disabled Adults	1,118.63
Dual Eligibles	242.77
Newborn Kick Payment	2,926.55
Neonatal Abstinence Syndrome Kick Payment	9,648.20
Maternity Kick Payment	2,838.56

NF Resident and Waiver Rate Cell	Capitation Rates
Nursing Facility Residents – Medicaid Only – Under 65	$2,640.90
Nursing Facility Residents – Medicaid Only – 65+	1,353.25
Nursing Facility Residents – Dual Eligibles – Under 65	278.52
Nursing Facility Residents – Dual Eligibles – 65+	96.73
Community Residents – Medicaid Only – Under 65	3,118.44
Community Residents – Medicaid Only – 65+	1,570.04
Community Residents – Dual Eligibles – Under 65	1,254.84
Community Residents – Dual Eligibles – 65+	450.30
Developmentally Disabled Adults – Medicaid Only	842.80
Developmentally Disabled Adults – Dual Eligibles	252.23
Developmentally Disabled and IHS Children	1,215.75
Acquired Brain Disorder – Medicaid Only	1,488.03
Acquired Brain Disorder – Eligibles Dual	339.41

Behavioral Health Population Rate Cells	Capitation Rates
Severe / Persistent Mental Illness – Medicaid Only	$2,358.94
Severe / Persistent Mental Illness – Dual Eligibles	1,783.25
Severe Mental Illness – Medicaid Only	1,715.63
Severe Mental Illness – Dual Eligibles	1,057.24
Low Utilizer – Medicaid Only	1,480.45
Low Utilizer – Dual Eligibles	710.82
Serious Emotionally Disturbed Child	954.70

July 1, 2018 – June 30, 2019
Capitation Payment – NH Health Protection Program, Alternative Benefit Plan for Medically Frail

Eligibility Category	Capitation Rate
Medically Frail	$ 1,028.83

July 1, 2018 – December 31, 2018
Capitation Payment – NH Health Protection Program, Transitional Population

Eligibility Category	Capitation Rate
NHHPP Transitional Population	$ 509.37
Maternity Kick Payment	$ 2,838.60

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for State Fiscal Year 2019, to be served among all contracts is 1,553,254. Accordingly, the price limitation for SFY 2019 among all contracts is $655,426,236.40 based on the projected members per month.

3. Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement within 30 days following its review and acceptance of the Contractor's Adjusted Fee.

To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

Exhibit O – Amendment #09
NH Medicaid Care Management Quality and Oversight Reporting – SFY 2019

The Exhibit O items shall be submitted according to the schedule and method specified and as modified in the NH DHHS's New Hampshire Medicaid Care Management Quality Oversight Reporting Specifications document, related templates, and as specified by the Medicaid Quality Information System specifications using the specifications relevant for each item's data period.

Table Notes:

"Change for 2019" column indicates whether the item is Unchanged, New, Changed, or Retired after final submission.

"Requires Subpopulation Breakout" column indicates measures where reporting requires population subgrouping system as defined by DHHS.

Reporting Reference IDs starting with "CAHPS_CPA_SUP" or "CAHPS_GP_SUP" are for CAHPS supplemental questions, to include the screening questions used.

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
ACCESSREQ.05	U		Member Requests for Assistance Accessing MCO Designated Primary Care Providers per Average Members by County	Measure	Quarterly	2 months after the end of the quarter		
ACCESSREQ.06	U		Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers per Average Members by County	Measure	Quarterly	2 months after the end of the quarter		
ACCIDENT.01	U		Accident and Trauma Claim Log	Table	Monthly	15 calendar days after end of month		
ACCRED.01	U		NCQA Accreditation Submission Overview Report	Report	Annually	15 Days after MCO receives final accreditation results from NCQA.		
AMBCARE.10	U	X	Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		

Exhibit O – Amendment #09
NH Medicaid Care Management Quality and Oversight Reporting – SFY 2019

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
AMBCARE.11	U	X	Ambulatory Care: Emergency Department Visits for Medical Health Conditions per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.12	U	X	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.13	U	X	Ambulatory Care: Emergency Department Visits for Behavioral Health Conditions per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.14	U	X	Ambulatory Care: Emergency Department Visits for Substance Use Related (Chronic or Acute) Conditions per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.18	U	X	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
APPEALS.01	U		Resolution of Standard Appeals Within 30 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.02	U		Resolution of Extended Standard Appeals Within 44 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.03	U		Resolution of Expedited Appeals Within 72 Hours	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.04	U		Resolution of All Appeals Within 45 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.05	U		Resolution of Appeals by Disposition Type	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.16	C		Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Table	Quarterly	2 months after the end of the quarter	11/30/2018	
APPEALS.17	U		Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Table	Quarterly	2 months after the end of the quarter		

Exhibit O – Amendment #09
NH Medicaid Care Management Quality and Oversight Reporting – SFY 2019

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
APPEALS.18	U		Services Authorized within 72 Hours Following A Reversed Appeal	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.19	U		Member Appeals Received per Member Month	Measure	Quarterly	2 months after the end of the quarter		
BHCHLDMEDMGT.01	R		Follow-up Psychiatric Consultations for Children Using Behavioral Health Medications	Measure	CY	June 30th	6/30/2016	No Submissions Required
BHDISCHARGE.01	U	X	Community Hospital Discharges for Mental Health Conditions Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
BHDISCHARGE.02	U	X	Community Hospital Discharges for Mental Health Conditions Where Patient Had a Visit With a Mental Health Practitioner Within 30 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
BHDRUG.01	N		Severe Mental Illness Drug Preauthorization Report	Table	Monthly	10 calendar days after end of each month	8/10/2018	
BHHOMELESS.01	U		New Hampshire Hospital Homelessness Reduction Plan	Plan	Agreement year	September 30th		
BHHOMELESS.02	U		New Hampshire Hospital Homelessness Quarterly Report	Narrative Report	Quarterly	Within 30 days of the end of each quarter		
BHPARITY.01	C		Behavioral Health Parity Certification Report	Narrative Report	Annually	4 months after the end of the calendar year	4/30/2019	
BHPARITY.02	C		Behavioral Health Parity Semi-Annual Compliance Report	Narrative Report	Semi-Annually	4 months after the end of the reporting period	10/31/2018	

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
BHREADMIT.01	U	X	Readmission to Community Hospital for Mental Health Conditions at 30 days by Subpopulation	Measure	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	September 1st		
BHREADMIT.02	U	X	Readmission to Community Hospital for Mental Health Conditions at 180 days by Subpopulation	Measure	January 1 of the prior SFY to June 30 of the measurement year. An 18 month period	September 1st		
BHSURVEY.01	U		Behavioral Health Satisfaction Survey Annual Report	Narrative Report	Annually	June 30th		
BOARDCERT.01	U		MCO Network Board Certification Report	Table	Annually	July 31st		
CAHPS_A.01	C		Adult CAHPS: Validated Member Level Data File (VMLDF)	Data File	Standard HEDIS schedule	May 30	5/30/2019	
CAHPS_A.02	C		Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	Data File	Standard HEDIS schedule	May 30	5/30/2019	
CAHPS_A.03	U		Adult CAHPS: Medicaid Adult Survey Results Report	Report	Standard HEDIS schedule	June 30		
CAHPS_A.04	U		Adult CAHPS: CAHPS Survey Results with Confidence Intervals	Data File	Standard HEDIS schedule	July 15		
CAHPS_A.05	U		Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Report	Standard HEDIS schedule	February 28		
CAHPS_A_ALL	U		Adult CAHPS: CAHPS 5.0H Core Survey - Adults	Measure	Standard HEDIS schedule	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CAHPS_C_ALL	U		Child CAHPS: CAHPS 5.0H Core and Children with Chronic Conditions Survey - Children	Measure	Standard HEDIS schedule	June 30th		
CAHPS_CCC.01	C		Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Data File	Standard HEDIS schedule	May 30	5/30/2019	
CAHPS_CCC.02	C		Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	Data File	Standard HEDIS schedule	May 30	5/30/2019	
CAHPS_CCC.03	U		Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	Report	Standard HEDIS schedule	June 30		
CAHPS_CCC.04	U		Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	Data File	Standard HEDIS schedule	July 15		
CAHPS_CCC.05	U		Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	Report	Standard HEDIS schedule	February 28		
CAHPS_CGP.03	U		Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	Report	Standard HEDIS schedule	June 30		
CAHPS_CGP.04	U		Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	Data File	Standard HEDIS schedule	July 15		
CAHPS_CPA_SUP.101	U		In the last 6 months, did you need any treatment or counseling for a personal or family problem? (Screening Question for CAHPS_CPA_SUP.102)	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_CPA_SUP.102	U		Adult CAHPS®: Ease in Getting Treatment or Counseling: Usually or Always	Measure	Standard HEDIS schedule	July 15th		
CAHPS_CPA_SUP.112	R		In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment? (Screening Question for CAHPS_CPA_SUP.113)	Measure	Standard HEDIS Schedule	July 15th		7/15/2018

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CAHPS_CPA_SUP.113	R		Adult CAHPS®: Ease in Getting Special Medical Equipment: Usually or Always	Measure	Standard HEDIS schedule	June 30th		7/15/2018
CAHPS_CPA_SUP.231	U		Adult CAHPS®: Days to Get Appointment When Care Needed Right Away	Measure	Standard HEDIS schedule	July 15th		
CAHPS_CPA_SUP.232	U		Adult CAHPS®: Days to Get Appointment For Check-up or Routine Care	Measure	Standard HEDIS schedule	July 15th		
CAHPS_CPA_SUP.233	U		In the last 6 months, did you need care during evenings, weekends, or holidays? (Screening Question for CAHPS_CPA_SUP.234)	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_CPA_SUP.234	U		Adult CAHPS®: Getting Needed Care from a Doctor's Office or Clinic During Evenings, Weekends, or Holidays - Usually or Always	Measure	Standard HEDIS schedule	July 15th		
CAHPS_CPA_SUP.900121	U		Adult CAHPS®: Personal Doctor Had Medical Records or Other Information about Care: Usually or Always	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_CPA_SUP.900122	U		In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service? (Screener Question #1 for CAHPS_CPA_SUP.900124)	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_CPA_SUP.900123	U		In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services? (Screener Question #2 for CAHPS_CPA_SUP.900124)	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_CPA_SUP.900124	U		Adult CAHPS®: Personal Doctor Provided Help Needed to Manage Care Among Different Providers and Services: Usually or Always	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_CPA_SUP.TBD05	N		Adult CAHPS®: Knowledge of Health Plan Complaint Process	Measure	Standard HEDIS schedule	July 15th	7/15/2019	

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CAHPS_GP_SUP.231	U		Child CAHPS®: Days to Get Appointment When Care Needed Right Away	Measure	Standard HEDIS schedule	July 15th		
CAHPS_GP_SUP.232	U		Child CAHPS®: Days to Get Appointment For Check-up or Routine Care	Measure	Standard HEDIS schedule	July 15th		
CAHPS_GP_SUP.233	U		In the last 6 months, did your child need care during evenings, weekends, or holidays? (Screening Question for CAHPS_GP_SUP.234)	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_GP_SUP.234	U		Child CAHPS®: Getting Needed Care from a Doctor's Office or Clinic During Evenings, Weekends, or Holidays - Usually or Always	Measure	Standard HEDIS schedule	July 15th		
CAHPS_GP_SUP.900120	U		Child CAHPS®: Personal Doctor Had Medical Records or Other Information about Child's Care: Usually or Always	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_GP_SUP.990096	U		In the last 6 months, did anyone help coordinate your child's care? (Screening Question for CAHPS_GP_SUP.990097 and CAHPS_GP_SUP.990098)	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_GP_SUP.990097	U		Child CAHPS®: Who Helped to Coordinate Child's Care	Measure	Standard HEDIS schedule	July 15th		
CAHPS_GP_SUP.990098	U		Child CAHPS®: Satisfaction with Help Received to Coordinate Child's Care - Satisfied or Very Satisfied	Measure	Standard HEDIS schedule	July 15th		
CAHPS_GP_SUP.TBD02	N		Child CAHPS®: Knowledge of Health Plan Complaint Process	Measure	Standard HEDIS schedule	July 15th	7/15/2019	
CARECOORD.01	U	X	Percent of Members Receiving Care Management Services by Subgroup	Measure	Quarterly	4 months after the end of the data period		
CARECOORD.03	U		Quality Assessment: Referral to Case Management for All Infants with a Diagnosis of Neonatal Abstinence Syndrome	Measure	quarterly	4 months after the end of the quarter		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CAREMGT.01	U		Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Plan	N/A	May 1st		
CAREMGT.06	U		Special Needs Assessment Report	Table	Monthly	15 days after the end of the reporting quarter		
CAREMGT.20	U		Medicaid Care Management Program Comprehensive Annual Report	Narrative and Analytic Report	Agreement year	August 30		
CLAIM.01	U		Timely Professional and Facility Medical Claim Processing	Measure	Numerator and denominator calculated daily / summary measure reported monthly	50 calendar days after end of reporting period		
CLAIM.05	U		Claims Quality Assurance: Claims Processing Accuracy	Measure	Monthly	50 calendar days after end of reporting period		
CLAIM.06	U		Claims Quality Assurance: Claims Payment Accuracy	Measure	Monthly	50 calendar days after end of reporting period		
CLAIM.07	U		Claims Quality Assurance: Claims Financial Accuracy	Measure	Monthly	50 calendar days after end of reporting period		
CLAIM.08	U		Interest on Late Paid Claims	Measure	Monthly	50 calendar days after end of reporting period		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CLAIM.09	U		Timely Professional and Facility Medical Claim Processing: Sixty Days of Receipt	Measure	Numerator and denominator calculated daily / summary measure reported monthly	80 calendar days after end of reporting period		
CLAIM.10	U		Claims Payment Quality Assurance Corrective Action Plans	Plan	N/A	As needed		
CLAIM.11	U		Professional and Facility Medical Claim Processing Results - Paid, Suspended, Denied	Measure	Numerator and denominator calculated daily / summary measure reported monthly	50 calendar days after end of reporting period		
CLAIM.17	U		Average Pharmacy Claim Processing Time	Measure	Monthly	50 calendar days after end of reporting period		
CLAIM.18	R		High Risk Provider - Professional and Facility Medical Claim Processing Results by Provider Subgroup	Table	Monthly	50 calendar days after end of reporting period		No Submissions Required
CMHCDIRECTPAY.01	N		Community Mental Health Center Direct Payment Report	Report	TBD	TBD	TBD	
CMS_A_ABA	U		Adult BMI Assessment (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CMS_A_AMM.01	U		Antidepressant Medication Management: Effective Acute Phase Treatment (CMS Adult Core Set)	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	September 30th		
CMS_A_AMM.02	U		Antidepressant Medication Management: Effective Continuation Phase Treatment (CMS Adult Core Set)	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	September 30th		
CMS_A_AMR	N		Asthma Medication Ratio (CMS Adult Core Set)	Measure	Calendar Year	September 30th	9/30/2018	
CMS_A_BCS	U		Breast Cancer Screening (CMS Adult Core Set)	Measure	2 CY	September 30th		
CMS_A_CBP	U		Controlling High Blood Pressure (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_CCP.01	U		Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days by Age Group (CMS Adult and Child Core Sets)	Measure	CY	September 30th		
CMS_A_CCP.02	U		Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days by Age Group (CMS Adult and Child Core Sets)	Measure	CY	September 30th		
CMS_A_CCP.03	U		Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 Days by Age Group (CMS Adult and Child Core Sets)	Measure	CY	September 30th		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CMS_A_CCP.04	U		Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 60 Days by Age Group (CMS Adult and Child Core Sets)	Measure	CY	September 30th		
CMS_A_CCS	R		Cervical Cancer Screening (CMS Adult Core Set)	Measure	3 CY	September 30th		9/30/2016
CMS_A_CDF	U		Screening for Clinical Depression and Follow-up Plan by Age Group (CMS Adult and Child Core Sets)	Measure	CY	September 30th		
CMS_A_CUOB	N		Concurrent Use of Opioids and Benzodiazepines	Measure	Calendar Year	September 30th	9/30/2018	
CMS_A_FUA.01	C		Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence: Within 7 Days of ED Visit (FUA, CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_FUA.02	C		Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence: Within 30 Days of ED Visit (FUA, CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_FUH.01	R		Follow-Up After Hospitalization for Mental Illness: Within 7 Days of Discharge (CMS Adult Core Set)	Measure	CY	September 30th		9/30/2016
CMS_A_FUH.02	R		Follow-Up After Hospitalization for Mental Illness: Within 30 days of Discharge (CMS Adult Core Set)	Measure	CY	September 30th		9/30/2016
CMS_A_HA1C	U		Comprehensive Diabetes Care: Hemoglobin A1c Testing (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_HPC	U		Comprehensive Diabetes Care: Hemoglobin A1C Poor Control (>9.0%)	Measure	CY	September 30th		
CMS_A_HPCMI	U		Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%) (CMS Adult Core Set)	Measure	CY	September 30th		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CMS_A_IET.01	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_IET.02	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_INP_PQI01	U		Diabetes Short-Term Complications Admission Rate per 100,000 Member Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_INP_PQI05	U		Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_INP_PQI08	U		Heart Failure Admission Rate per 100,000 Enrollee Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_INP_PQI15	U		Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.01	U		Annual Monitoring for Members on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB) (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.02	U		Annual Monitoring for Members on Digoxin (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.03	U		Annual Monitoring for Members on Diuretic (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.04	U		Annual Monitoring for Patients on Persistent Medications (Total) (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MSC.01	U		CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CMS_A_MSC.02	U		CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th		
CMS_A_MSC.03	U		CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th		
CMS_A_OHD	U		Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_C_BHRA.01	R		Behavioral Health Risk Assessment for Pregnant Women (CMS Child Core Set)	Measure	CY	September 30th		No Further Submissions Required
CMS_C_BHRA.02	R		Behavioral Health Risk Assessment for Pregnant Women (CMS Child Core Set) - Individual Screening Rates	Table	CY	September 30th		No Further Submissions Required
CMS_C_CCP	R		Contraceptive Care – Postpartum (CMS Child Core Set)	Measure	CY	September 30th	9/30/2017	No Submissions Required – New submitting via CMS_A_CCP.01 - CMS_A_CCP.04
CMS_C_DEV	U		Developmental Screening in the First Three Years of Life (CMS Child Core Set) (Administrative only data for 9/30/2015 report)	Measure	CY	September 30th		
CMS_CCW.01	N		Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception (CCW, CMS Adult & Child Core Sets)	Measure		September 30th	9/30/2018	
CMS_C_SRA	R		Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (CMS Child Core Set)	Measure	CY	September 30th	9/30/2017	No Submissions Required
COMMUNICATION.01	U		Communications Plan	Plan	N/A	May 1st		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CULTURALCOMP.01	U		Cultural Competency Strategic Plan	Plan	N/A	September 30th		
DEMGPROF.01	U		Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language	Measure	July 1 (for initial submission use any date prior to due date) Annually	September 30th		
DEMGPROF.03	U		Community Demographic, Cultural, and Epidemiologic Profile: Ethnicity	Measure	July 1 (for initial submission use any date prior to due date)	September 30th		
DEMGPROF.04	U		Community Demographic, Cultural, and Epidemiologic Profile: Race	Measure	July 1 (for initial submission use any date prior to due date)	September 30th		
DSH.01	U		Disproportionate Hospital Claims Report	Table	Hospital Fiscal Year	December 10th		
DUR.01	U		Drug Utilization Review (DUR) Annual Report	Report	Federal Fiscal Year	June 15th		
EMERGENCYRESPONSE.01	U		Emergency Response Plan	Plan	N/A	May 1st		
EPSDT.20	U		Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	Plan	N/A	May 1st		
FWA.02	U		Fraud Waste and Abuse Log: FWA Related to Providers	Table	Monthly	30 days after the end of the month		
FWA.04	U		Fraud Waste and Abuse Log: Date of Death Report	Table	Monthly	30 days after the end of the month		
FWA.05	U		Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Table	Quarterly	30 days after the end of the quarter		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
FWA.07	R		Provider Inappropriate Use of Modifier 59	Table	Quarterly	30 calendar days after end of reporting period		No Submissions Required
FWA.20	U		Comprehensive Annual Fraud Waste and Abuse Summary Annual Report	Narrative Report	Agreement Year	September 30th		
GRIEVANCE.01	U		Grievance Dispositions Made Within 45 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
GRIEVANCE.02	C		Grievance Log Including State Plan / 1915B Waiver Flag	Table	Quarterly (Last Monthly Submission Due 7/15/2016)	15 calendar days after the end of the quarter	10/15/2018	
GRIEVANCE.03	U		Member Grievances Received	Measure	Quarterly	2 Months following the end of the measurement quarter		
HEDIS.01	U		HEDIS Roadmap	Report	Standard HEDIS Schedule	February 5		
HEDIS.02	U		HEDIS Data Filled Workbook	Data File	Standard HEDIS Schedule	June 30		
HEDIS.03	U		HEDIS Comma Separated Values Workbook	Data File	Standard HEDIS Schedule	June 30		
HEDIS.04	U		NCQA HEDIS Compliance Audit™ Final Audit Report	Report	Standard HEDIS Schedule	July 31		
HEDIS_AAB	U		Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Measure	CY	June 30th		
HEDIS_AAP	U		Adults' Access to (use of) Preventive/Ambulatory Health Services	Measure	CY	June 30th		
HEDIS_ABA	U		Adult BMI Assessment	Measure	CY	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_ADD.01	U		Follow Up Care for Children Prescribed ADHD Medication - Initiation	Measure	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	June 30th		
HEDIS_ADD.01_SUB	U	X	Follow Up Care for Children Prescribed ADHD Medication - Initiation by Subpopulation	Measure	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	July 31st		
HEDIS_ADD.02	U		Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	Measure	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_ADD.02_SUB	U	X	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase by Subpopulation	Measure	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	July 31st		
HEDIS_AMB-1a	U		Outpatient and Emergency Dept. Visits/1000 Member Months - Total Population	Measure	CY	June 30th		
HEDIS_AMB-1b	U		Outpatient and Emergency Dept. Visits/1000 Member Months - Medicaid/Medicare Dual-Eligibles	Measure	CY	June 30th		
HEDIS_AMB-1c	U		Outpatient and Emergency Dept. Visits/1000 Member Months - Disabled	Measure	CY	June 30th		
HEDIS_AMB-1d	U		Outpatient and Emergency Dept. Visits/1000 Member Months - Other Low Income	Measure	CY	June 30th		
HEDIS_AMM.01	U		Antidepressant Medication Management - Effective Continuation Phase Treatment - Adults	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_AMM.01_SUB	U	X	Antidepressant Medication Management - Effective Continuation Phase Treatment - Adults by Subpopulation	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	July 31st		
HEDIS_AMM.02	U		Antidepressant Medication Management - Effective Acute Phase Treatment - Adults	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	June 30th		
HEDIS_AMM.02_SUB	U	X	Antidepressant Medication Management - Effective Acute Phase Treatment - Adults by Subpopulation	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	July 31st		
HEDIS_AMR.A	U		Asthma Medication Ratio (AMR)	Measure	CY	June 30th		
HEDIS_APC	U		Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Measure	CY	June 30th		
HEDIS_APM	U		Metabolic Monitoring for Children and Adolescents on Antipsychotics	Measure	Annually	June 30th		
HEDIS_APP	U		Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Measure	CY	June 30th		
HEDIS_APP_SUB	U	X	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics by Subpopulation	Measure	CY	July 31st		
HEDIS_AWC	U		Adolescent Well Care Visits	Measure	CY	June 30th		
HEDIS_BCS	U		Breast Cancer Screening - Age 50-74	Measure	2 CY	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_BCS_SUB	U	X	Breast Cancer Screening - Age 50-74 by Subpopulation	Measure	2 CY	July 31st		
HEDIS_CAP	U		Children and Adolescents' Access To PCP - Age 12 Months - 19 Years	Measure	CY	June 30th		
HEDIS_CBP	U		Controlling High Blood Pressure - Age 18 to 85	Measure	CY	June 30th		
HEDIS_CCS	U		Cervical Cancer Screening - Age 24-64	Measure	See HEDIS Specification	June 30th		
HEDIS_CDC.01	U		Comprehensive Diabetes Care - HbA1c Testing	Measure	CY	June 30th		
HEDIS_CDC.02	U		Comprehensive Diabetes Care - HbA1c Poor Control (>9%)	Measure	CY	June 30th		
HEDIS_CDC.03	U		Comprehensive Diabetes Care - HbA1c Control (<8%)	Measure	CY	June 30th		
HEDIS_CDC.04	R		Comprehensive Diabetes Care – HbA1c Control (<7%) for a Selected Population	Measure	CY	June 30th		6/30/2018
HEDIS_CDC.05	U		Comprehensive Diabetes Care - Eye Exam	Measure	CY	June 30th		
HEDIS_CDC.08	U		Comprehensive Diabetes Care - Medical Attention for Nephropathy	Measure	CY	June 30th		
HEDIS_CDC.10	U		Comprehensive Diabetes Care - BP Control (<140/90)	Measure	CY	June 30th		
HEDIS_CHL	U		Chlamydia Screening in Women - Age 16 to 24	Measure	CY	June 30th		
HEDIS_CIS.01	U		Childhood Immunization Status - Combo 2	Measure	CY	June 30th		
HEDIS_CIS.02	U		Childhood Immunization Status - Combo 3	Measure	CY	June 30th		
HEDIS_CIS.03	U		Childhood Immunization Status - Combo 4	Measure	CY	June 30th		
HEDIS_CIS.04	U		Childhood Immunization Status - Combo 5	Measure	CY	June 30th		
HEDIS_CIS.05	U		Childhood Immunization Status - Combo 6	Measure	CY	June 30th		
HEDIS_CIS.06	U		Childhood Immunization Status - Combo 7	Measure	CY	June 30th		
HEDIS_CIS.07	U		Childhood Immunization Status - Combo 8	Measure	CY	June 30th		
HEDIS_CIS.08	U		Childhood Immunization Status - Combo 9	Measure	CY	June 30th		
HEDIS_CIS.09	U		Childhood Immunization Status - Combo 10	Measure	CY	June 30th		
HEDIS_CIS.10	U		Childhood Immunization Status - DTaP	Measure	CY	June 30th		
HEDIS_CIS.11	U		Childhood Immunization Status - IPV	Measure	CY	June 30th		
HEDIS_CIS.12	U		Childhood Immunization Status - MMR	Measure	CY	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_CIS.13	U		Childhood Immunization Status - HIB	Measure	CY	June 30th		
HEDIS_CIS.14	U		Childhood Immunization Status - Hepatitis B	Measure	CY	June 30th		
HEDIS_CIS.15	U		Childhood Immunization Status - VZV	Measure	CY	June 30th		
HEDIS_CIS.16	U		Childhood Immunization Status - Pneumococcal Conjugate	Measure	CY	June 30th		
HEDIS_CIS.17	U		Childhood Immunization Status - Hepatitis A	Measure	CY	June 30th		
HEDIS_CIS.18	U		Childhood Immunization Status - Rotavirus	Measure	CY	June 30th		
HEDIS_CIS.19	U		Childhood Immunization Status - Influenza	Measure	CY	June 30th		
HEDIS_COU	N		Risk of Chronic Opioid Use (COU)	Measure	Annually	June 30	6/30/2019	
HEDIS_CWP	U		Appropriate Testing for Children With Pharyngitis	Measure	July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.	June 30th		
HEDIS_FPC	R		Frequency of Ongoing Prenatal Care by Percent of Expected Number of Visits (<21%, 21-40%, 41-60%, 61-80%, >=81%)	Measure	CY	June 30th		6/30/2017
HEDIS_FMC	N		Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	Measure	CY	June 30th	6/30/2019	
HEDIS_FUA.01	U		Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (within 30 days of the ED visit)	Measure	CY	June 30th		
HEDIS_FUA.02	U		Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (within 7 days of the ED visit)	Measure	CY	June 30th		
HEDIS_FUH.01	U		Follow Up After Hospitalization For Mental Illness - 7 days	Measure	January 1 through December 1 of the measurement year	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_FUH.02	U		Follow Up After Hospitalization For Mental Illness - 30 days	Measure	January 1 through December 1 of the measurement year	June 30th		
HEDIS_FUM.01	U		Follow-Up After Emergency Department Visit for Mental Illness (within 30 days of the ED visit)	Measure	CY	June 30th		
HEDIS_FUM.02	U		Follow-Up After Emergency Department Visit for Mental Illness (within 7 days of the ED visit.)	Measure	CY	June 30th		
HEDIS_IET.01	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation	Measure	CY	June 30th		
HEDIS_IET.01_SUB	U	X	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation by Subpopulation	Measure	CY	July 31st		
HEDIS_IET.02	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement	Measure	CY	June 30th		
HEDIS_IET.02_SUB	U	X	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement by Subpopulation	Measure	CY	July 31st		
HEDIS_IMA.01	U		Immunizations for Adolescents - Combination 1	Measure	CY	June 30th		
HEDIS_IMA.02	U		Immunizations for Adolescents - Meningococcal	Measure	CY	June 30th		
HEDIS_IMA.03	U		Immunizations for Adolescent - Tdap/Td	Measure	CY	June 30th		
HEDIS_IMA.04	U		Immunizations for Adolescent - HPV	Measure	CY	June 30th	6/30/2017	
HEDIS_IMA.05	U		Immunizations for Adolescents (IMA, Hybrid Specification): Combination 2	Measure	CY	June 30th	6/30/2017	
HEDIS_LBP	U		Use of Imaging Studies for Low Back Pain	Measure	CY	June 30th		
HEDIS_LSC	N		Lead Screening in Children	Measure	CY	June 30th	6/30/2018	

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_MMA.01	U		Medication Management for People with Asthma - At Least 75% of Treatment Period	Measure	CY	June 30th		
HEDIS_MMA.02	U		Medication Management for People with Asthma - At Least 50% of Treatment Period	Measure	CY	June 30th		
HEDIS_MPM.01	U		Annual Monitoring for Patients on Persistent Medications - Adults - ACE or ARB	Measure	CY	June 30th		
HEDIS_MPM.01_SUB	U	X	Annual Monitoring for Patients on Persistent Medications - Adults - ACE or ARB by Subpopulation	Measure	CY	July 31st		
HEDIS_MPM.02	U		Annual Monitoring for Patients on Persistent Medications - Adults - Digoxin	Measure	CY	June 30th		
HEDIS_MPM.02_SUB	U	X	Annual Monitoring for Patients on Persistent Medications - Adults - Digoxin by Subpopulation	Measure	CY	July 31st		
HEDIS_MPM.03	U		Annual Monitoring for Patients on Persistent Medications - Adults - Diuretics	Measure	CY	June 30th		
HEDIS_MPM.03_SUB	U	X	Annual Monitoring for Patients on Persistent Medications - Adults - Diuretics by Subpopulation	Measure	CY	July 31st		
HEDIS_MPM.04	U		Annual Monitoring for Patients on Persistent Medications - Adults - Total Rate	Measure	CY	June 30th		
HEDIS_NCQA	U		MCO Submission of Audited HEDIS Results as Submitted to NCQA in NCQA Format	Measure	CY	June 30th		
HEDIS_PCE	U		Pharmacotherapy Management of COPD Exacerbation	Measure	CY	June 30th		
HEDIS_PCE.01_SUB	U	X	Pharmacotherapy Management of COPD Exacerbation by Subpopulation	Measure	CY	July 31st		
HEDIS_PCE.02_SUB	U	X	Pharmacotherapy Management of COPD Exacerbation by Subpopulation	Measure	CY	July 31st		
HEDIS_PPC.01	U		Prenatal and Postpartum Care - Timeliness of Prenatal Care	Measure	CY	June 30th		
HEDIS_PPC.02	U		Prenatal and Postpartum Care - Postpartum Care	Measure	CY	June 30th		
HEDIS_SAA	U		Adherence to Antipsychotics for Individuals with Schizophrenia - Adults Age 19-64	Measure	CY	June 30th		
HEDIS_SMC	U		Statin Therapy for Patients with Cardiovascular Disease	Measure	Annual	June 30th		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_SMD	U		Statin Therapy for Patients with Diabetes	Measure	Annual	June 30th		
HEDIS_SSD	U		Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Measure	CY	June 30th		
HEDIS_UOD	N		Use of Opioids at High Dosage	Measure	CY	June 30th	6/30/2019	
HEDIS_URI	U		Appropriate Treatment for Children With Upper Respiratory Infection	Measure	July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.	June 30th		
HEDIS_W15	U		Well-Child Visits in the first 15 Months of Life (0 visits, 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, 6 or more visits)	Measure	CY	June 30th		
HEDIS_W34	U		Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Total Population	Measure	CY	June 30th		
HEDIS_WCC.01	U		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile documentation	Measure	CY	June 30th		
HEDIS_WCC.02	U		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	Measure	CY	June 30th		
HEDIS_WCC.03	U		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	Measure	CY	June 30th		
HNA.01	U		New Member Health Needs Assessment – Best Effort to Have Member Conduct a Health Needs Self-Assessment	Measure	Quarterly	Four months after the end of the quarter		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HNA.07	U		New Member Health Needs Assessment – Member Successfully Completed MCO's Health Needs Self-Assessment	Measure	Quarter	4 Months after end of measure data source time period		
INPASC.03	C	X	Inpatient Hospital Utilization by Adults for Ambulatory Care Sensitive Conditions by Subpopulation	Measure	Annual	4 months after the end of Reporting Year	4/30/2019	
INPUTIL.02	U	X	Inpatient Hospital Utilization for All Conditions Excluding Maternity/Newborns by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
INTEGRITY.01	U		Program Integrity Plan	Plan	N/A	Upon revision		
LOCKIN.01	U		Pharmacy Lock-In Member Enrollment Log	Table	Monthly	30 calendar days after end of month		
LOCKIN.03	U		Pharmacy Lock-In Activity Summary	Table	Monthly	30 calendar days after end of month		
MAINTMED.02	R		Maintenance Medication Gaps by Age Group	Measure	Quarterly	3 months after the end of the quarter		No Further Submissions Required
MCISPLANS.01	U		Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	Plan	N/A	June 1st		
MEMCOMM.01	U		Member Communications: Speed to Answer Within 30 Seconds	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.03	U		Member Communications: Calls Abandoned	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.05	U		Member Communications: Voice Mails Returned by Next Business Day	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.06	U		Member Communications: Reasons for Telephone Inquiries	Measure	Monthly	20 calendar days after end of reporting period		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
MLR.01	U		Medical Loss Ratio Report: NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program	Table	Quarterly	9 months after the end of the quarter		
MSQ.01	U		Medical Services Inquiry Letter	Table	Monthly	30 Day after end of Reporting Month	10/31/2017	
NEMT.12	U		NEMT Requests Delivered by Mode of Transportation	Measure	Quarterly	2 month after end of reporting period		
NEMT.13	U		NEMT Request Authorization Approval Rate by Mode of Transportation	Measure	Quarterly	2 months after end of reporting period		
NEMT.15	U		NEMT Services Delivered by Type of Medical Service	Measure	Quarterly	2 months after end of reporting period		
NEMT.17	U		NEMT Scheduled Trip Member Cancellations by Reason for Member Cancellation for Contracted Providers	Measure	Quarterly	2 months after end of reporting period		
NEMT.18	U		Non-Emergent Transportation Contracted Transportation & Wheelchair Van Provider Scheduled Trip Results by Outcome	Measure	Quarterly	2 months after end of reporting period		
NEMT.19	U		Non-Emergent Transportation - Contracted Transportation & Wheelchair Van Provider Scheduled Trips (Excluding Rides for Methadone Treatment) - Timeliness	Measure	Quarterly	2 months after end of reporting period		
NEMT.21	U		Non-Emergent Transportation - Contracted Transportation & Wheelchair Van Provider Scheduled Trips Timeliness	Measure	Quarterly	2 months after end of reporting period	9/31/2018	
NETWORK.01	C		Comprehensive Provider Network and Equal and Timely Access Semi-Annual Filing	Narrative Report	Semi-annual	45 days after the end of the semi-annual period	2/14/2019	
NETWORK.02	U		Corrective Action Plan for Non-Compliance With Timely Access Standards	Plan	N/A	As needed		
NETWORK.03	U		Plan to Recruit and Maintain Sufficient Networks of SUD Service Providers and Member Access	Plan	Agreement Year	May 1st		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
NETWORK.10	C		Corrective Action Plan to Restore Provider Network Adequacy	Plan	Semi-annual, As Needed	45 days after the end of the semi-annual period	2/14/2019	
NHHDISCHARGE.01	U		New Hampshire Hospital Discharges Where Members Received Discharge Instruction Sheet	Measure	Quarterly	2 months after the end of the quarter		
NHHDISCHARGE.10	U	X	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.12	U	X	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 30 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.13	U		New Hampshire Hospital Discharges With Discharge Plan Provided to Aftercare Provider Within 7 Days of Member Discharge	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.16	U		New Hampshire Hospital Dischargos - NEW CMHC Patient Had An Intake Appointment With A CMHC Within 7 Calendar Days of Discharge	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.17	U		New Hampshire Hospital Discharges - MCO Contacts and Contact Attempts	Measure	Quarterly	Two months after the end of the data period		
NHHREADMIT.05	U	X	Readmission to New Hampshire Hospital at 30 days by Subpopulation	Measure	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	September 1st		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
NHHREADMIT.06	U	X	Readmission to New Hampshire Hospital at 180 days by Subpopulation	Measure	January 1 of the prior SFY to June 30 of the measurement year. An 18 month period	September 1st		
PAYREFORM.01	U		Payment Reform Plan	Plan	N/A	May 1st		
PAYREFORM.03	U		Payment Reform Quarterly Update Report	Narrative Report	Quarterly	30 days after the end of the reporting period		
PDN.04	U		Private Duty Nursing: RN-Level Hours Delivered and Billed (replaces monthly measure)	Measure	Quarterly	2 months after the end of the reporting period		
PDN.05	U		Private Duty Nursing: LPN-Level Hours Delivered and Billed (replaces monthly measure)	Measure	Quarterly	2 months after the end of the reporting period		
PDN.07	U		Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Table	Quarterly	2 months after the end of each quarter.		
PHARM_PDC	U		Proportion of Days Covered	Measure	Annual	March 31st	6/30/2010	
PHARMQI.01	U		Pharmacy Quality Improvement Initiative Plans	Plan	Annual Plan	September 30th		
PHARMQI.08	U		Safety Monitoring - Use of at Least One High-Risk Medication in the Elderly, Excluding Medicare/Medicaid Dual Enrollees	measure	quarterly	2 months after the end of the quarter		
PHARMQI.09	U		Safety Monitoring Prior Authorized Fills for Opioid Prescriptions With a Dosage Over 100 mg	measure	quarterly	2 months after the end of the quarter		
PHARMQI.10	U		Safety monitoring of psychotropics: polypharmacy; ADHD, antipsychotics (typical and atypical), antidepressants, mood stabilizers	Table	Quarterly	2 months after the end of the quarter		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
PHARMQI.12	U		Safety Monitoring - Use of at Least Two High-Risk Medications in the Elderly, Excluding Medicare/Medicaid Dual Enrollees	measure	quarterly	2 months after the end of the quarter		
PHARMQI.13	R		Polypharmacy Members Offered an Annual Comprehensive Medication Review, by Completion Status and Age Group	Measure	semi-annually	2 months after the end of semi-annual period	2/28/2018	No Further Submissions Required
PHARMQI.15	U		Polypharmacy Members Offered Annual Comprehensive Medication Review	Measure	Semi-Annual	March 31st	6/30/2018	
PHARMQI.16	U		Polypharmacy Members Who Utilized Annual Comprehensive Medication Review	Measure	Semi-Annual	March 31st	6/30/2018	
PHARMUTLMGT.02	U		Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Measure	Quarterly	2 months after the end of the quarter		
PHARMUTLMGT.03	U		Pharmacy Utilization Management: Generic Drug Substitution	Measure	Quarterly	2 months after the end of the quarter		
PHARMUTLMGT.04	U		Pharmacy Utilization Management: Generic Drug Utilization	Measure	Quarterly	2 months after the end of the quarter		
PIP.01	R		Performance Improvement Project Semi-Annual Report	Narrative Report	Semi-Annual	July 31st and January 31st		No Further Submission Required
PMP.01	U		Program Management Plan	Plan	N/A	August 1st		
POLYPHARM.04	U		Polypharmacy: Children >=4 Drugs	measure	quarterly	2 months after the end of the quarter		
POLYPHARM.05	U		Polypharmacy: Adults ≥ 10 Drugs	measure	quarterly	2 months after the end of the quarter		
PRIVACYBREACH.01	U		Privacy Breach Notification	Narrative Report	As Needed	Preliminary notice within one (1) day of breach and final detailed notice after MCO assessment		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
PROVCOMM.01	U		Provider Communications: Speed to Answer Within 30 Seconds	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMM.03	U		Provider Communications: Calls Abandoned	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMM.05	U		Provider Communications: Voice Mails Returned by Next Business Day	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMM.06	U		Provider Communications: Reasons for Telephone Inquiries	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMPLAINT.01	U		Provider Complaint and Appeals Log	Table	Quarterly	2 months after the end of the reporting quarter		
PROVQUAL.01	U		MCO Provider Quality Report Card	Table	N/A	Upon request		
PROVSATISFACTION.01	U		Provider Satisfaction Survey	Narrative Report	Semi-Annual First Year, Then Annual	September 30th		
PROVTERM.01	U		Provider Termination Log	Table	As needed or weekly	Within 15 calendar days of the notice of termination or effective date, whichever is sooner		
PROVTERM.02	U		Provider Termination Report	Table	Monthly	1 month after the end of the reporting month.		
PROVTRAINING.03	U		Community Mental Health Center Staff Training Plan	Plan	N/A	April 1st		
QAPI.01	U		Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	Narrative Report	Annual	September 30th		

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Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
QAPI.02	U		Quality Assessment and Performance Improvement (QAPI) Semi-Annual Update Report	Narrative Report	Semi-Annual	March 31st		
QAPI.03	U		Quality Assessment and Performance Improvement (QAPI) Annual Program Description and Annual Work Plan	Plan	Annual	December 31st		
SERVICEAUTH.01	U		Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.02	R		Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Continued/Extended Urgent Services	Measure	Quarterly	2 months after the end of the quarter		6/31/2019
SERVICEAUTH.03	U		Medical Service, Equipment and Supply Service Authorization Timely (14 Day) Determination Rate: New Routine Requests (excludes NEMT and Complex Diagnostic Radiology)	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.04	U		Pharmacy Service Authorization Timely Determination Rate	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.05	C		Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Table	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.06	U		Service Authorization Denial Detail Log	Table	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.08	U		Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests That Were Extended	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.09	U		Number of Pharmacy Prior Authorizations Stratified By Behavioral Health and Other Drugs	Measure	quarterly	2 months after the end of the quarter		
SERVICEAUTH.12	U		Complex Diagnostic Radiology Authorization Timely (2 Day) Determination Rate: Routine Requests	Measure	Quarterly	2 months after the end of the quarter		

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
SERVICEAUTH.13	U		Medical Service, Equipment and Supply Post Delivery Service Authorization Timely (30 Day) Determination Rate	Measure	Quarterly	2 months after the end of the quarter		
STAFFINGPLAN.01	U		MCO Staffing Contingency Plan	Plan	Annually	August 1		
SUD.01	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Any SUDSM Specific Service, by Age Group	Measure	Quarterly	4 months after the end of the quarter		No Further Submissions Required
SUD.02	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using One or More Opioid Treatment Center Services, by Age Group	Measure	Quarterly	4 months after the end of the quarter		No Further Submissions Required
SUD.03	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Buprenorphine Through Point of Service Pharmacy, by Age Group	Measure	Quarterly	4 months after the end of the quarter		No Further Submissions Required
SUD.04	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using General Acute Care Inpatient Hospital Withdrawal Services, by Age Group	Measure	Quarterly	4 months after the end of the quarter		No Further Submissions Required
SUD.06	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Outpatient Non-Facility Individual, Family, or Group SUDSM Counseling Service, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.07	R		Substance Use Disorder and Substance Misuse Services: Average Number of Outpatient Non-Facility Individual, Family, or Group SUDSM Counseling Services Used Per Service User, By Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.08	R		Substance Use Disorder and Substance Misuse Services: Average Number of Opioid Treatment Center Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
SUD.09	R		Substance Use Disorder and Substance Misuse Services: Average Number of Day's Supply of Buprenorphine Through a Point of Service Pharmacy Per Buprenorphine User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.10	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Partial Hospitalization for SUDSM, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.11	R		Substance Use Disorder and Substance Misuse Services: Average Number of Partial Hospitalizations for SUDSM Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.12	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Intensive Outpatient Treatment for SUDSM, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.13	R		Substance Use Disorder and Substance Misuse Services: Average Number of Intensive Outpatient Treatment Services for SUDSM Using Specific Service Per Member Per Month, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.14	R		Substance Use Disorder and Substance Misuse Services: Average Number of General Acute Care Inpatient Hospital Withdrawal Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.15	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using SUDSM Rehabilitation Facility Service, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.16	R		Substance Use Disorder and Substance Misuse Services: Average Number of SUDSM Rehabilitation Facility Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
SUD.17	R		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Outpatient Crisis Intervention Services (in Provider Office or Community) for SUDSM, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.18	R		Substance Use Disorder and Substance Misuse Services: Average Number of Outpatient Crisis Intervention Services (in Provider Office or Community) for SUDSM Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.19	R	X	Substance Use Disorder and Substance Misuse ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.20	R		Substance Use Disorder and Substance Misuse ED Use: Rate of ED Visits for Substance Abuse Disorder and Substance Misuse Diagnoses per 1,000 Member Months, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.21	R		Substance Use Disorder and Substance Misuse ED Use: Rate of ED Visits for Substance Use Disorder and Substance Misuse Diagnoses for the Population Using Any SUDSM Service Per 1,000 Member Months, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD.22	R		Substance Use Disorder and Substance Misuse ED Use: Rate of ED Use for Any Diagnosis (SUDSM or Other) for Members Using Any SUDSM Service in Quarter per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		No Further Submissions Required
SUD_1115.01	N		Continuity of Pharmacotherapy for Opioid Use Disorder	Measure	Annually	TBD	TBD	
SUD_1115.02	N		Critical Incidents Related to SUD Treatment Services	Table	Quarterly	TBD	TBD	
SUD_1115.TBD	N		Additional Measures and Reports to Support SUD 1115 Waiver Monitoring (Specifics TBD)	TBD	TBD	TBD	TBD	

Exhibit O – Amendment #09
NH Medicaid Care Management Quality and Oversight Reporting – SFY 2019

Reporting Reference ID	Change for 2019	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
TERMINATIONPLAN.01	U		MCO Termination Plan	Plan	N/A	As needed		
TIMELYNOTICE.02	U		Timeliness of Notice Delivery: Standard Service Authorization Denial	Measure	Quarterly	2 months after the end of the quarter		
TIMELYNOTICE.03	U		Timeliness of Notice Delivery: Standard Service Authorization Denial With Extension	Measure	Quarterly	2 months after the end of the quarter		
TIMELYNOTICE.04	U		Timeliness of Notice Delivery: Expedited Process	Measure	Quarterly	2 months after the end of the quarter		
TPLCOB.01	U		Coordination of Benefits: Costs Avoided	Table	Quarterly	2 months after the end of the quarter		
TPLCOB.02	U		Coordination of Benefits: Medical Costs Recovered Claim Log	Table	Quarterly	2 months after the end of the quarter		
TPLCOB.03	U		Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Table	Quarterly	2 months after the end of the quarter		
TRANSFORM.XX	R		Measures to Support 1115 Transformation Waiver Monitoring (Specifics TBD; measures will be claims, survey, & operations based)	Measure	N/A	TBD		No Submissions Required

HEALTH INSURANCE PORTABLITY 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 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.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 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, TitleXIII, 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 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 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 160.103, 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 164.103.

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, unreadable, 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) Business Associate 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, Business Associate, including but not limited to all its directors, officers, employees and agents, shall 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 HIPAA Privacy, Security, and Breach Notification Rules 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. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. 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.

e. 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 (l). 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 Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. 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.

g. 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.

h. 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.

i. 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.

j. 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.

k. 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.

l. 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 Paragraph 10 of the standard terms and conditions (P-37) 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, 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.

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 destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Granite State Health Plan
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Henry D. Lipman	Jennifer Wiegand
Name of Authorized Representative	Name of Authorized Representative
Medicaid Director	CEO
Title of Authorized Representative	Title of Authorized Representative
May 29, 2018	5-29-18
Date	Date

HEALTH INSURANCE PORTABILITY 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 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.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 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, TitleXIII, 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 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

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k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, 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 164.103.

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, unreadable, 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) **Business Associate 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, Business Associate, including but not limited to all its directors, officers, employees and agents, shall 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 HIPAA Privacy, Security, and Breach Notification Rules 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. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
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- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. 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.

e. 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 (l). 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 Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. 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.

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k. 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.

l. 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 Paragraph 10 of the standard terms and conditions (P-37) 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, 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.

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 destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Boston Medical Center Health Plan, Inc. (DBA/ Well Sense)
The State	Name of the Contractor
X Henry D. Lipman	Susan Conley
Signature of Authorized Representative	Signature of Authorized Representative
X Henry D. Lipman	Susan Coakley
Name of Authorized Representative	Name of Authorized Representative
X Medicaid Director	President
Title of Authorized Representative	Title of Authorized Representative
X May 29, 2018	5/25/18
Date	Date

7B mac

G+C Approved 12-6-17 #7B

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID SERVICES

Jeffrey A. Meyers
Commissioner

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

November 29, 2017

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend the existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to (1) revise the contract value downward for SFY 2018 **retroactively** to account for an adjusted actuarially certified rate structure to $617,356,040.00 (a reduction of $1,925,905.00) and (2) extend the contract completion date from June 30, 2018 to June 30, 2019 **prospectively** in amount totaling $590,626,204.20[1]. The combined aggregate total is $3,493,121,368.21 for all Medicaid Care Management program contracts effective upon Governor and Executive Council approval.

Governor and Executive Council approved the original agreements on May 9, 2012, Item #54A, and approved subsequent amendments on June 19, 2013, Item #67A; February 12, 2014, Item #25; April 9, 2014, Item #44; June 18, 2014, Item #65A; July 16, 2014, Late Item "A"; December 23, 2014, Item #11; June 24, 2015, Item #30; August 5, 2015, Tabled Item 'A'; December 16, 2015, Late Item 'A3'; January 27, 2016, Item #7B; March 9, 2016, Item #10A; June 29, 2016. Late Item 'A2'; October 5, 2016, Item #12A; and June 21, 2017, Tabled Item #18. Funds are 50% Federal and 50% General Funds for the currently eligible Medicaid population except for the NH Health Protection Program services funds are 95% Federal and 5% Other for Calendar Year 2017; and 94% Federal and 6% Other for Calendar Year 2018.

Funds to support this request are available in the following accounts in SFY 2018 and are anticipated to be available in SFY 2019 upon availability and continued appropriation of funds in future operating budgets.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18 (Prior Figures Amendment 14)	SFY18 (Revised figures Amendment 15)	SFY19	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000.00	$460,000,000.00	$490,897,701.00	$536,601,871.35	$540,813,917.00	$539,100,917.00	$548,245,172.00	$2,826,845,461.35
New Hampshire Health Protection Program: 010-047-3099-102	$0	$0.00	$193,000,000.00	$218,624,347.94	$134,015,403.72	$78,468,028.00	$78,255,123.00	$42,381,032.20 [1]	$666,275,906.86
TOTAL	$0	$250,000,000.00	$653,000,000.00	$709,522,048.94	$672,617,075.07	$619,281,945.00	$617,356,040.00	$590,626,204.20	$3,493,121,368.21

[1] Please note, the SFY 2019 amount is only for the first six (6) months of SFY 2019 as it is funded only through the approval date of December 31, 2018 for the New Hampshire Health Protection Program.

EXPLANATION

The purpose of these amendments is to change the actuarial certified rate structure and extend the two agreements with the managed care health plans until June 30, 2019.

The Department is retroactively and prospectively amending the existing individual agreements with the state's two managed care health plans that commenced July 1, 2017 to reflect an updated actuarially certified rate structure. The retroactive element of these amendments is required to account for how the HB 400 and HB 517 mental health programs are being implemented in SFY 2018. The SFY 2018 decreases from $619,281,945.00 (in Amendment #14 approved by Governor and Executive Council on June 21, 2017 tabled Item #18) to $617,356,040.00.

Another purpose of this amendment is to extend the existing individual agreements with the state's two managed care health plans by an additional year to June 30, 2019 in accordance with SB155. The SB155 legislation requires the Department to re-procure contracts commencing July 1, 2019. This extension provides the state the necessary time to plan for and implement a robust and open re-procurement process for the Medicaid Care Management program.

Exhibit B to the Agreement reflects the adjusted capitated rate information for SFY 2018. Tables 1 through 3 below show the average per member per month and percentage changes in the capitation rates for the Medicaid Care Management program; and Medically Frail and Transitional population. Transitional members are those individuals that lose eligibility for standard Medicaid, but gain eligibility for the New Hampshire Health Protection Program and are finalizing enrollment into a Qualified Health Plan under the Premium Assistance Program. These three tables illustrate that overall capitation payments will decrease.

Table 1
New Hampshire Department of Health and Human Services
Medicaid Care Management Program Capitation Rates
Updated SFY 2018 Capitation Rate Reconciliation

Change Component	PMPM Change	Percentage Change
Original SFY 2018 MCM Rates	$356.68	N/A
Removal of Designated Receiving Facility Beds	-0.78	-0.22%
Removal of Community Residential Beds	-0.53	-0.15%
Removal of Mobile Crisis Team and Apartments	-0.21	-0.06%
Adjusted Prescription Drug Trends	+0.38	+0.11%
Updated SFY 2018 MCM Rates	$355.55	-0.32%

Table 2
New Hampshire Department of Health and Human Services
Medically Frail Population Capitation Rates
Updated SFY 2018 Capitation Rate Reconciliation

Change Component	PMPM Change	Percentage Change
Original SFY 2018 Medically Frail Rates	$1,210.76	N/A
Removal of Designated Receiving Facility Beds	-2.53	-0.21%
Removal of Community Residential Beds	-1.72	-0.14%
Removal of Mobile Crisis Team and Apartments	-0.67	-0.05%
Adjusted Prescription Drug Trends	+1.61	+0.13%
Updated SFY 2018 Medically Frail Rates	$1,207.45	-0.27%

Table 1
New Hampshire Department of Health and Human Services
Transitional Population Capitation Rates
Updated SFY 2018 Capitation Rate Reconciliation

Change Component	PMPM Change	Percentage Change
Original SFY 2018 Transitional Population Rates	$444.54	N/A
Removal of Designated Receiving Facility Beds	-0.56	-0.13%
Removal of Community Residential Beds	-0.39	-0.09%
Removal of Mobile Crisis Team and Apartments	-0.15	-0.03%
Adjusted Prescription Drug Trends	+0.16	+0.04%
Updated SFY 2018 Transitional Population Rates	$443.60	-0.21%

The November 29, 2017 Governor and Council submission has been attached to this request as background information. Please note that only one copy of Exhibit A and Exhibit B have been attached as the Exhibits were voluminous, but were identical for both vendors.

Area Served: Statewide.

Source of funds: Federal financial participation rates for the currently eligible population will be 50% Federal Funds as appropriated by Congress for the entire period of this amendment, and 50% General Funds. Federal financial participation rates for the New Hampshire Health Protection services are 95% Federal Funds and 5% Other Funds in Calendar Year 2017, and 94% Federal Funds and 6% Other Funds in Calendar Year 2018, as appropriated by Congress.

In the event that Federal funds become no longer available or are decreased below the 94% level for the New Hampshire Health Protection population in CY 2018, consistent with RSA 126-A:5-b,c General Funds will not be requested to support this program; and medical services for the new adult population would end consistent with RSA 126-A:5-b,c and the Special Terms and Conditions of the Premium Assistance Program Demonstration.

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

November 29, 2017

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to **retroactively** amend two existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families of Bedford, NH and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan of Boston, MA as described below and referenced as DoIT No. 2012-074O.

The purpose of this request is to enter into a contract amendment is to retroactively change the actuarial certified rate structure to July 1, 2017 and to extend the two agreements with the managed care health plans.

The funding amount for this amendment is $588,700,299.20, increasing the current aggregate contract amount from $2,904,421,069.01 to $3,493,121,368.21. The contract shall become effective upon Governor and Council approval through June 30, 2019.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/kaf
DoIT #2012-074O

cc: Bruce Smith, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #15 to the
Medicaid Care Management Contract

This 15th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment Fifteen") dated this 21st day of November, 2017, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Granite State Health Plan, Inc., (hereinafter referred to as "the Contractor"), a New Hampshire Corporation with a place of business at 2 Executive Park Drive, Bedford, NH 03110.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013, Item #, 67A, Amendment #2 February 12, 2014, Item #25, Amendment #3 April 9, 2014, Item #44, Amendment #4 June 18, 2014, Item #65A, Amendment #5 July 16, 2014, Late Item "A", Amendment #6 December 23, 2014, Item #11, Amendment #7 June 24, 2015, Item #30, Amendment #8 August 5, 2015, Tabled Item "A", Amendment #9 December 16, 2015, Late Item "A3", Amendment #10 January 27, 2016, Item #7B, Amendment #11 March 9, 2016, Item #10A, Amendment #12 June 29, 2016, Late Item "A2", Amendment #13 October 5, 2016, Item #12A, and Amendment #14 June 21, 2017 Tabled Item #18, 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to modify the price limitation, extend the completion date, and modify the scope of services to support continued delivery of these services, and modify the capitation rates, 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:

1. Amend Form P-37, General Provisions, Block1.7 Completion Date to read: June 30, 2019
2. Amend Form P-37, General Provisions, Block 1.8 Price Limitation to Increase the Price Limitation by $588,700,299.20 from $2,904,421,069.01 to read: $3,493,121,368.21 for a cumulative contract value for all Medicaid Care Management contracts.
3. Amend Form P-37, Block 1.9, to read Maria Reinemann, Director of Contracts and Procurement.
4. Amend Form P-37, Block 1.10 to read 603-271-9330.
5. Delete Exhibit A Amendment #12 in its entirety and replace with Exhibit A Amendment #13.
6. Delete Exhibit B Amendment #14 in its entirety and replace with Exhibit B Amendment #15.

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

Date

Name: Henry Lipman
Title: Interim Medicaid Director

Granite State Health Plan, Inc.

11-27-17
Date

Name: Jennifer Weisgerber
Title: Plan President

Acknowledgement of Contractor's signature:

State of MO, County of St Louis on 11/27/17, before the undersigned officer, personally appeared the person identified directly 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

LAURA GREENO - NOTARY PUBLIC
Name and Title of Notary or Justice of the Peace

My Commission Expires: 12/18/2020

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

LAURA L GREENO
My Commission Expires
December 18, 2020
St Louis County
Commission #12426339

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

11/28/2017
Date

Name: Henry Lipman
Title: Interim Medicaid Director

Granite State Health Plan, Inc.

11-27-17
Date

Name: Jennifer Wellford
Title: Plan President

Acknowledgement of Contractor's signature:

State of MO, County of St Louis on 11/27/17, before the undersigned officer, personally appeared the person identified directly 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

LAURA GREENO - NOTARY PUBLIC
Name and Title of Notary or Justice of the Peace

My Commission Expires: 12/18/2020

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

LAURA L GREENO
My Commission Expires
December 18, 2020
St. Louis County
Commission #12426339

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

OFFICE OF THE ATTORNEY GENERAL

11/28/2017
Date

Name: Nancy J. Smith
Title: Senior Asst. Attorney General

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:

State of New Hampshire
Department of Health and Human Services
Amendment #15 to the
Medicaid Care Management Contract

This 15th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment Fifteen") dated this 21st day of November, 2017, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Boston Medical Center Health Plan, Inc., (hereinafter referred to as "the Contractor"), a Massachusetts nonprofit corporation with a place of business at 2 Copley Place, Suite 600, Boston, MA 02116.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013, Item #, 67A, Amendment #2 February 12, 2014, Item #25, Amendment #3 April 9, 2014, Item #44, Amendment #4 June 18, 2014, Item #65A, Amendment #5 July 16, 2014, Late Item "A", Amendment #6 December 23, 2014, Item #11, Amendment #7 June 24, 2015, Item #30, Amendment #8 August 5, 2015, Tabled Item "A", Amendment #9 December 16, 2015, Late Item "A3", Amendment #10 January 27, 2016, Item #7B, Amendment #11 March 9, 2016, Item #10A, Amendment #12 June 29, 2016, Late Item "A2", Amendment #13 October 5, 2016, Item #12A, and Amendment #14 June 21, 2017 Tabled Item #18, 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to modify the price limitation, extend the completion date, and modify the scope of services to support continued delivery of these services, and modify the capitation rates, 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:

1. Amend Form P-37, General Provisions, Block1.7 Completion Date to read: June 30, 2019
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5. Delete Exhibit A Amendment #12 in its entirety and replace with Exhibit A Amendment #13.
6. Delete Exhibit B Amendment #14 in its entirety and replace with Exhibit B Amendment #15.

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

11-29-2017
Date

Name: Henry Lipman
Title: Interim Medicaid Director

Boston Medical Center Health Plan, Inc.

11.28.17
Date

Name: Susan Coakley
Title: President

Acknowledgement of Contractor's signature:

State of Massachusetts County of Suffolk on 11.28.17, before the undersigned officer, personally appeared the person identified directly 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

Kim Graham, Executive Administrator
Name and Title of Notary or Justice of the Peace

My Commission Expires: 3.11.22

New Hampshire Department of Health and Human Services
Medicaid Care Management 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

11/28/2017
Date

Name: Henry Lipman
Title: Interim Medicaid Director

Boston Medical Center Health Plan, Inc.

11.28.17
Date

Name: Susan Coakley
Title: President

Acknowledgement of Contractor's signature:

State of Massachusetts County of Suffolk on 11.28.17, before the undersigned officer, personally appeared the person identified directly 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

Kim Graham, Executive Administrator
Name and Title of Notary or Justice of the Peace

My Commission Expires: 3.11.22

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

OFFICE OF THE ATTORNEY GENERAL

11/28/2017
Date

Name: Nancy J. Smith
Title: Senior Asst. Attorney General

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

Medicaid Care Management Contract
Exhibit A - Amendment 13

Table of Contents

1. Introduction

1.1. Purpose

1.1.1. The purpose of this Agreement is to set forth the terms and conditions for the MCO's participation in the NH Medicaid Care Management Program.

1.2. Type of Agreement

1.2.1. This is a comprehensive full risk prepaid capitated contract. The MCO is responsible for the timely provision of all medically necessary services as defined under this Agreement. In the event the MCO incurs costs that exceed the capitation payments, the State of New Hampshire and its agencies are not responsible for those costs and will not provide additional payments to cover such costs.

1.3. Agreement Period

1.3.1. The Department of Health and Human Services (DHHS) and the MCO agree to extend this agreement by 12 months to June 30, 2019.

2. Glossary of Terms and Acronyms

Abuse

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. 455.2]

Administrative Review Committee

Applies appropriate risk management principles to ensure due diligence and oversight to protect the patient, community and hospital in treating high risk or high profile patients.

Acquired Brain Disorder (HCBC-ABD) Waiver

"Acquired Brain Disorder (HCBC-ABD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of services and supports to individuals age 22 years and older with traumatic brain injuries or neurological disorders who are financially eligible for Medicaid and medically qualify for institutional level of care provided with a need for specialized nursing care or specialized rehabilitation services. Covered services are identified in He-M 522.

Adequate Network of Providers

A network sufficient in numbers, types and geographic location of providers, as defined in the Agreement, to ensure that covered persons will have access to health care services without unreasonable delay.

Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of New Hampshire, relating to the provision of health care when an individual is incapacitated (42 CFR 438.6, 438.10, 422.128, and 489.100).

Agreement

"Agreement" means the entire written Agreement between DHHS and the MCO, including any Exhibits, documents, and materials incorporated by reference.

Agreement Period

Dates indicated in the P-37 of this Agreement.

Agreement Year

NH State Fiscal Year.

Appeal

"Appeal" means a request for review of an action as described in this Agreement (42 CFR 438.400(b)).

Auxiliary aids

"Auxiliary aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of programs or activities conducted by the MCO. Such aids shall include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Care coordination

"Care coordination" is the deliberate organization of patient care activities between two or more participants (including the individual) involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial, and long term services and supports. Organizing care involves the marshalling of personnel and other resources needed to carry out all required services and supports, and requires the exchange of information among participants responsible for different aspects of care. (42 CFR 438.208).

Effective care coordination includes the following:

- Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Employs evidence-based clinical practices;
- Coordinates care across health care settings and providers, including tracking referrals;
- Actively assists patients to take personal responsibility for their health care;
- Provides education regarding avoidance of inappropriate emergency room use;
- Emphasizes the importance of participating in health promotion activities; Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- Uses appropriate community resources to support individual patients, families and caregivers in coordinating care.
- Adheres to conflict of interest guidelines set forth by the health plan and contractor (State of NH)
- Ensures the patient is aware of all appeal and grievance processes including how to request a different care coordinator.

- Facilitates ready and consistent access to long term supports and services that are, to the extent possible, integrated with all other aspects of the member's health care.

Centers for Medicare and Medicaid Services (CMS)

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare program.

Children's Health Insurance Program

"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009.

Children with Special Health Care Needs

Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Choices for Independence (HCBC-CFI) Waiver

"Choices for Independence (HCBC-CFI) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities. This term is also known as home and community based care for the elderly and chronically ill (HCBC-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and covered services are identified in He-E 801.

Chronic Condition

"Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence and includes, but is not limited to: a mental health condition; a substance use disorder; asthma; diabetes; heart disease; or obesity, as evidenced by a body mass index over twenty-five.

Cold Call Marketing

"Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential member or a member with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

Communications Plan

"Communications Plan" means a written strategy for timely notification to DHHS regarding expected or unexpected interruptions or changes that impact MCO policy, practice, operations, members or providers. The Communications Plan shall define the purpose of the communication, the paths of communication, the responsible MCO party required to communicate, and the time line and evaluation of effectiveness of MCO messaging to DHHS and to affected parties. The

Communications Plan shall also provide for the MCO to communicate with DHHS and respond to correspondence received from DHHS within one (1) business day on emergent issues and five (5) business days on non-emergent issues.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under federal or state law. Confidential Information includes, but is not limited to, Personal Information.

Conflict Free Care Coordination

"Conflict Free Care Coordination" separates clinical or non-financial eligibility determination from direct service provision. Care Coordinators and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual, their paid caregivers or to anyone financially responsible for the individual; robust monitoring and oversight are in place to promote consumer-direction and beneficiaries are clearly informed about their right to appeal or submit a grievance decisions about plans of care, eligibility determination and service delivery. State level oversight is provided to measure the quality of care coordination services and to ensure meaningful stakeholder engagement. In circumstances when one entity is responsible for providing care coordination and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

Conflict Free Care Management

(see Care Coordination)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

"Consumer Assessment of Healthcare Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey used to measure member experience of health care.

Consumer Direction

"Consumer Direction", also known as participant direction or self-direction, means a service arrangement whereby the individual or representative, if applicable, directs the services and makes the decisions about how the funds available for the individual's services are to be spent. It includes assistance and resources available to individuals in order to maintain or improve their skills and experiences in living, working, socializing, and recreating.

Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through member transitions between: facilities and home; facilities; providers; service areas; managed care contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral

(mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.

Contracted Services

"Contracted Services" means covered services that are to be provided by the MCO under the terms of this Agreement.

Covered Services

"Covered Services" means health care services as defined by DHHS and State and Federal regulation.

Debarment

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Developmental Disabilities (HCBC-DD) waiver

"Developmental Disabilities (HCBC-DD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports in non-institutional settings to individuals of any age with mental retardation and/or developmental disabilities who are financially eligible for Medicaid and medically qualify for institutional level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Division for Children, Youth & Families (DCYF) Services

"Division of Children, Youth & Families (DCYF) Services" means community based services and residential treatment services as indicated in Section 8.2 Covered Services Matrix as DCYF..

Early, Periodic Screening, Diagnostic and Treatment (EPSDT)

"EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of services in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r), 42 CFR 441.50, and DHHS EPSDT program policy and billing instructions. Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The MCO shall be responsible for all services found to be medically necessary services during the EPSDT exam.

Eligible Members

"Eligible Members" means individuals determined eligible by DHHS and eligible to enroll for health care services under the terms of this Agreement.

Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

Emergency Services

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

Equal Access

"Equal Access" means Steps 1 and 2, and NHHPP members having the same access to providers and services for those services common to both populations.

Execution Date

Date Agreement approved by Governor and Executive Council.

External Quality Review (EQR)

"External Quality Review (EQR" means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the MCO or its subcontractors furnish to members (42 CFR 438.320).

External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358.

Fraud

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 C.F.R. 455.2]

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights (42 CFR 438.400(b)).

Grievance Process

"Grievance Process" means the procedure for addressing member grievances (42 CFR 438.400(b)).

Grievance System

"Grievance System" means the overall system that includes grievances and appeals handled by the MCO and access to the State fair hearings (42 CFR 438, Subpart F).

Healthcare Effectiveness Data and Information Set (HEDIS)

"Healthcare Effectiveness Data and Information Set (HEDIS)" means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes a standardized survey of members' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

Health Home

"Health Home" means coordinated health care provided to members with special health care needs. At minimum, health home services include:

- Comprehensive care coordination including, but not limited to, chronic disease management;
- Self-management support for the member, including parents of caregivers or parents of children and youth;
- Care coordination and health promotion;
- Multiple ways for the member to communicate with the team, including electronically and by phone;
- Education of the member and his or her parent or caregiver on self-care, prevention, and health promotion, including the use of patient decision aids;
- Member and family support including authorized representatives;
- The use of information technology to link services, track tests, generate patient registries and provide clinical data;
- Linkages to community and social support services;
- Comprehensive transitional health care including follow-up from inpatient to other settings;
- A single care plan that includes all member's treatment and self-management goals and interventions ; and
- Ongoing performance reporting and quality improvement.

Home and Community Based Care (HCBC)

"Home and Community Based Care (HCBC)", also known as Home and Community Based Services (HCBS), means the waiver of sections 1902 (a) (10) and 1915 (c) of the Social Security Act which allows the federal Medicaid funding of long term services and supports in non-institutional settings for individuals who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility. This includes services provided under the Choices for Independence Waiver (HCBC-CFI) waiver program, Developmental Disabilities (HCBC-DD) waiver program, Acquired Brain Disorders (HCBC-ABD) waiver program, and In Home Supports (HCBC-IHS) waiver program.

Implementation Period

"Implementation Period" means each period of time prior to Program Start Date for the following segments: Step 1, NHHPP, SUD Phases 1, 2 and 3, and Step 2 Phases 1, 2, 3 and 4.

Implementation Plan

"Implementation Plan" means a proposed and agreed upon written and detailed listing of all objectives, tasks, activities, time allocation, deliverables, dependencies and responsible parties required to design, develop and implement the steps and phases of the Care Management Program. The Implementation Plan(s) shall include documentation of approvals as well as document change history.

In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver

"In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to families with children diagnosed with autism and other developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization. Covered services are identified in He-M524.

Long Term Services and Supports (LTSS)

"Long Term Services and Supports (LTSS)" means a broad array of supportive medical, personal, and social services needed when a person's ability to care for themselves is limited due to a chronic illness, disability, or frailty. Long term services and supports include nursing facility services, all four of New Hampshire's Home and Community Based Care Waivers, and services provided to children and families through the Division for Children, Youth & Families. Other applicable terms and definitions are identified in RSA 151 E, and Administrative Rules He-E 801, 803 and 805.

Managed Care Organization (MCO)

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible DHHS members under the DHHS Care Management Program.

Marketing

"Marketing" means any communication from the MCO to a potential member or member with another DHHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the MCO or to either not enroll or end enrollment with another DHHS contracted MCO (42 CFR 438.104(a)).

Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).

Medically Frail

"Medically frail" means a member who identifies as having a physical, mental, or emotional health condition that causes limitations in activities (e.g. bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Medically Necessary Services

"Medically Necessary Services" means services that are "medically necessary" as is defined in Section 23.2.2.

Member

"Member" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having an Agreement with DHHS (42 CFR 438.10(a)).

Member Handbook

"Member Handbook" means the handbook published by the Managed Care Organization (MCO) which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Member participation in Medicaid Managed Care and which means all informing requirements as set forth in 42 CFR 438.10.

Mental Health Court

A "Mental Health Court" is a specialized court docket for certain defendants with mental illnesses that substitutes a problem solving model for traditional criminal court processing.

National Committee for Quality Assurance (NCQA)

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

Necessary Services

"Necessary Services" means services to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no

other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term service and support.

New Hampshire Community Passport (NHCP) Program or Money Follows the Person (MFP) Demonstration

"Money Follows the Person (MFP)" means a federal demonstration that assists individuals residing in nursing institutions who meet CMS eligibility requirements find suitable healthcare programs to support them in the community and then assists them to transition from nursing institution care to community care. The program's intent is to help strengthen and improve community based systems of long term care for low-income seniors and individuals with disabilities. "New Hampshire Community Passport (NHCP) Program" means the MFP program specific to New Hampshire.

New Hampshire Health Protection Program (NHHPP)

Coverage provided through the MCOs for individuals newly eligible for Medicaid based the new income levels established in Senate Bill 413, Chapter 3, Laws of 2014; provided, however, that on and after January 1, 2016, coverage under this program shall be limited to said individuals who are Medically Frail and who choose to participate in the New Hampshire Health Protection Program and those MCO members who transition from an eligibility category other than the New Hampshire Health Protection Program who have not yet begun their coverage in the Premium Assistance Program.

New Member

"New Member" means a member transferring from FFS to an MCO, or transferring from another MCO.

Non-Participating Provider

"Non-Participating Provider" means a person, health care provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with the MCO to participate in a managed care organization's provider network, but provides health care services to members.

Participating Provider

"Participating Provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice and licensure, and who is under a written contract with the MCO to provide services to members under the terms of this Agreement.

Payment Reform Plan

"Payment Reform Plan" means an MCO's plan to engage its provider network in health care delivery and payment reform activities such as pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements, and shall contain information on the anticipated impact on member health outcomes, providers affected.

Physician Group

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Provider Incentive Plan

"Provider Incentive Plan" means any compensation arrangement between the MCO and a provider or provider group that may directly or indirectly improve the delivery of healthcare services as directed by a provider under the terms of this Agreement.

Program Management Plan

"Program Management Plan" means a proposed and agreed upon written detailed plan that includes a framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program as provided for in the Agreement. Includes documentation of approvals as well as document change history.

Program Start Date

Each date when MCO is responsible for coverage of services to its members with respect to the steps and phases of the Medicaid Care Management program.

Post-stabilization Services

"Post-stabilization Services" means contracted services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition (42 CFR 438.114 and 422.113).

Primary Care Provider (PCP)

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Agreement.

Provider

"Provider " means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Referral Provider

"Referral Provider" means a provider, who is not the member's PCP, to whom a member is referred for covered services

Regulation

"Regulation" means any federal, state, or local regulation, rule, or ordinance.

Risk

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a provider incentive plan, as defined herein.

Special Needs

Special Needs include chronic physical, developmental, behavioral or emotional conditions or adverse social circumstances resulting in need for help with related services of a type or amount beyond that required by members generally. Members with Special Needs include both Children and Adults.

Start Date of the Program

Date initial member enrollment begins.

Start of Program

Date initial member enrollment begins.

State

"State" or "state" means the State of New Hampshire

Step 1

Services as indicated in Section 8.2 Covered Services Matrix as Step 1.

Step 2

Services as indicated in Section 8.1 Covered Populations Matrix and Section 8.2 Covered Services Matrix as Step 2.

Subcontract

"Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

Substance Use Disorder

"Substance Use Disorder" is marked by a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. The cluster of symptoms includes tolerance; withdrawal or

use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substance or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol, tobacco and/or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use; craving or strong desire to use. Specific diagnostic criteria are specified in "Substance-Related and Addictive Disorders", in the Diagnostic and Statistical Manual of Disorders, 5th Edition, American Psychiatric Association, 2013.

Willing Provider

"Willing Provider" is a provider credentialed according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's provider agreement, including rates, and policy manual.

2.1. Acronyms

Unless otherwise indicated acronyms used in this Agreement are as follows:

Acronym	Description
ABD	Acquired Brain Disorders Waiver
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ANB	Aid to the Needy Blind
ANSA	Adult Needs and Strengths
APTD	Aid to the Permanently and Totally Disabled
ASC	Accredited Standards Committee
ASL	American Sign Language
BCCP	Breast and Cervical Cancer Program
BMH	Bureau of Mental Health
CAD	Coronary Artery Disease
CANS	Child and Adolescent Needs and Strengths Assessment
CDC	Centers for Disease Control and Prevention
CFI	Choices for Independence Waiver
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure

Acronym	Description
CHIP	Children's Health Insurance Program
CLA	Community Living Assessment
CLAS	Cultural and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
DCYF	Division of Children, Youth & Families
DD	Developmental Disabilities Waiver
DHHS	Department of Health and Human Services (New Hampshire)
DOB	Date of Birth
DME	Durable Medical Equipment
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospitals
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EST	Eastern Standard Time
ETL	Extract Transformation Load
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HC-CSD	Home Care for Children with Severe Disabilities
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ICF	Intermediate Care Facility

Acronym	Description
IHS	In Home Supports for Children with Developmental Disabilities Waiver
IME	Indirect Medical Education
LTSS	Long term services and supports
MCO	Managed Care Organization
MCIS	Managed Care Information System
MFP	Money Follows the Person Program
MIC	Medicaid Integrity Contractor
MEAD	Medicaid for Employed Adults with Disabilities
MMIS	Medicaid Management Information System
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NHCP	New Hampshire Community Passport Program
NF	Nursing Facility
NHHPP	New Hampshire Health Protection Program
NHID	New Hampshire Insurance Department
NPI	National Provider Identifier
OAA	Old Age Assistance
OBRA	Omnibus Budget Reconciliation Act
PBM	Pharmacy Benefit Management
PCP	Primary Care Provider
PE	Presumptive Eligibility
PIN	Personal Identification Number
POA	Present on Admission
QAPI	Quality Assessment and Performance Improvement
QIP	Quality Incentive Program
QM	Quality Management
QMB	Qualified Medicare Beneficiaries

Acronym	Description
RAC	Recovery Audit Contractors
RBC	Risk-Based Capital
RFP	Request for Proposal
RHC	Rural Health Center
RIMP	Risk Identification Mitigation Plan
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse and Mental Health Services Administration
SLMB	Special Low-Income Medicare Beneficiaries
SLRC	ServiceLink Resource Center network under the New Hampshire Aging and Disability Resource Center model
SNF	Skilled Nursing Facility
SSA	Social Security Act
SSI	Supplemental Security Income
SSAE	Statement on Standards for Attestation Engagements
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TQM	Total Quality Management
USC	United States Code
VA	Veteran's Administration

3. General Terms and Conditions

3.1. Agreement Elements

The Agreement between the parties shall consist of the following:

3.1.1. P-37 Agreement General Provisions.

3.1.2. 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 MCO.

3.1.3. Exhibit B – Capitation Rates.

3.1.4. Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS that must be adhered to in addition to those outlined in the P-37.

3.1.5. Exhibit D – Certification Regarding Drug Free Workplace Requirements – MCO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988.

3.1.6. Exhibit E – Certification Regarding Lobbying – MCO's Agreement to comply with specified lobbying restrictions.

3.1.7. 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.

3.1.8. Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – MCO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act.

3.1.9. Exhibit H – Certification Regarding Environmental Tobacco Smoke – MCO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities.

3.1.10. Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the MCO in reference to the Health Insurance Portability and Accountability Act.

3.1.11. Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.

3.1.12. Exhibit K – MCO's Program Management Plan approved by DHHS in accordance with Section 7.4 of this Agreement.

3.1.13. Exhibit L – MCO's Implementation Plan approved by DHHS in accordance with Sections 7.6-7.8 of this Agreement.

3.1.14. Exhibit M – MCO's RFP (#12-DHHS-CM-01) Technical Proposal, including any addenda, submitted by the MCO.

3.1.15. Exhibit N – Encounter Data.

3.1.16. Exhibit O –Quality and Oversight Reporting.

3.1.17. Exhibit P – Substance Use Disorder (SUD) Services.

3.2. Order of Documents.

In the event of any conflict or contradiction between or among the Agreement documents, the documents shall control in the above order of precedence.

3.3. 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 unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS and NHID.

3.4. Authority of the New Hampshire Insurance Department

Wherever, by any provision of this Agreement or by the laws and rules of the State of New Hampshire the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a Managed Care Organization in the State of New Hampshire.

3.5. Errors & Omissions

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

3.6. Time of the Essence

In consideration of the need to ensure uninterrupted and continuous Medicaid Managed Care services, time is of the essence in the performance of the Scope of Work under the Agreement.

3.7. CMS Approval of Agreement & Any Amendments

This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to the prior approval of the Centers for Medicare and Medicaid Services ("CMS."). Notwithstanding any other provision of this Agreement, DHHS agrees that enrollment for any step or phase will not commence until DHHS has received required CMS approval.

3.8. Cooperation with Other Vendors and Prospective Vendors

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. The MCO 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.

3.9. Renegotiation and Reprocurement Rights

3.9.1. Renegotiation of Agreement Terms

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

3.9.2. Reprocurement of the Services or Procurement of Additional Services

3.9.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO'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 MCO under the Agreement. DHHS shall give the MCO ninety (90) calendar days notice of intent to replace another MCO participating in the Medicaid Managed Care program or to add an additional MCO to the Medicaid Managed Care program.

3.9.3. Termination Rights Upon Reprocurement.

3.9.3.1. 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, the MCO shall have the rights and responsibilities set forth in Section 32 ("Termination"), Section 33 ("Agreement Closeout") and Section 35 ("Dispute Resolution Process").

4. Organization

4.1. Organization Requirements

4.1.1. Registrations and Licenses

The MCO shall be licensed by the New Hampshire Department of Insurance to operate as an Managed Care Organization in the State as required by New Hampshire RSA 420-B, and shall have all necessary registrations and licensures as required by the New Hampshire Insurance Department and any relevant federal and state laws and regulations. An MCO must be in compliance with the requirements of this section in order to participate in any Steps and Phases of the Medicaid Care Management program.

4.2. Articles & Bylaws

4.2.1. The MCO shall provide by the beginning of each Agreement year or at the time of any substantive changes written assurance from MCO's legal counsel that the MCO 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.

4.3. Relationships

4.3.1. Ownership and Control

4.3.1.1. The MCO shall notify DHHS of any person or corporation that has five percent (5%) or more ownership or controlling interest in the MCO, parent organization, subcontractors, and/or affiliates and shall provide

a. financial statements;

b. Date of Birth in the case of an individual;

c. Social Security numbers in the case of an individual; and

d. In the case of corporations primary business address, every business location, P.O. Box address, and tax identification number 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]. The MCO shall certify by its Chief Executive Officer that this information provided to DHHS is accurate to the best of the officer's information, knowledge, and belief [42 CFR 438.606].

4.3.1.2. The MCO shall inform DHHS and the New Hampshire Insurance Department (NHID) of its intent for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of the action.

4.3.1.3. The MCO shall inform key DHHS and NHID staff by phone and by email within one business day of when any key MCO staff learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement with DHHS.

4.3.2. Prohibited

4.3.2.1. The MCO shall not knowingly have a relationship with the following:

4.3.2.1.1. 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

4.3.2.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 4.3.2.1.

4.3.2.1.3. An individual is described as follows:

a. A director, officer, or partner of the MCO;

b. A subcontractor of the MCO;

c. A person with beneficial ownership of five percent (5%) or more of the MCO's equity; or

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

4.3.3. The MCO shall retain any data, information, and documentation regarding the above described relationships for a period no less than 10 years [42 CFR 438.3(u)].

4.3.4. The MCO shall conduct background checks on all employees actively engaged in the Care Management Program. 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.

4.3.5. The MCO shall not and shall certify it does not employ or contract, directly or indirectly, with:

4.3.5.1. 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;

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

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

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

4.3.5.5. 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.

5. Subcontractors

5.1. MCO Obligations

5.1.1. The MCO remains fully responsible for the obligations, services and functions performed by its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by MCO employees, and for the purposes of this Agreement such work will be deemed performed by the MCO. DHHS reserves 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 or use of a subcontractor.

5.1.2. The MCO shall provide written policies for all employees and subcontractors describing in detail the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the SSA including information about rights of employees to be protected as whistleblowers.

5.1.3. The MCO regardless of its written agreements with any subcontractors maintains ultimate responsibility for complying with this Agreement.

5.1.4. The MCO shall inform all subcontractors at the time of entering into an agreement with the MCO about the grievance and appeal system as described in 42 CFR 438.10(g).

5.1.5. The MCO shall have a written agreement between the MCO and each subcontractor in which the subcontractor:

5.1.5.1.Agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and MCO contract provisions;

5.1.5.2.Agrees to hold harmless DHHS and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO;

5.1.5.3.Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors;[

5.1.5.4. Agrees that the State, CMS, the HHS Inspector General, or their designees shall have the right to audit, evaluate, and inspect any premises,

physical facilities, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO Managed Care activities;

5.1.5.5. Agrees that it can be audited for ten years from the final date of the contract period or from the date of any completed audit, whichever is later; and

5.1.5.6. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk [42 CFR 438.230].

5.1.4 The MCO shall notify DHHS in writing within 10 business days if a subcontractor is cited for corrective action by any federal or state regulatory authority.

5.2. Notice and Approval

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

5.2.2. The MCO 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.

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

5.2.4. DHHS may grant a written exception to the notice requirements of 5.2.1 and 5.2.2 if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period or deems that the subcontractor is not a material subcontractor.

5.2.5. The MCO shall notify DHHS within twenty four (24) hours after receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

5.2.6. The MCO shall notify DHHS of any material breach of an agreement between the MCO and the subcontractor within twenty four (24) hours of validation that such breach has occurred.

5.3. MCO's Oversight

5.3.1. The MCO shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor in accordance with 42 CFR 438.230 and SMM 2087.4, including:

5.3.1.1. The MCO shall have a written agreement between the MCO and the subcontractor that specifies the activities and responsibilities delegated to the subcontractor and its transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate as determined by the MCO or NH DHHS. In such written agreement, the subcontractor shall also agree to perform the delegated activity and related reporting responsibilities as specified in the subcontractor agreement and the applicable responsibilities in this Agreement.

5.3.1.2. All subcontracts related to any aspect of the MCO Managed Care activities shall fulfill the applicable requirements of 42 CFR Part 438 for those responsibilities delegated to the subcontractor.

5.3.1.3. The MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

5.3.1.4. The MCO shall monitor the subcontractor's performance on an ongoing basis consistent with industry standards and State and Federal laws and regulations.

5.3.1.5. The MCO shall audit the subcontractor's care systems at least annually and when there is a substantial change in the scope or terms of the subcontract agreement.

5.3.1.6. The MCO shall identify deficiencies or areas for improvement, if any, with respect to which the MCO and the subcontractor shall take corrective action.

5.3.1.7. The MCO shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the Agreement between the MCO and DHHS.

5.3.1.8. If the MCO identifies deficiencies or areas for improvement are identified, the MCO shall notify DHHS and take corrective action within seven (7) calendar days of identification. The MCO shall provide DHHS with a copy of the Corrective Action Plan, which is subject to DHHS approval.

5.4. Transition Plan

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

6. Staffing

6.1. Key Personnel

6.1.1. The MCO shall commit key personnel to the New Hampshire Care Management program on a full-time basis. Positions considered to be key personnel are listed below, along with any specific requirements for each position:

6.1.1.1. Executive Director: Individual has clear authority over the general administration and day-to-day business activities of this Agreement.

6.1.1.2. Finance Officer: Individual is responsible for accounting and finance operations, including all audit activities.

6.1.1.3. Medical Director: Physician licensed by the NH Board of Medicine shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health). The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

6.1.1.4. The MCO will also have a physician available to the New Hampshire Care Management program with experience in the diagnosis and treatment of SUD.

6.1.1.5. Quality Improvement Director: Individual is responsible for all Quality Assessment and Performance Improvement (QAPI) program activities. This person shall be a licensed clinician with relevant experience in quality management for physical and/or behavioral healthcare.

6.1.1.6. Coordinators for the following five (5) functional areas shall be responsible for overseeing care coordination activities for MCO members with complex medical, behavioral health, developmental disability and long term care needs. They shall also serve as liaisons to DHHS staff for their respective functional areas:

6.1.1.6.1. Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

6.1.1.6.2. Behavioral Health Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within community mental health services.

6.1.1.6.3. Developmental Disabilities Coordinator: The individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

6.1.1.6.4. Substance Use Disorder Coordinator: The individual will have a minimum of a Master's Degree in a SUD related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to substance use disorders.

6.1.1.6.5. Long Term Services and Supports Coordinator: The individual will have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a LTSS related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care.

6.1.1.7. Network Management Director: Individual is responsible for development and maintenance of the MCO's provider network.

6.1.1.8. Member Services Manager: Individual is responsible for provision of all MCO member-services activities. The manager shall have prior experience with Medicaid or Medicare populations.

6.1.1.9. Utilization Management (UM) Director: Individual is responsible for all UM activities. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services and Necessary Services.

6.1.1.10. Systems Director/Manager: Individual is responsible for all MCO information systems supporting this Agreement including, but not limited to, continuity and integrity of operations, continuity flow of records with DHHS' information systems and providing necessary and timely reports to DHHS.

6.1.1.11. Claims/Encounter Manager: Individual is responsible for and is qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

6.1.1.12. Grievance Coordinator: Individual is responsible for overseeing the MCO's Grievance System.

6.1.1.13. Fraud, Waste, and Abuse Coordinator: Individual is responsible for tracking, reviewing, monitoring, and reducing fraud, waste, and abuse.

6.1.1.14. Compliance Officer: Individual is responsible for MCO's compliance with the provisions of this Agreement and all applicable state and federal regulations and statutes.

6.1.2. The MCO shall have an on-site presence in New Hampshire. The following key personnel shall be located in New Hampshire:

6.1.2.1. Executive Director

6.1.2.2. Medical Director

6.1.2.3. Quality Improvement Director

6.1.2.4. Special Needs Coordinator

6.1.2.5. Behavioral Health Coordinator

6.1.2.6. Developmental Disabilities Coordinator

6.1.2.7. Long Term Services and Supports Coordinator

6.1.2.8. Network Management Director

6.1.2.9. Fraud, Waste, and Abuse Coordinator

6.1.2.10. Grievance Coordinator

6.1.2.11. Substance Use Disorder Coordinator

6.1.2.12. Claim Encounter Manager

6.1.2.13. Provider Relations Manager

6.1.3. The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) days prior to start of program.

6.1.4. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.

6.1.5. DHHS may grant a written exception to the notice requirements of this Section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

6.2. General Staffing Provisions

6.2.1. The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 34.

6.2.2. The MCO shall ensure that all staff have appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

6.2.3. All key staff shall be available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

6.2.4. The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in New Hampshire with DHHS.

6.2.5. The MCO shall notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

6.2.6. If a member of the MCO's key staff is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit proposed alternate staff to DHHS for review and approval, which approval shall not be unreasonably withheld.

6.3. Staffing Contingency Plan

6.3.1. The MCO shall, deliver to DHHS a Staffing Contingency Plan within thirty (30) calendar days of signing this Agreement and after any substantive changes to the Staffing Contingency Plan. The Plan shall include but is not limited to:

6.3.1.1. The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the Agreement;

6.3.1.2. Allocation of additional resources to the Agreement in the event of inability to meet any performance standard;

6.3.1.3. Replacement of key personnel with staff with similar qualifications and experience;

6.3.1.4. Discussion of time frames necessary for obtaining replacements;

6.3.1.5. MCO's capabilities to provide, in a timely manner, replacements/additions with comparable experience; and

6.3.1.6. The method of bringing replacements/additions up-to-date regarding this Agreement.

7. Program Management and Planning

7.1. General

7.1.1. The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to members enrolled in the New Hampshire Medicaid Program and provide for all aspects of managing such program, including claims processing and operational reports. The MCO shall establish and demonstrate audit trails for all claims processing and financial reporting carried out by the MCO's staff, system, or designated agents.

7.2. Representation and Warranties

7.2.1. The MCO warrants that all Managed Care 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.

7.2.2. The MCO acknowledges that in entering this Agreement, DHHS has relied upon representations made by the MCO in its RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda, with respect to delivery of Managed Care. In reviewing and approving the program management and planning requirements of this Section, DHHS reserves the right to require the MCO to develop plans that are substantially and materially consistent with the representations made in the MCO's RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda.

7.3. Audit Requirements

7.3.1. No later than forty (40) business days after the end of the State Fiscal Year each June 30, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period. DHHS will share the report with internal and external auditors of the State of New Hampshire and federal oversight agencies. The SSAE 16 Type 2 report shall include:

7.3.1.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period.

7.3.1.2. Written assertion by the MCO's management about whether:

7.3.1.2.1. The aforementioned description fairly presents the system in all material respects;

7.3.1.2.2. The controls were suitably designed to achieve the control objectives stated in that description; and

7.3.1.2.3. The controls operated effectively throughout the specified period to achieve those control objectives.

7.3.1.3. Report of the MCO's auditor, which:

7.3.1.3.1. Expresses an opinion on the matters covered in management's written assertion; and

7.3.1.3.2. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

7.3.2. The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO. If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

7.3.3. The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

7.3.4. DHHS, CMS, the Office of the Inspector General, the Comptroller General, and their designees have the right to inspect and audit any records of the MCO, or its subcontractors and conduct on-site reviews of the MCO's operations at the MCO's expense. These on-site visits may be unannounced. The MCO shall fully cooperate with DHHS' on-site reviews. This right exists for ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

7.3.5. DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing Corrective Action Plans and review MCO compliance with requirements and standards as specified in this Agreement.

7.3.6. The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.

7.4. Program Management and Communications Plans

7.4.1. The MCO shall submit a Program Management Plan (PMP) to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Annually, thereafter, the MCO shall submit an updated PMP to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.4.1.1. The PMP shall elaborate on the general concepts outlined in the MCO's proposal and the section headings of Exhibit A;

7.4.1.2. The PMP shall describe how the MCO will operate in New Hampshire by outlining management processes such as communications, workflow, overall systems as detailed in the section headings of Exhibit A, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to member and provider experiences; and

7.4.1.3. The PMP shall outline the MCO integrated organizational structure including New Hampshire-based resources and its support from corporate, subcontractors, and workgroups or committees.

7.4.1.4. The MCO shall submit a Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the scheduled start date of the program. Thereafter, the MCO shall submit an updated Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5. Emergency Response Plan

7.5.1. The MCO shall submit an Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Thereafter, the MCO shall submit an updated Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5.2. The plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

7.5.2.1. Employee training;

7.5.2.2. Essential business functions and key employees within the organization necessary to carry them out;

7.5.2.3. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; and

7.5.2.4. Communication with staff, members, providers, subcontractors and suppliers when normal systems are unavailable;

7.5.2.5. Plans to ensure continuity of services to providers and members;

7.5.2.6. How the MCO will coordinate with and support DHHS and the other MCOs; and

7.5.2.7. How the plan will be tested, updated and maintained.

7.6. Step 1 Program Implementation Plan

7.6.1. Submission and Contents of the Plan

7.6.1.1. The MCO shall submit a "Step 1 Program Implementation Plan" (Step 1 Implementation Plan) to DHHS for review and approval no later than fourteen (14) calendar days after the signing of this Agreement. The Step 1 Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for implementation of the Plan:

7.6.1.1.1. Provider credentialing/contracting;

7.6.1.1.2. Provider payments;

7.6.1.1.3. Member Services;

7.6.1.1.4. Member Enrollment;

7.6.1.1.5. Pharmacy Management;

7.6.1.1.6. Care Coordination;

7.6.1.1.7. Utilization Management;

7.6.1.1.8. Grievance System;

7.6.1.1.9. Fraud, Waste, and Abuse;

7.6.1.1.10. Third-Party Liability;

7.6.1.1.11. MCIS ;

7.6.1.1.12. Financial management; and

7.6.1.1.13. Provider and member communications.

7.6.1.2. The Step 1 Program Implementation Plan shall become an addendum to this Agreement as Exhibit L.

7.6.2. Implementation

7.6.2.1. Upon approval of the Step 1 Implementation Plan, the MCO shall implement the Plan as approved covering the Step 1 populations and services identified in Sections 8.1 and 8.2 of this Agreement.

7.6.2.2. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.6.2.3. The MCO must obtain prior written approval from DHHS for any changes or deviations from the submitted and approved Plan.

7.6.2.4. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.6.2.4.1. Progress on Step 1 Implementation Plan;

7.6.2.4.2. Risks/Issues and mitigation strategy;

7.6.2.4.3. Modifications to the Step 1 Implementation Plan;

7.6.2.4.4. Progress on any Corrective Action Plans;

7.6.2.4.5. Program delays; and

7.6.2.4.6. Upcoming activities.

7.6.2.5. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.6.3. Readiness Reviews

7.6.3.1. DHHS intends to conduct two (2) readiness reviews of the MCO during the implementation phase prior to the Program Start Date. The first review shall take place thirty (30) days after contract effective date or scheduled after DHHS has verified that at least two MCOs have satisfied the DHHS Substantial Provider Network reporting requirements, whichever comes later, and will take place ninety(90) calendar days prior to the Program Start Date. The second review shall take place thirty (30) calendar days prior to the Program Start Date. The MCO shall fully cooperate with DHHS during these readiness reviews. During the readiness reviews, DHHS shall assess the MCO's progress towards a successful program implementation through regular reporting activities. The review shall include validation of readiness in multiple areas, including but not limited to:

7.6.3.1.1. MCO's ability to pay a claim;

7.6.3.1.2. MCO's network adequacy;

7.6.3.1.3. MCO's member transition plan;

7.6.3.1.4. MCO's system preparedness;

7.6.3.1.5. MCO's member experience procedures;

7.6.3.1.6. Grievance System; and

7.6.3.1.7. MCO subcontracts.

7.6.3.2. DHHS may adjust the timing, number and requirements of Readiness Reviews at its sole discretion.

7.6.3.3. Should the MCO fail to pass either readiness review, the MCO shall submit a Corrective Action Plan to DHHS sufficient to ensure the MCO passes the readiness review and shall complete implementation on schedule. This Corrective Action Plan shall be integrated into the overall program Step 1 Implementation Plan as a modification subject to review and approval by DHHS. DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified and/or apply liquidated damages as provided in Section 34.

7.6.3.4. During the first one hundred and eighty (180) days following the effective date of this Agreement or within ninety (90) days prior to the Program Start Date, whichever comes later, DHHS may give tentative approval of the MCO's required policies and procedures.

7.6.3.5. DHHS may at its discretion suspend application of the remedies specified in Section 34, except for those required under 42 CFR 700 and Section 1903(m) or Section 1932 of the Social Security Act, provided that the MCO is in compliance with any Corrective Action Plans developed during the readiness period, unless the MCO fails to meet the start date of the NH Medicaid Care Management program.

7.6.3.6. The start date of the Medicaid Care Management program shall be when at least two MCOs have met the readiness requirements 7.6.3.1.

7.7. Step 2 Program Implementation Plans

7.7.1. Implementation of Step 2 will take place in four phases:

7.7.1.1. Phase 1. Mandatory Enrollment populations indicated in Section 8.1 – Program Start Date February 1, 2016;

7.7.1.2. Phase 2. Choices For Independence Waiver ("CFI") – Program Start Date upon approval by DHHS of Implementation and Transition Plans developed by DHHS and the MCOs with consideration of stakeholder input and in compliance with legislative requirements;

7.7.1.3. Phase 3. Nursing Facility services ("NF") and DCYF services – Program Start Date upon approval by DHHS of Implementation and Transition Plans developed by DHHS and the MCOs with consideration of stakeholder input and in compliance with legislative requirements;

7.7.1.4. Phase 4. Developmental Disabilities, Acquired Brain Disorder and In Home Supports for Children with Developmental Disabilities waivers ("Waiver Services") will commence on a date to be determined by DHHS in consultation with the MCOs.

7.7.1.5. The MCO shall submit a Program Implementation Plan for each phase described above for DHHS approval no later than sixty (60) calendar days prior to the start date of initial member enrollment for each phase of Step 2, or as otherwise specified by DHHS.

7.7.2. The MCO shall participate in all DHHS trainings in preparation of implementing new phases of the program.

7.7.3. Each Step 2 Program Implementation Plan shall address the following elements and include timelines and identify staff responsible for implementation of the applicable Step 2 phase:

7.7.3.1. Provider credentialing/contracting processes for specific provider types

7.7.3.2. Capacity to pay providers according to the methodologies prescribed by DHHS

7.7.3.3. Provider capacity sufficient to serve the population of each Step 2 phase without compromising access for Step 1 and NH Health Protection Plan (NHHPP) members

7.7.3.4. Plans to conduct communication, training, and outreach to specific provider groups

7.7.3.5. Plans to conduct communication, training and outreach to members and member families

7.7.3.6. Production of new Member handbooks or updates to reflect the differences in Step 2 covered services

7.7.3.7. Call center training for Step 2 covered service-related inquiries

7.7.3.8. Performance standards for call center staff

7.7.3.9. Continuity of Care Policy;

7.7.3.10. Continuity of Care Transition Plan;

7.7.4. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for Step 2 implementation work.

7.7.5. The MCO shall follow its Step 2 Program Implementation Plan as approved by DHHS. The MCO must obtain prior written approval from DHHS for any change to the approved Step 2 Plans.

7.7.6. Throughout the implementation phase, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall including representatives of key MCO implementation staff and relevant DHHS personnel.

7.7.7. Throughout the implementation phase, the MCO shall submit a weekly status report to DHHS. The status reports at a minimum, shall include:

7.7.7.1. Risks/Issues and mitigation strategy;

7.7.7.2. Progress on Step 2 Implementation Plan;

7.7.7.3. Modifications to the Step 2 Implementation Plan;

7.7.7.4. Status report(s) on Corrective Action Plan(s);

7.7.7.5. Program delays; and

7.7.7.6. Upcoming activities.

7.7.8. DHHS shall conduct readiness reviews as follows:

7.7.8.1. Two readiness reviews for each phase of Step 2: one ninety (90) days prior to the Program Start Date of the Step 2 phase, and one thirty (30) days prior to the Program Start Date of the Step 2 phase

7.7.9. The MCO shall fully cooperate with DHHS during these readiness review(s).

7.7.10. DHHS may modify the timing and focus of the readiness reviews as appropriate, in consultation with the MCOs.

7.7.11. Should the MCO fail to successfully pass the readiness review(s), the MCO shall submit a Corrective Action Plan to pass the readiness review(s) and complete implementation on schedule. Corrective Action Plans will be incorporated into the Step 2 Implementation Plan and reported on in the weekly status report.

7.7.12. Should an MCO fail to correct deficiencies within twenty (20) calendar days, DHHS reserves the right to terminate the MCO's Agreement.

7.8. NHHPP Program Implementation Plan

7.8.1. Submission and Contents of the NHHPP Implementation Plan

7.8.1.1. The MCO shall submit a NHHPP Implementation Plan to DHHS for review and approval no later than fourteen days (14) calendar days after signing the related contract amendment. The Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for the implementation of the Plans:

7.8.1.1.1. Provider credentialing/contracting for SUD and chiropractic providers;

7.8.1.1.2. Provider agreements and or amendments for services provided to NHHPP members;

7.8.1.1.3. Paying NHHPP providers according to the methodology prescribed by DHHS Section 21.2.10.4;

7.8.1.1.4. Sufficient provider capacity to serve NHHPP population without compromising access for Step 1 members;

7.8.1.1.5. Production of new Member handbooks or updates to reflect the differences for the NHHPP plan members;

7.8.1.1.6. Implementation of a process by which to reduce inappropriate emergency room utilization;

7.8.1.1.7. Implementation of new member co-payments and cost sharing as required in Medicaid Care Management; and

7.8.1.1.8. Call center training for NHHPP related inquiries.

7.8.2. NHHPP Implementation

7.8.2.1. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.8.2.2. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.8.2.2.1. Progress on NHHPP Implementation Plan;

7.8.2.2.2. Risks/Issues and mitigation strategy;

7.8.2.2.3. Modifications to the NHHPP Implementation Plan;

7.8.2.2.4. Progress on any Corrective Action Plans;

7.8.2.2.5. Program delays; and

7.8.2.2.6. Upcoming activities.

7.8.2.3. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.8.3. NHHPP Readiness Review

7.8.3.1. DHHS intends to conduct one (1) readiness review no sooner than thirty (30) days prior to the enrollment of NHHPP members. The MCO shall fully cooperate with DHHS during this review.

8. Covered Populations and Services

8.1. Covered Populations Matrix

The MCO shall provide managed care services to population groups deemed by DHHS to be eligible for managed care. The planned phase-in of population groups is depicted in the matrix below.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[1]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Beckett) - With Member Opt Out	X			
HC-CSD (Katie Beckett) - Mandatory Enrollment		X		
Children with special health care needs (enrolled in Special Medical Services / Partners in Health) - Mandatory Enrollment		X		
Children with Supplemental Security Income (SSI) - Mandatory Enrollment		X		
M-CHIP	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			

[1] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
Pregnant Women	X			
Native Americans and Native Alaskans w/ member opt out[2]	X			
Native Americans and Native Alaskans - Mandatory Enrollment (w/CMS waiver)		X		
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
Members with VA Benefits				X
NHHPP Enrollees			X	
Medically Frail			X	
Family Planning Only Benefit				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X
Health Insurance Premium Payment Program (HIPP)				X

8.2. Covered Services Matrix Overview

The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with CMS-approved Medicaid State Plan, to its members, reflecting the planned phase-in.

[2] Per 42 USC §1396u-2(a)(2)(c); however, NH has no recognized tribes.

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl/ FFS
Maternity & Newborn Kick Payments	x	x	x				
Inpatient Hospital	x	x	x				
Outpatient Hospital[3]	x	x	x				
Inpatient Psychiatric Facility Services Under Age 21[4]	x	x	x				
Physicians Services	x	x	x				
Advanced Practice Registered Nurse	x	x	x				
Rural Health Clinic & FQHC	x	x	x				
Prescribed Drugs[5]	x	x	x				
Community Mental Health Services	x	x	x				
Psychology	x	x	x				
Ambulatory Surgical Center	x	x	x				
Laboratory (Pathology)	x	x	x				
X-Ray Services	x	x	x				
Family Planning Services	x	x	x				
Medical Services Clinic (mostly methadone clinic)	x	x	x				
Physical Therapy[6]	x	x	x				
Occupational Therapy[7]	x	x	x				

[3] Including facility and ancillary services for dental procedures

[4] Under age 22 if individual admitted prior to age 21

[5] Except as indicated in Section 14.1.15

[6] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl/ FFS
Speech Therapy[8]	X	X	X				
Audiology Services	X	X	X				
Podiatrist Services	X	X	X				
Home Health Services	X	X	X				
EPSDT Services	X	X	X				
Private Duty Nursing	X	EPSDT only	X				
Adult Medical Day Care	X	EPSDT only	X				
Personal Care Services	X	EPSDT only	X				
Hospice	X	X	X				
Optometric Services Eyeglasses	X	X	X				
Furnished Medical Supplies & Durable Medical Equipment	X	X	X				
Non-Emergent Medical Transportation [9]	X	X	X				
Ambulance Service	X	X	X				
Wheelchair Van	X	X	X				
Independent Care Management	X	EPSDT only	X				
Home Visiting Services	X	X[10]					

[7] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[8] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[9] Also includes mileage reimbursement for medically necessary travel

[10] Provided within the SUD benefit

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl/ FFS
Acquired Brain Disorder Waiver Services						x	
Developmentally Disabled Waiver Services						x	
Choices for Independence Waiver Services				x			
In Home Supports Waiver Services						x	
Skilled Nursing Facility					x		
Skilled Nursing Facility Atypical Care					x		
Inpatient Hospital Swing Beds, SNF					x		
Intermediate Care Facility Nursing Home					x		
Intermediate Care Facility Atypical Care					x		
Inpatient Hospital Swing Beds, ICF					x		
Glencliff Home					x		
Developmental Services Early Supports and Services						x	
Home Based Therapy – DCYF					x		
Child Health Support Service – DCYF					x		
Intensive Home and Community Services – DCYF					x		
Placement Services – DCYF					x		
Private Non-Medical Institutional For Children – DCYF					x		
Crisis Intervention – DCYF					x		
Substance use disorder services as per He-W 513	x	x	x				
Chiropractic services (NHHPP population only)		x					

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl./ FFS
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)[11]					x		
Medicaid to Schools Services							x
Dental Benefit Services[12]							x

8.3. Covered Services Additional Provisions

8.3.1. While the MCO may provide a higher level of service and cover additional services than required by DHHS, the MCO shall, at a minimum, cover the services identified at least up to the limits described in N.H. Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by informing the MCO [42 CFR 438.210(a)(1) and (2)]. Changes to the Medicaid State Plan, state statutes and rules shall be done in accordance with Federal and state requirements.

8.3.2. Pursuant to 42 CFR 438.3, the MCO shall provide enrollees with services or settings that are in lieu of services or settings described in 8.2 that are authorized by DHHS, which include, Medical Nutrition & Diabetes Self Management. The MCO shall not require the enrollee to use these alternate services.

8.3.3. Effective November 1, 2014, with the exception of HCBC waiver participants and nursing facility residents, the MCO shall require co-payment for services for members deemed by DHHS to have annual incomes at or above 100% of the FPL as follows:

8.3.3.1. Co-payments for drug prescriptions of up to $1 for generic drugs and $2 for brands and compound drugs for Step 1 members with annual incomes higher than 100% of the FPL, and for Step 2 members with annual incomes higher than 100% of the FPL consistent with the beneficiary and service exemptions as found in federal regulations and the approved Medicaid State Plan; and

[11] e.g. Cedarcrest

[12] except facility and ancillary services for dental procedures

8.3.3.2. Co-payments for drugs prescriptions of up to $1 for generic drugs and $4 for brands and compound drugs for NHHPP members with annual incomes higher than 100% of the FPL.

8.3.4. Effective 3/1/2016, the MCO Shall require point-of-service copayment for services for members deemed by DHHS to not be exempt from cost-sharing and have incomes above 100 percent of the federal poverty level as follows:

8.3.5. For Medicaid recipients subject to copayments:

8.3.5.1. A copay of $1.00 will be required for each preferred prescription drug and each refill of a preferred prescription drug.

8.3.5.2. A copay of $2.00 will be required for each non-preferred prescription drug and each refill of a nonpreferred prescription drug, unless the prescribing provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the copay for the non-preferred drug will be $1.00.

8.3.5.3. A copay of $1.00 will be required for a prescription drug that is not identified as either a preferred or nonpreferred prescription drug.

8.3.5.4. Copays are not required for family planning products or for Clozaril (Clozapine) prescriptions. All Cost sharing shall be applied consistent with beneficiary and service exemptions as found at 42 USC §§ 1396-o and 1396o-1, 42 C.F.R. §447.50 - 447.90, and New Hampshire's Medicaid State Plan.

8.3.6. The MCO may, with DHHS approval, require co-payment for services that do not exceed current Medicaid co-payment amounts established by DHHS.

8.3.7. The MCO shall with no disruption in service delivery to members or providers transition these services into managed care from fee-for-service (FFS).

8.3.8. All services shall be provided in accordance with 42 CFR 438.210.

8.3.9. The MCO shall adopt written policies and procedures to verify that services are actually provided [42 CFR 455.1(a)(2)].

8.3.10. The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Medicaid members for specialty care only.

8.3.11. The MCO shall cover services consistent with 45 CFR 92.207(b) including gender reassignment surgery.

8.4. Emergency Services

8.4.1. The MCO shall cover and pay for emergency services at rates that are no less than the equivalent DHHS fee-for-service rates if the provider that furnishes the services has an agreement with the MCO [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98].

8.4.2. If the provider that furnishes the emergency services has no agreement with the MCO, the MCO shall cover and pay for the emergency services in compliance with 1932(b)(2)(D) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98.

8.4.3. In accordance with the Deficit Recovery Act of 2005, the MCOs will cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall pay non-contracted providers of Emergency and Post-Stabilization services an amount no more than the amount that would have been paid under the DHHS Fee-For-Service system in place at the time the service was provided.

8.4.4. The MCO shall not deny treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(ii)(A); SMD letter 2/20/98].

8.4.5. The MCO shall not deny payment for treatment obtained when a representative, such as a network provider, of the MCO instructs the member to seek emergency services [42 CFR 438.114(c)(1)(ii)(B); SMD letter 2/20/98].

8.4.6. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

8.4.7. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or DHHS of the member's screening and treatment within ten (10) calendar days of presentation for emergency services [42 CFR 438.114(d)(1)(ii)].

8.4.8. The MCO may not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient [42 CFR 438.114(d)(2)].

8.4.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment [42 CFR 438.114(d)(3)].

8.5. **Post-Stabilization Services**

8.5.1. Post-stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for post-stabilization services obtained within or outside the MCO that are pre-approved by a MCO provider or other MCO representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i); SMD letter 8/5/98]

8.5.2. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii); SMD letter 8/5/98.]

8.5.3. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain, improve or resolve the member's stabilized condition if:

8.5.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

8.5.3.2. The MCO cannot be contacted; or

8.5.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with a MCO physician and the treating physician may continue with care of the patient until a MCO physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)].

8.5.4. The MCO shall limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the MCO. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv); SMD letter 8/5/98]

8.5.5. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

8.5.5.1. A MCO physician with privileges at the treating hospital assumes responsibility for the member's care;

8.5.5.2. A MCO physician assumes responsibility for the member's care through transfer;

8.5.5.3. A MCO representative and the treating physician reach an agreement concerning the member's care; or

8.5.5.4. The member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3); SMD letter 8/5/98]

9. Payment Reform Plan

9.1. Payment Reform Plan Timeline

9.1.1. The MCO shall submit within sixty (60) calendar days from a Program Start Date and sixty (60) calendar days prior to the start of each Agreement year, its Payment Reform Plan to engage its provider network in health care delivery and payment reform activities, subject to review and approval by DHHS. These activities may include, but are not limited to, pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements.

9.1.1.1. DHHS shall respond to the MCO regarding the Payment Reform Plan within thirty (30) calendar days of receipt.

9.1.2. Beginning July 1, 2018, DHHS will withhold one percent (1%) of MCO capitation payments in each year of the Agreement under the Payment Reform Plan. The MCO will earn a pay-out of that withheld amount if it meets the implementation milestones described in the Payment Reform Plan. The pay-out will be pro-rated to the number of milestones achieved by the MCO at the end of the year.

9.1.3. The MCO shall submit a report to DHHS describing its performance against the MCO's healthcare delivery and Payment Reform Plan within ninety (90) calendar days of the end of each year of the Agreement.

9.1.3.1. The report shall indicate, by provider type, the number and percentage participating in each type of payment reform activities.

9.1.3.2. DHHS will evaluate the MCO's performance and make payments to the MCO, if warranted, within ninety (90) calendar days of receipt of the report. DHHS shall provide the MCO with a written explanation of DHHS's evaluation of the MCO's performance within thirty (30) days of the MCO's request.

9.1.3.3. In the event that MCO disputes DHHS's evaluation of MCO's performance, MCO will have thirty (30) calendar days from receipt of DHHS's written explanation to submit a written request for reconsideration along with a description of MCO's reasons for the dispute, after which DHHS shall meet with the MCO within a reasonable time frame to achieve a good faith resolution of the disputed matter.

9.2. Payment Reform Plan Content

9.2.1. The Payment Reform Plan shall contain:

9.2.1.1. Information on the anticipated impact on member health outcomes of each specific activity, providers affected by the specific activity, outcomes anticipated as a result of the implementation of a process by which to reduce inappropriate emergency room use, an implementation plan for each activity and an implementation milestone to be met by the end of each year of the Agreement for each activity;

9.2.1.2. A process to ensure Equal Access to services; and

9.2.1.3. A process for engaging LTSS providers in health care delivery and payment reform activities.

9.3. Payment Reform Plan Compliance Requirements

9.3.1. The MCO's Payment Reform Plan(s) shall be in compliance with the following requirements:

9.3.1.1. FQHCs and RHCs will be paid at minimum the encounter rate paid by DHHS at the time of service.

9.3.1.2. The Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

9.3.1.3. The MCO's provider incentive plan shall comply with requirements set forth in 42 CFR 422.208 and 42 CFR 422.210 [42 CFR 438.6(h)].

9.3.1.4. The MCO's payment reform plan must comply with state and federal laws requiring nonpayment to a Contracted Provider for hospital-acquired conditions and for provider preventable conditions. The MCO shall report to NH DHHS all provider-preventable conditions in a form and frequency as specified by the State [42 CFR 438.3(g)].

9.3.1.5. The MCO may not make payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.6. The MCO shall provide information on its provider incentive program to any New Hampshire recipient upon request (this includes the right to adequate and

timely information on the plan) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.6(h)].

9.3.1.7. The MCO shall report whether services not furnished by physician/group are covered by an incentive plan. No further disclosure is required if the incentive plan does not cover services not furnished by the physician/group [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.7.1. The MCO shall report the type of incentive arrangement (e.g., withhold, bonus, capitation) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.8. The MCO shall report the percent of withhold or bonus (if applicable) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.9. The MCO shall report panel size, and if patients are pooled, the approved method used [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.10. If the physician/group is at substantial financial risk, the MCO shall report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss [§1903(m)(2)(A)(x)of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.11. Primary Care reimbursement to follow DHHS policy and to comply with 42 CFR 438, 42 CFR 441 and 42 CFR 447 II.A.5

9.3.1.11.1. MCO shall pass on the full benefit of the payment increase to eligible providers; and

9.3.1.11.2. MCO shall adhere to the definitions and requirements for eligible providers and services as specified in Section 1902(a)(13)(C), as amended by the Affordable Care Act of 2010 (ACA) and federal regulations; and

9.3.1.11.3. MCO shall submit sufficient documentation, as per DHHS policy, to DHHS to validate that enhanced rates were made to eligible providers.

10. Care Coordination Program

10.1. Minimum Care Coordination Program Components

10.1.1. The MCO shall implement a comprehensive care array of care coordination services that have at a minimum the following components:

10.1.1.1. Care Coordination

10.1.1.2. Support of Patient-Centered Medical Homes and Health Homes

10.1.1.3. Non-Emergent Medical Transportation

10.1.1.4. Wellness and Prevention programs

10.1.1.5. Chronic Care Coordination programs

10.1.1.6. High Risk/ High Cost Member Management programs

10.1.1.7. A Special Needs program

10.1.1.8. Coordination and Integration with Social Services and Community Care

10.1.1.9. A Long Term Services and Supports Program

10.2. Care Coordination: Role of the MCO

10.2.1. The MCO shall develop a strategy for coordinating all care for all members. Care coordination for its members includes coordination of primary care, specialty care, and all other MCO covered services as well as services provided through the fee-for-service program and non-Medicaid community based services. Care coordination shall promote and assure service accessibility, focus attention to individual needs, actively assist members or their caregiver to take personal responsibility for their health care, provide education regarding the use of inappropriate emergency room care, emphasize the importance of participating in health promotion activities, provide for continuity of care, and assure comprehensive coordinated and integrated culturally appropriate delivery of care.

10.2.2. The MCO shall ensure that services provided to children are family driven and based on the needs of the child and the family. The MCO shall support the family in having a primary decision making role in the care of their children utilizing the Substance Abuse and Mental Health Services Administration (SAMHSA) core elements of a children's services system of care. The MCO shall employ the SAMHSA principles in all children's behavioral health services assuring they:

10.2.2.1. Are person centered;

10.2.2.2. Include active family involvement;

10.2.2.3. Deliver behavioral health services that are anchored in the community;

10.2.2.4. Build upon the strengths of the member and the family;

10.2.2.5. Integrate services among multiple providers and organizations working with the child; and

10.2.2.6. Utilize a wraparound model of care within the context of a family driven model of care.

10.2.2.6.1. MCO shall submit a written policy to DHHS describing the integrated model of care including but not limited to the involvement of each member and family in the development of the plan.

10.2.3. The MCO will ensure that its providers are providing services to children, youth members, and their families in accordance with RSA 135-F.

10.2.4. The MCO shall provide a written policy to DHHS for approval that ensures that services to individuals who are homeless are to be prioritized and made available to those individuals.

10.3. Care Coordination: Role of the Primary Care Provider

10.3.1. MCO Cooperation with Primary Care Provider

10.3.1.1. The MCO shall implement procedures that ensure that each member has access to an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with 42 CFR 438.208(b)(1) through (6).

10.3.1.2. The MCO shall submit a written plan that describes the development, implementation and evaluation of programs to assess and support, wherever possible, primary care providers to act as a patient centered medical home. A patient centered medical home shall include all of the five key domains outlined by the Agency for Healthcare Research and Quality (AHRQ):

10.3.1.2.1. Comprehensive care;

10.3.1.2.2. Patient-centered care;

10.3.1.2.3. Coordinated care;

10.3.1.2.4. Accessible services; and

10.3.1.2.5. Quality and safety.

10.3.1.3. DHHS recognizes that there is a variety of ways in which these domains can be addressed in clinical practices. External accreditation is not required by DHHS to qualify as a medical home. The MCO's support to primary care providers acting as patient centered medical homes shall include, but is not limited to, the development of systems, processes and information that promote coordination of the services to the member outside of that provider's primary care practice.

10.4. Care Coordination: Role of Obstetric Providers

10.4.1. If, at the time of entering the MCO as a new member, the member is transferring from another MCO within the state system, is in her first trimester of pregnancy and is receiving, medically necessary covered prenatal care services, as defined within this Agreement as covered services, before enrollment the MCO shall be responsible for the costs of continuation of medically necessary prenatal care services, including prenatal care, delivery, and postpartum care.

10.4.2. If the member is receiving services from an out-of-network provider prior to enrollment in the MCO, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services until such time as the MCO can reasonably transfer the member to a network provider without impeding service delivery that might be harmful to the member's health.

10.4.3. If the member, at the time of enrollment, is receiving services from a network provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider through the postpartum period.

10.4.4. In the event a member entering the MCO, either as a new member or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services at the time of enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider, whether an out of network or in network provider, through the postpartum period.

10.4.5. Postpartum care includes the first postpartum visit, any additional visits necessary to manage any complications related to delivery, and completion of the medical record.

10.4.6. The MCO shall develop and maintain policies and procedures, subject to DHHS approval, regarding the transition of any pregnant members.

10.5. Non-Emergent Transportation (NEMT)

10.5.1. The MCO shall be required to arrange for the non-emergent medical transportation of its members to ensure members receive medically necessary services covered by the New Hampshire Medicaid program regardless of whether those medically necessary services are covered by the MCO. The MCO shall ensure that a member's lack of personal transportation is not a barrier to accessing care.

10.5.2. The MCO and/or any subcontractors shall be required to perform background checks on all non-emergent medical transportation providers.

10.5.3. The MCO shall provide quarterly reports to DHHS on its non-emergent medical transportation activities to include but not be limited to:

10.5.3.1. NEMT requests delivered by mode of transportation;

10.5.3.2. NEMT request authorization approval rates by mode of transportation;

10.5.3.3. NEMT scheduled trip results by outcome;

10.5.3.4. NEMT services delivered by type of medical service;

10.5.3.5. NEMT service use by population; and

10.5.3.6. Number of transportation requests that were delivered late and not on time.

10.5.3.6.1. On-time shall be defined as less than or equal to fifteen (15) minutes after the appointed time; and

10.5.3.6.2. Transportation requests for methadone services will be excluded from the calculation of late and not-on-time services.

10.5.3.7. Member cancellations of scheduled trips by reason for member cancellations.

10.6. Wellness and Prevention

10.6.1. The MCO shall develop and implement wellness and prevention programs for its members.

10.6.2. The MCO shall, at a minimum, develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs in consultation with DHHS.

10.6.3. The MCO shall, at minimum, provide primary and secondary preventive care services, rated A or B, in accordance with the recommendations of the U.S.

Preventive Services Task Force, and for children, those preventive services recommended by the American Academy of Pediatrics Bright Futures Program.

10.6.4. The MCO may substitute generally recognized accepted guidelines for the requirements set forth in 10.6.3, provided that such substitution is approved in advance by DHHS. The MCO shall provide members with a description of preventive care benefits to be used by the MCO in the member handbook and on the MCO's website.

10.6.5. The MCO shall provide members with general health information and provide services to help members make informed decisions about their health care needs. The MCO shall encourage patients to take an active role in shared decision making.

10.6.6. The MCO shall also participate in other public health initiatives at the direction of DHHS.

10.7. Member Health Education

10.7.1. The MCO shall develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of empowering patients to actively participate in their healthcare.

10.7.2. The MCO shall conduct a Health Needs Assessment for all new members within the following timeframes from the date of enrollment in the MCO:

10.7.2.1. thirty (30) calendar days for pregnant women, children with special health care needs, adults with special health care needs; and

10.7.2.2. ninety (90) calendar days for all other members, including members residing in a nursing facility longer than 100 days.

10.7.2.3. The MCO shall document at least three attempts to conduct the screen. If unsuccessful, the MCO shall document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.

10.7.3. The MCO will submit their Health Needs Assessment forms to DHHS for review and approval.

10.7.4. The MCO shall report quarterly, with reports due the last day of the month following the reporting quarter, with the first report due January 31, 2015. Reports shall include:

10.7.4.1. the number of members and the percentage of eligible members who completed a Health Needs Assessment in the quarter;

10.7.4.2. the percentage of eligible members who completed the Health Needs Assessment in the prior year; and

10.7.4.3. the percentage of members eligible for chronic care coordination, high cost/high risk care coordination, complex care coordination and/or the MCO's special needs program who completed a Health Needs Assessment in the prior year.

10.7.5. The MCO shall actively engage members in both wellness program development and in program participation and shall provide additional or alternative outreach to members who are difficult to engage or who utilize the emergency room inappropriately.

10.8. Chronic Care Coordination, High Risk/High Cost Member and Other Complex Member Management

10.8.1. The MCO shall develop effective care coordination programs that assist members in the management of chronic and complex health conditions, as well as those clients that demonstrate high utilization of services indicating a need for more intensive management services. The MCO may delegate the chronic and complex care member management to a patient centered medical home or health home provided that all the criteria for qualifying as a patient centered medical home or a health home and the additional conditions of this section have been met. These programs shall incorporate a "whole person" approach to ensure that the member's physical, behavioral, developmental, and psychosocial needs are comprehensively addressed. The MCO or its delegated entity shall ensure that the member, and/or the member's care giver, is actively engaged in the development of the care plan.

10.8.2. The MCO shall submit status reports to DHHS on MCO care coordination activities and any delegated medical home or health home activities as requested or required by DHHS.

10.8.3. The MCO shall at, a minimum, provide chronic care coordination services for members with the following or other chronic disease states who are appropriate for such care coordination services based on MCO's methodologies, which have been approved by DHHS, for identifying such members:

10.8.3.1. Diabetes, in coordination with the forthcoming federal diabetes initiative;

10.8.3.2. Congestive Heart Failure (CHF);

10.8.3.3. Chronic Obstructive Pulmonary Disease (COPD);

10.8.3.4. Asthma;

10.8.3.5. Coronary Artery Disease (CAD), in coordination with the Million Hearts Campaign;

10.8.3.6. Obesity;

10.8.3.7. Mental Illness;

10.8.3.8. Requiring wound care.

10.8.4. The MCO shall report on the number and types of members receiving chronic care coordination services.

10.9. Special Needs Program

10.9.1. The MCO shall create an organizational structure to function as patient navigators to:

10.9.1.1. Reduce any barriers to care encountered by members with special needs

10.9.1.2. Ensure that each member with special needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists as appropriate

10.9.1.3. Support in accessing all covered services appropriate to the condition or circumstance.

10.9.2. The MCO shall identify special needs members based on the member's physical, developmental, behavioral condition, or adverse social circumstances, including but not limited to:

10.9.2.1. A member with at least two chronic conditions;

10.9.2.2. A member with one chronic condition and is at risk for another chronic condition;

10.9.2.3. A member with one serious and persistent mental health condition;

10.9.2.4. A member living with HIV/AIDS;

10.9.2.5. A member who is a child in foster care;

10.9.2.6. A member who is a child and a client of DCYF receiving services through a court order; and

10.9.2.7. A member who is homeless.

10.9.3. The MCO shall assess, pursuant to 42 CFR 438.208(c)(2), and reach out to members identified with special needs and their PCP to inform them of additional services and supports available to them through the MCO's special needs program.

10.9.4. The MCO shall share the results of its identification and assessment of any enrollee with special health care needs as described in this section with the State so that those activities will not be duplicated.

10.9.5. The MCO shall ensure enrollees determined to have special health care needs as described in this section and who need a course of treatment or regular care monitoring, will have direct access to a specialist as appropriate for the enrollee's condition and identified needs.

10.9.6. For enrollees with special health needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.9.7. The MCO shall report on the number and types of members in the special needs program.

10.10. Coordination and Integration with Social Services and Community Care

10.10.1. The MCO shall develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including not limited to:

10.10.1.1. Juvenile Justice and Adult Community Corrections;

10.10.1.2. Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

10.10.1.3. Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

10.10.1.4. Public Health Agencies;

10.10.1.5. Schools;

10.10.1.6. Step 2 Programs and Services;

10.10.1.7. The court system;

10.10.1.8. ServiceLink Resource Network; and

10.10.1.9. Housing

10.10.1.9.1. Veterans Administration Hospital and other programs and agencies serving service members, veterans and their families.

10.10.2. The MCO shall report on the number of referrals for social services and community care provided to members by member type.

10.11. Long Term Services and Supports (LTSS)

10.11.1. Navigators. The MCO shall create an organizational structure to function as navigators for members in need of LTSS to:

10.11.1.1. Reduce any barriers to care encountered by members with long term care needs;

10.11.1.2. Ensure that each member with long term care needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists, as appropriate; and

10.11.1.3. Ensure that each member with long term care needs receives conflict free care coordination that facilitates the integration of physical health, behavioral health, psychosocial needs, and LTSS through person-centered care planning to identify a member's needs and the appropriate services to meet those needs; arranging, coordinating, and providing services; facilitating and advocating to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

10.11.2. Integrated Care. The MCO shall ensure that LTSS are delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation, based on the member's preferences and pursuant with 28 C.F.R. Pt. 35, App. A (2010), the Americans with Disabilities Act (ADA) [42 USC 126.12101] and Olmstead v. L.C., 527 U.S. 581 (1999).

10.11.2.1. The MCO shall support accessing all covered services appropriate to the medical, behavioral, psychosocial, and/or LTSS condition or circumstance.

10.11.2.2. The MCO shall identify members with long term care needs based on the member's physical, developmental, psychosocial, or behavioral conditions including but not limited to:

10.11.2.2.1. Children with DCYF involvement;

10.11.2.2.2. Children with special needs other than DCYF;

10.11.2.2.3.Children with Waiver, NF or CMHC services;

10.11.2.2.4.Adults with Special Needs with Waiver, NF or CMHC services;

10.11.2.2.5.Adults with Waiver, NF or CMHC services;

10.11.2.2.6.Older Adults with Waiver or CMHC services; or

10.11.2.2.7.Older adults with NF services.

10.11.2.3. The MCO shall reach out to members identified with long term care needs and their PCP to inform them of additional services and supports available to them through the MCO.

10.11.2.4. For enrollees with long term care needs determined through an assessment or through regular care monitoring to need services, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.11.2.5. For enrollees with long term care needs determined through an assessment or regular care monitoring, the MCO must have a mechanism in place to assist enrollees to access medically necessary and necessary services.

11. EPSDT

11.1. Compliance

11.1.1. The MCO shall provide Early Periodic Screening Diagnostic Treatment (EPSDT) services to members less than twenty-one (21) years of age in compliance with all requirements found below:

11.1.1.1. The MCO shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the SSA and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The MCO shall comply with all EPSDT requirements pursuant to the New Hampshire Medicaid Rules.

11.1.1.2. The MCO shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through Health Check screens and exams and follow-up on any abnormal screening exams. The EPSDT Plan shall also include procedures for referral, tracking, and follow up for annual dental examinations and visits, upon receipt of dental claims information from DHHS. The EPSDT Plan shall consider and be consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists to the extent that such policy statements relate to the role of the primary care provider in coordinating care for infants, children and adolescents. The MCO shall submit its EPSDT Plan to DHHS for review and approval ninety (90) days prior to program start and annually sixty (60) calendar days prior to the first day of each Agreement year.

11.1.1.3. The MCO shall ensure providers perform a full EPSDT visit according to the periodic schedule approved by DHHS and the American Academy of Pediatrics periodicity schedule. The visit shall include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements §1902(a)(43) of the SSA, §1905(a)(4)(B) of the SSA and 42 CFR 441.50-.62, and health education/anticipatory guidance. All five (5) components shall be performed for the visit to be considered an EPSDT visit.

12. Behavioral Health

12.1. Behavioral Health - General Provisions

12.1.1. This section applies to individuals who have been determined to be eligible for community mental health services based on diagnosis, level of impairment and the requirements outlined in N.H. Code of Administrative Rules, chapter He-M 401.

12.1.2. Community mental health services, as set forth in Section 8.2, shall be provided in accordance with the NH Medicaid State Plan, He-M 426, He-M 408 and all other applicable state and federal regulations.

12.1.3. All clinicians providing community mental health services are subject to the requirements of He-M 426 and any other applicable state and federal regulations.

12.1.4. All individuals approved to provide community mental health services through a waiver granted by NH DHHS shall be recognized as qualified providers under the MCO plan subject to NCQA credentialing requirements.

12.1.5. All other behavioral health services shall be provided to all NH Medicaid-eligible recipients in accordance with the NH Medicaid State Plan.

12.1.6. The MCO shall pay for all NH Medicaid State Plan Services for its members as ordered to be provided by the Mental Health Court.

12.1.7. The MCO shall continue to support and ensure that culturally and linguistically competent community mental health services currently provided for people who are deaf continue to be made available. These services shall be similar to services currently provided through the Deaf Services Team at Greater Nashua Mental Health Center.

12.2. Community Mental Health Services

12.2.1. The MCO shall ensure, through review of individual service plans and quarterly reviews, that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall inform DHHS of their findings on a monthly basis.

12.2.2. The MCO shall employ a trauma informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan, pursuant to He-M 401, that will effectively address the individual's trauma history.

12.2.3. The MCO shall make Community Mental Health Services available to all members who have a severe mental disability. DHHS encourages agreement between the MCO and CMHCs to develop a capitated payment program with the intent to establish payment mechanisms to meet the goals of DHHS to strengthen the State's outpatient community health service system and the requirements of the Community Mental Health Agreement, and to further payment reform. In the event that any CMHC fails to sign a contract with the MCO within thirty (30) days before the current contract end date, the MCO shall notify DHHS of the failure to reach agreement with a CMHC and DHHS shall implement action steps to designate a community mental health program to provide services in the designated community mental health services region.

12.2.3.1. The MCO shall submit to DHHS a plan to assure continuity of care for all members accessing a community mental health agency.

12.2.4. In the event that an alternative community mental health program is approved and designated by DHHS, a transition plan shall be submitted for approval by DHHS including implementation strategy and timeframes. State Administrative Rule He-M 426, Community Mental Health Services, details the services available to adults with a severe mental illness and children with serious emotional disturbance. The MCO shall, at a minimum, make these services available to all members determined eligible for community mental health services under State Administrative Rule He-M 401.

12.2.4.1. The MCO shall be required to continue the implementation of evidence based practices across the entire service delivery system.

12.2.4.2. Behavioral Health Services shall be recovery and resiliency oriented, based on SAMHSA's definition of recovery and resiliency.

12.2.4.3. The MCO shall ensure that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans.

12.2.4.4. The MCO shall ensure that community mental health services to individuals who are homeless continue to be prioritized and made available to those individuals.

12.2.4.5. The MCO shall maintain or increase the ratio of community based to office based services for each region in the State, as specified in He-M 425, to be greater than or equal to the regional current percentage or 50%, whichever is greater.

12.2.4.6. The MCO shall monitor the ratio of community based to office based services for each region in the State, as specified in He-M 425.

12.2.4.7. The Department of Health and Human Services (DHHS) will issue a list of covered office and community based services annually, by procedure code, that are used to determine the ratio outlined in 12.2.4.5.

12.2.4.8. The MCO shall submit a written report to the Department of Health and Human Services DHHS every six (6) months, by region, of the ratio of community based services to office based services.

12.2.5. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

12.2.5.1. Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web-based training and certification system.

12.2.5.1.1. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member eligibility renewal following clinician certification to utilize the CANS and the ANSA and upon eligibility determination for newly evaluated consumers effective July 1, 2015.

12.2.5.1.2. The community mental health long term care eligibility tool, specified in He-M 401, and in effect on January 1, 2012 shall continue to be utilized by a clinician until such time as the Department of Health and Human Services implements web-based access to the CANS and the ANSA, the clinician is certified in the use of the CANS and the ANSA, and the member annual review date has passed.

12.2.6. The MCO shall ensure that community mental health service providers operate in a manner that enables the State to meet its obligations under Title II of the Americans with Disabilities Act, with particular attention to the "integration mandate" contained in 28 CFR 35.130(d).

12.2.7. The MCO shall continue the implementation of New Hampshire's 10-year Olmstead Plan, as updated from time to time, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration."

12.2.7.1. The MCO shall include in its written Program Management Plan:

12.2.7.1.1. Screening criteria for Assertive Community Treatment Teams for all persons with serious mental disabilities.

12.2.7.1.2. A needs assessment, capacity analysis and access plan for Community Residential and Supported Housing.

12.2.7.1.3. New and innovative interventions that will reduce admissions and readmissions to New Hampshire Hospital and increase community tenure for adults with a severe mental illness and children with a serious emotional disturbance.

12.2.8. The MCO shall work collaboratively to support the implementation of the Medicaid-funded services described in the Class Action Settlement Agreement in the case of Amanda D. et al. v. Hassan, et al., US v. State of New Hampshire, Civ. No. 1:12-cv-53-SM in conjunction with DHHS and the Community Mental Health Centers.

12.2.8.1. Adult Assertive Community Treatment Teams (ACT). The MCO shall ensure that ACT teams are available twenty-four (24) hours per day, seven (7) days per week, with on-call availability from midnight to 8:00 am. At a minimum, ACT teams shall deliver comprehensive, individualized, and flexible services, supports, treatment, and rehabilitation in a timely manner as needed, onsite in the individuals homes and in other natural environments and community settings, or alternatively, via telephone where appropriate to meet the needs of the individual. Each ACT team shall be composed of a multi-disciplinary group of between seven (7) and ten (10) professionals, including, at a minimum, a psychiatrist, a nurse, a Masters-level clinician (or functional equivalent therapist), functional support worker and a peer specialist. The team also will have members who have been trained and are competent to provide substance abuse support services, housing assistance and supported employment. Caseloads for ACT teams serve no more than ten (10) to twelve (12) individuals per ACT team member (excluding the psychiatrist who will have no more than seventy (70) people served per 0.5 FTE psychiatrist).

12.2.8.2. Evidence-based Supported Employment (EBSE). The MCO shall ensure that EBSE is provided to eligible consumers in accordance with the Dartmouth model. The MCO shall ensure that the penetration rate of individuals receiving EBSE increases to 18.6 percent by June 30, 2017. The penetration rate is determined by dividing the number of adults with severe mental illness (SMI) receiving EBSE by the number of adults who have SMI being served.

12.2.9. The Department of Health and Human Services will lead regional planning activities in each community mental health region to develop and refine community mental health services in New Hampshire. The MCO shall support and actively participate in these activities.

12.2.9.1. The focus of the regional planning process will be on reducing the need for inpatient care and emergency department utilization, and on increasing community tenure.

12.2.10. The MCO shall develop a Training Plan each year of the Agreement for how it will support the New Hampshire community mental health service system's effort to hire and train qualified staff. The MCO shall submit this Training Plan to DHHS sixty (60) calendar days prior to program start and annually ninety (90) calendar days prior to beginning of each Agreement year.

12.2.10.1. The MCO shall submit a report summarizing what training was provided, a copy of the agenda for each training, a participant registration list for each contracted CMHC and a summary, for each training provided, of the evaluations done by program participants, within ninety (90) calendar days of the conclusion of each Agreement year.

12.2.10.2. As part of that Training Plan, the MCO shall promote provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

12.2.10.3. The MCO Training Plan outlined in 12.2.10.1 shall be designed to sustain and expand the use of the Evidence Based Practices of Illness Management and Recovery (IMR), Evidence Based Supported Employment (EBSE), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Treatment (DBT) and Assertive Community Treatment (ACT), and to improve NH's penetration rates for Illness Management and Recovery (IMR) and Supported Employment, by 2% each year of the Agreement. The baseline measure for penetration rates shall be the NH submission to the SAMHSA Uniform Reporting System for 2011.

12.2.10.4. The MCO shall offer a minimum of 2 hours of training each contract year to all contracted community mental health center staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the State's objective of reducing the number of suicides in New Hampshire.

12.2.10.5. The MCO shall submit an annual report no later than ninety (90) calendar days following the close of each Agreement year with a summary of the trainings provided, a list of attendees from each contracted community mental health program, and the proposed training for the next fiscal year.

12.3. Emergency Services

12.3.1. The MCO shall ensure, through its contracts with local providers, that regionally based crisis lines and Emergency Services as defined in He-M 403 and He-M 426 are in place 24 hours a day/ 7 days a week for individuals in crisis. These crisis lines and Emergency Services Teams shall employ clinicians who are trained in managing crisis intervention calls and who have access to a clinician available to evaluate the member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

12.3.2. The MCO shall submit for review to the DHHS MCM Account Manager and the Director of the Bureau of Mental Health an annual report identifying innovative and cost effective models of providing crisis and emergency response services that will provide the maximum clinical benefit to the consumer while also meeting the State's objectives in reducing admissions and increasing community tenure.

12.4. Care Coordination

12.4.1. The MCO shall develop policies governing the coordination of care with primary care providers and community mental health programs. These policies shall be submitted to DHHS for review and approval ninety (90) calendar days prior to the beginning of each Agreement year, including Year 1.

12.4.2. The MCO shall ensure that there is coordination between the primary care provider and the community mental health program.

12.4.3. The MCO shall ensure that both the primary care provider and community mental health program request written consent from the member to release information to coordinate care regarding mental health services or substance abuse services or both, and primary care.

12.4.4. The MCO shall monitor instances in which consent was not given, and if possible the reason why, and submit this report to DHHS no later than sixty (60) calendar days following the end of the fiscal year.

12.4.5. The MCO shall review with DHHS the approved policy, progress toward goals, barriers and plans to address identified barriers.

12.4.6. The MCO shall ensure integrated care coordination by requiring that providers accept all referrals for its members from the MCO that result from a court order or a request from DHHS.

12.5. New Hampshire Hospital

12.5.1. The MCO shall maintain a collaborative agreement with New Hampshire Hospital, the State of New Hampshire's state operated inpatient psychiatric facility. This collaborative agreement subject to the approval of DHHS shall at a minimum address the Americans with Disabilities Act requirement that individuals be served in the most integrated setting appropriate to their needs, include the responsibilities of the community mental health program in order to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.

12.5.2. It is the policy of the State to decrease discharges from inpatient care at New Hampshire Hospital to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning from New Hampshire Hospital. The MCO shall utilize the collaborative agreement to track any discharges that the MCO, through its provider network, was unable to place into the community and who instead were discharged to a shelter or into homelessness. The MCO shall submit a report to the Department of Health and Human Services DHHS, quarterly, detailing the reasons why members were placed into homelessness and include efforts made by the MCO to arrange appropriate placements.

12.5.3. The MCO shall designate a liaison with privileges, as required by New Hampshire Hospital, to continue members' care coordination activities, and assist in facilitating a coordinated discharge planning process for adults and children admitted to New Hampshire Hospital. Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital treatment team meetings and discharge planning meetings to ensure that individuals receive treatment in the least restrictive environment complying with the Americans with Disabilities Act and other applicable federal and State regulations.

12.5.3.1. The liaison shall actively participate, and assist New Hampshire Hospital staff in the development of a written discharge plan within twenty-four (24) hours of admission.

12.5.3.2. The MCO shall ensure that the final NHH Discharge Instruction Sheet shall be provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of members discharged. The MCO shall ensure that the discharge progress note shall be provided to the aftercare provider within 7 calendar days of member discharge for at least ninety percent (90%) of members discharged.

12.5.3.3. The MCO shall make at least three (3) attempts to contact members for whom the MCO has record of a telephone number within three (3) business days of discharge from New Hampshire Hospital in order to review the discharge plan, support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the member may have. The performance metric shall be that at least ninety-five percent (95%) of members discharged shall have been attempted to be contacted within three (3) business days.

12.5.3.4. The MCO shall ensure an appointment with a community mental health program or other appropriate mental health clinician for the member is scheduled prior to discharge. Such appointment shall occur within seven (7) calendar days after discharge.

12.5.3.4.1. Persons discharged from psychiatric hospitalization and new to a CMHC must have an intake appointment within seven (7) days.

12.5.3.5. The MCO shall work with DHHS to review cases of members that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

12.5.3.6. The MCO shall establish a reduction in readmissions plan, subject to approval by DHHS, to monitor the 30-day and 180-day readmission rates to New Hampshire Hospital, review member specific data with each of the community mental health programs, and implement measurable strategies within 90 days of the execution of this Agreement to reduce 30-day and 180-day readmission. The MCO shall include benchmarks and reduction goals in the Program Management Plan.

12.5.4. The MCO shall perform in-reach activities to New Hampshire Hospital designed to accomplish transitions to the community.

12.6. In Shape Program

12.6.1. The MCOs shall promote community mental health service recipients' whole health goals. Functional support services may be utilized to enable recipients to pursue and achieve whole health goals within an In Shape program or other program designed to improve health.

12.7. Parity

12.7.1. The MCO and its subcontractors must comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which requires the MCOs

to not discriminate based upon an enrollee's health status of having a mental health or substance use disorder.

12.7.1.1. The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.

12.7.1.2. The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

12.7.1.3. The MCO shall not impose Non- Quantitative Treatment Limits for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

12.7.1.4. Annual Certification with Federal Mental Health Parity Law: The MCOs must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the Federal Mental Health Parity Law, regulations and guidance issued by state and federal entities.

12.7.1.4.1. The MCO must submit a certification signed by the chief executive officer and chief medical officer stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.2. If the MCO determines that all administrative, clinical, and utilization practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will affirmatively state, that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.3. If the MCO determines that any administrative, clinical, and utilization practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law or guidance issued by state and federal entities during the calendar year, the certification will state that not all practices were in compliance with Federal Mental Health Parity Law or any guidance issued by state or federal entities and will include a list of the practices not in compliance and the steps the managed care entity has taken to bring these practices into compliance.

12.7.1.5. The MCO shall complete the DHHS Parity Compliance Report annually and shall include:

12.7.1.5.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCOs pursuant to DHHS criteria;

12.7.1.5.2. All member grievances and appeals regarding a parity violation and resolutions;

12.7.1.5.3. The processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification; and

12.7.1.5.4. Any other requirements identified by DHHS.

12.7.1.6. A member enrolled in any MCO may file a complaint with the New Hampshire Insurance Department at **https://www.nh.gov/insurance/consumers/complaints.htm** if services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance.

13. Substance Use Disorder

13.1. Substance Use Disorder - General Provisions

13.1.1. The MCO will offer contracts to Medicaid enrolled SUD providers who meet the MCO's credentialing standards. The MCO will reimburse those SUD providers in accordance with Section 21.2.10.

13.1.2. The MCO will submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of SUD service providers so that services are accessible without reasonable delays.

13.1.2.1. If the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours this provider is required to provide interim substance use disorder counselors services until such a time that the clients starts receiving the identified level of care. If the type of service is not provided by this agency they are then responsible for making an active referral to a provider of that type of service (for the identified level of care) within fourteen (14) days from initial contact and to provider interim substance use disorder counselors services until such a time that the member is accepted and starts receiving services by the receiving agency.

13.1.3. The MCO shall provide data, reports and plans in accordance with Exhibit O.

13.2. Compliance Metrics for Access to SUD Services

13.2.1. Agencies under contract with MCOs to provide SUD services to provide SUD services shall respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The SUD provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face to face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but not later than two (2) business days following the date of first contact.

13.2.2. Members who have screened positive for SUD services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation (as identified in the He-W 513 administrative rules) as soon as possible following the ASAM Level of Care Assessment and no later than (3) days after admission.

13.2.3. Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed. Members identified for Partial

Hospitalization (PH) or Rehabilitative Residential (RR) Services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

13.2.3.1. Pregnant women shall be admitted to the identified level of care within 24 hours of the ASAM Level of Care Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor shall:

13.2.3.1.1. Assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance must include actively reaching out to identify providers on the behalf of the client; and

13.2.3.1.2. Provide interim services until the appropriate level of care becomes available at either the contractor agency or an alternative provider. Interim services shall include:

a. At least one 60 minute individual or group outpatient session per week;

b. Recovery support services as needed by the client; and

c. Daily calls to the client to assess and respond to any emergent needs.

13.2.4. If the type of service identified in the ASAM Level of Care Assessment will not be available from the provider that conducted the initial assessment within the fourteen (14) business day period, or if the type of service is not provided by the agency that conducts the ASAM Level of Care Assessment, this agency is responsible for making an active referral to a provider of that type of services (for the identified level of care) within fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

14. Pharmacy Management

14.1. Pharmacy Management – General Provisions

14.1.1. The MCO's, including any pharmacy subcontractors, shall create: formulary and pharmacy prior authorization criteria and other point of service edits (i.e. prospective drug utilization review edits and dosage limits), pharmacy policies and pharmacy programs subject to DHHS approval, and in compliance with §1927 of the SSA [42 CFR 438.3(s)]. The MCO shall not include drugs by manufacturers not enrolled in the OBRA 90 Medicaid rebate program on its formulary without DHHS consent.

14.1.2. The MCO shall adhere to New Hampshire law with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, law 2004, SB 383-FN, Sect. IVa. Specifically, a MCO member shall continue to be treated, or, if newly diagnosed, may be treated with a non-preferred drug based on any one of the following criteria:

14.1.2.1. Allergy to all medications within the same class on the preferred drug list;

14.1.2.2. Contraindication to or drug-to-drug interaction with all medications within the same class on the preferred drug list;

14.1.2.3. History of unacceptable or toxic side effects to all medications within the same class on the preferred drug list;

14.1.2.4. Therapeutic failure of all medications within the same class on the preferred drug list;

14.1.2.5. An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal Food and Drug Administration-approved indication;

14.1.2.6. Age specific indication;

14.1.2.7. Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or

14.1.2.8. Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

14.1.3. The MCO shall submit all of its policies, prior authorizations, point-of-sale and drug utilization review edits and pharmacy services procedures related to its maintenance drug policy, specialty pharmacy programs, and any new pharmacy service program proposed by the MCO to DHHS for its approval at least 60 calendar days prior to implementation.

14.1.4. The MCO shall submit the items described in 14.1.1 and 14.1.3 to DHHS for approval sixty (60) calendar days prior to the program start date of Step 1.

14.1.5. Any modifications to items listed in 14.1.1 and 14.1.3 shall be submitted for approval at least sixty (60) calendar days prior to the proposed effective date of the modification.

14.1.6. The MCO shall notify members and providers of any modifications to items listed in 14.1.1 and 14.1.3 thirty (30) calendar days prior to the modification effective date.

14.1.7. Implementation of a modification shall not commence prior to DHHS approval.

14.1.8. At the time a member with currently prescribed medications transitions to an MCO: upon MCO's receipt of (written or verbal) notification validating such prescribed medications from a treating provider, or a request or verification from a pharmacy that has previously dispensed the medication, or via direct data from DHHS, the MCO shall continue to cover such medications through the earlier of sixty (60) calendar days from the member's enrollment date, or until completion of a medical necessity review. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

14.1.9. The MCO shall adjudicate pharmacy claims for its members utilizing a point of service (POS) system where appropriate. System modifications, including but not limited to systems maintenance, software upgrades, implementation of International Classification of Diseases- 10 (ICD-10) code sets, and NDC code sets or migrations to new versions of National Council for Prescription Drug Programs (NCPDP) transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

14.1.10.In accordance with Section 1927 (d)(5)(A and B) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization and reimburse for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation when prior authorization cannot be obtained.

14.1.11.The MCO shall develop or participate in other State of New Hampshire pharmacy related quality improvement initiatives. At minimum, the MCO shall routinely monitor and address:

14.1.11.1. Polypharmacy (physical health and behavioral health medications);

14.1.11.2. Adherence to the appropriate use of maintenance medications, such as the elimination of gaps in refills;

14.1.11.3. The appropriate use of behavioral health medications in children by encouraging the use of and reimbursing for consultations with child psychiatrists;

14.1.11.4. For those beneficiaries with a diagnosis for substance use disorder (SUD) and all infants with a diagnosis of neonatal abstinence syndrome (NAS), or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall evaluate these patients needs for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment;

14.1.11.5. For those beneficiaries who enter the MCO lock-in program, the MCO shall evaluate the need for SUD treatment.

14.1.11.6. The MCO shall require prior authorization documenting the rationale for the prescription of more than 200 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective April 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescription of more than 120 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective October 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescriptions of more than 100 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries effective upon NH Board Administrative Rule MED 502 Opioid Prescribing;

14.1.12.In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 (CMS) rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process, in accordance with section 1927(b) of the SSA, and the MCO shall submit the encounter data file within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment.

14.1.13.The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for members for medications covered by other payers.

14.1.14.Specialty Drugs. The MCO shall pay for all specialty drugs consistent with the MCO's formulary and pharmacy edits and criteria.

14.1.15. DHHS will be directly responsible for the pharmacy benefit for Carbaglu and Ravicti, and those Hepatitis C and Hemophilia drugs specifically excluded from the actuarial rate calculations.

14.1.16.Other specialty and orphan drugs.

14.1.16.1. Other currently FDA approved specialty and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

14.1.16.2. When medically necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

14.1.17.Polypharmacy medication review. The MCO shall provide an offer for medication review and counseling to address polypharmacy.

14.1.17.1. MCO shall offer a medication review and counseling no less than annually by a pharmacist or other health care professional as follows:

14.1.17.1.1. To the primary care provider and care taker for children less than 19 years dispensed four (4) or more drugs per month (or prescriptions for 90 day supply covering each month); and

14.1.17.1.2.To adult beneficiaries dispensed more than 10 drugs each month (or prescriptions for 90 day supply covering each month).

14.1.18.The MCO shall adhere to federal regulation with respect to providing pharmacy data required to complete the Annual Drug Utilization Review Report to CMS:

14.1.18.1. The MCO must provide a detailed description of its drug utilization review program to DHHS on an annual basis in accordance with the Medicaid Drug Utilization Review Annual Report format and requirements; and

14.1.18.2. The MCO must operate a drug utilization review program in accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, which includes:

14.1.18.2.1. Prospective drug utilization review;

14.1.18.2.2.Retrospective drug utilization review; and

14.1.18.2.3. An educational program for providers including prescribers and dispensers.

14.2. Continuity of Care

14.2.1. The MCO shall provide continuity of care for current beneficiaries after the transition of the PDL to the MCO. For existing beneficiaries, the MCO shall provide coverage for all drugs for each current beneficiary for six months beginning September 1, 2015 for those drugs dispensed to the beneficiary within the six months prior to September 1, 2015.

14.3. Use of Psychotropic Medicines for Children in Foster Care – DCYF's SafeRx Program

14.3.1. The MCO shall assist in the oversight and management of the use of psychotropic medicines for children and youth in DCYF placement in accordance with PL (Public Law 112-34) and in accordance with DCYF policy 1653. Assistance includes:

14.3.1.1. Psychiatry review of Medications when requested by DCYF staff, with Peer To Peer discussion if warranted to include:

14.3.1.1.1. Pharmacy claims;

14.3.1.1.2. Provider progress notes;

14.3.1.1.3. Telephone contact with the providers, if necessary;

14.3.1.1.4. Current Diagnoses, DSM I-III;

14.3.1.1.5. Current Behavioral Functioning; and

14.3.1.1.6. Information from the placement provider, either foster care or residential re: behaviors and medication response.

14.3.1.2. Edits in pharmacy systems for outlying red flag criteria that would require further explanation and authorization including:

14.3.1.2.1. Children 5 and under being prescribed antipsychotics;

14.3.1.2.2. Children 3 and under on any psychotropic medicine; and

14.3.1.2.3. A child or youth being prescribed 4 or more psychotropic medicines, allowing for tapering schedules for ending one medicine and starting a new medicine.

15. Reserved.

16. Member Enrollment and Disenrollment

16.1. Eligibility

16.1.1. The State has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether he/she will be enrolled in the Care Management program. The State shall maintain its current responsibility for determining member eligibility. The MCO shall comply with eligibility decisions made by DHHS.

16.1.2. The MCO shall ensure that ninety-five percent (95%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. Data received Monday-Friday is to be uploaded Tuesday-Saturday between 12 AM EST and 8AM EST. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded by 10 AM EST. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond 10 AM EST.

16.1.3. The ASCX12 834 enrollment file will limit enrollment history to eligibility spans reflective of any assignment of the member with the MCO.

16.1.4. To ensure appropriate continuity of care, DHHS will provide up to two (2) years (as available) of all fee-for-service paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all fee-for-service Medicaid beneficiaries assigned to MCO. For members transitioning from another MCO, DHHS will also provide such claims data as well as available encounter information regarding the member supplied by other MCOs.

16.2. Relationship with Enrollment Services

16.2.1. DHHS or its designee shall be responsible for member enrollment and passing that information along to the MCO for plan enrollment [42 CFR 438.3(d)(2)].

16.2.2. The MCO shall accept individuals into its plan from DHHS or its designee in the order in which they apply without restriction, (unless authorized by the regional administrator), up to the limits set in this Agreement [42 CFR 438.3(d)(1)].

16.2.3. The MCO will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll [42 CFR 438.3(d)(3)].

16.2.4. The MCO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has a discriminatory effect [42 CFR 438.3(d)(4].

16.2.5. The MCO shall furnish information to DHHS or its designee so that it may comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the recipient receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; State Medicaid Manual (SMM) 2090.1; SMM 2101].

16.2.6. The MCO shall provide information, within five (5) business days, to DHHS or its designee that allows for a determination of a possible change in eligibility of members (for example, those who have died, been incarcerated, or moved out-of-state).

16.3. Enrollment

16.3.1. The MCO shall accept members who choose to enroll in the MCO:

16.3.1.1. During the initial enrollment period;

16.3.1.2. During an annual enrollment period;

16.3.1.3. During a renegotiation or reprocurement enrollment period;

16.3.1.4. If the member requests to be assigned to the same plan in which another family member is currently enrolled; or

16.3.1.5. Who have disenrolled with another MCO at the time described in 16.5.3.1.

16.3.2. The MCO shall accept that enrollee enrollment is voluntary, except as described in 42 CFR 438.50.

16.3.3. The MCO shall accept for automatic re-enrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less.

16.3.4. The MCO shall accept members who have been auto-assigned by DHHS to the MCO.

16.3.5. The MCO shall accept members who are auto-assigned to another MCO but have an established relationship with a primary care provider that is not in the network of the auto-assigned MCO. The member can request enrollment any time during the first twelve (12) months of auto-assignment.

16.4. Auto-Assignment

16.4.1. DHHS will use the following auto-assignment methodology:

16.4.1.1. Preference to an MCO with which there is already a family affiliation;

16.4.1.2. Equal assignment among the MCOs.

16.4.2. DHHS reserves the right to change the auto assignment process at its discretion.

16.4.3. DHHS may also revise its auto-assignment methodology during the Contract Period for new Medicaid members who do not select an MCO (Default Members). The new assignment methodology would reward those MCOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. DHHS will also consider other appropriate factors.

16.4.4. DHHS may revise its auto-assignment methodology when exercising renegotiation and reprocurement rights under section 3.9.1 of this Agreement.

16.5. Disenrollment

16.5.1. Disenrollment provisions of 42 CFR 438.56(d)(2) apply to all members, regardless of whether the member is mandatory or voluntary [42 CFR 438.56(a); SMD letter 01/21/98].

16.5.2. A member may request disenrollment with cause at any time when:

16.5.2.1. The member moves out of state;

16.5.2.2. The member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the member to unnecessary risk; or

16.5.2.3. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to providers experienced in dealing with the member's health care needs [42 CFR 438.56(d)(2)]

16.5.3. A member may request disenrollment without cause, at the following times:

16.5.3.1. During the ninety (90) calendar days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later;

16.5.3.2. For members who are auto-assigned to a MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO, the member can request disenrollment during the first twelve (12) months of enrollment at any time;

16.5.3.3. Any time for members who enroll on a voluntary basis;

16.5.3.4. During open enrollment every twelve (12) months;

16.5.3.5. During open enrollment related to renegotiation and reprocurement under Section 3.9.

16.5.3.6. For sixty (60) calendar days following an automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual enrollment/disenrollment opportunity (This provision applies to re-determinations only and does not apply when a member is completing a new application for Medicaid eligibility); and

16.5.3.7. When DHHS imposes the intermediate sanction on the MCO specified in 42 CFR 438.702(a)(3) [§1932(a)(4)(A) of the SSA; §1932(e)(2)(C) of the SSA; 42 CFR 438.56(c)(1); 438.56(c)(2)(i), (ii), (iii), and (iv); 42 CFR 438.702(a)(3); SMD letter 02/20/98; SMD letter 01/21/98]

16.5.4. The MCO shall provide members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period.

16.5.5. If a member is requesting disenrollment, the member (or his or her representative) shall submit an oral or written request to DHHS or its agent.

16.5.6. The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS' request for information.

16.5.7. The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons [42 CFR 438.56(b)(1); SMM 2090.12]:

16.5.7.1. Member has established out of state residence;

16.5.7.2. Member death;

16.5.7.3. Determination that the member is ineligible for enrollment based on the criteria specified in this Agreement regarding excluded populations; or

16.5.7.4. Fraudulent use of the member ID card.

16.5.8. The MCO shall not request disenrollment of a member for any reason not permitted in this Agreement [42 CFR 438.56(b)(3)].

16.5.9. The MCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular

member or other members) or abuse of substances, prescribed or illicit, and any legal consequences resulting from substance abuse. [42 CFR 438.56(b)(2)].

16.5.10. The MCO may request disenrollment in the event of threatening or abusive behavior that jeopardizes the health or safety of members, staff, or providers.

16.5.11. If an MCO is requesting disenrollment of a member, the MCO shall:

16.5.11.1. Specify the reasons for the requested disenrollment of the member; and

16.5.11.2. Submit a request for involuntary disenrollment to DHHS (or its agent) along with documentation and justification, for review and approval

16.5.12. Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member or the MCO files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); SMM 2090.6; SMM 2090.11].

16.5.13. DHHS (or its agent) shall provide for automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less [42 CFR 438.56(g)].

17. Member Services

17.1. Member Information

17.1.1. The MCO shall maintain a Member Services Department to assist members and their family members, guardians or other authorized individuals in obtaining covered services under the Care Management program.

17.1.2. The MCO shall have a 'No Wrong Door' approach, consistent with the DHHS Balancing Incentive Program, to member calls and inquiries, and shall have one toll-free number for members to contact.

17.1.3. The MCO shall have in place a mechanism to help members and potential members understand the requirement and benefits of the plan [42 CFR 438.10(c)(7)].

17.1.4. The MCO shall make a welcome call to each new member within thirty (30) days of the member's enrollment in the MCO. A minimum of three (3) attempts should be made at various times of the day, on different days, for at least ninety-five percent (95%) of new members. The welcome call shall at a minimum:

17.1.4.1. Assist the member to select a Primary Care Provider (PCP) or confirm selection of a PCP;

17.1.4.2. Include a brief Health Needs Assessment;

17.1.4.3. Screen for special needs and /or services of the member; and

17.1.4.4. Answer any other member questions about the MCO and ensure that members can access information in their preferred language.

17.1.5. Welcome calls shall not be required for members residing in a nursing facility longer than 120 days. The MCO shall:

17.1.5.1. Meet with each nursing facility no less than annually to provide an orientation to the MCM program and instructions regarding completion of the Health Needs Assessment for each member residing in a nursing facility longer than 120 days; and

17.1.5.2. Send letters to members residing in nursing facilities longer than 120 days or their authorized representatives describing welcome calls and how a member or their authorized representative can request a welcome call.

17.1.6. The MCO shall send a letter to a member upon initial enrollment, and anytime the member requests a new Primary Care Provider (PCP), confirming the member's PCP and providing the PCP's name address and telephone number.

17.1.7. The MCO shall issue an Identification Card (ID Card) to all new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. The ID Card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the ID card:

17.1.7.1. The member's name;

17.1.7.2. The member's date of birth;

17.1.7.3. The member's Medicaid ID number assigned by DHHS at the time of eligibility determination;

17.1.7.4. The name of the MCO; and

17.1.7.5. The name of MCO's NHHPP product;

17.1.7.6. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

17.1.7.7. How to file an appeal or grievance.

17.1.8. The MCO shall reissue a Member ID card if:

17.1.8.1. A member reports a lost card;

17.1.8.2. A member has a name change; or

17.1.8.3. Any other reason that results in a change to the information disclosed on the ID card.

17.1.9. The MCO shall publish member information in the form of a member handbook available at the time of member enrollment in the plan for benefits effective January 1, 2018. The member handbook shall be based upon the model enrollee handbook developed by DHHS.

17.1.9.1. Two weeks in advance of open enrollment, the MCOs shall inform all members by mail of their right to receive at no cost to any member a written copy of the member handbook effective for the new benefit year.

17.1.10. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives.

17.1.11. The MCO shall submit the member handbook to DHHS for approval at the time it is developed and after any substantive revisions, prior to publication and distribution

17.1.12. Pursuant to the requirements set forth in 42 CFR 438.10, the Member Handbook shall include, in easily understood language, but not be limited to:

17.1.12.1. A table of contents;

17.1.12.2. DHHS developed definitions so that enrollees can understand the following terminology: appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, grievance, habilitation services and devices, home health care, hospice services, hospitalization, hospital, outpatient care, physician services, prescription drug coverage, prescription drugs, primary care physician, PCP, rehabilitation services and devices, skilled nursing care, and specialist.

17.1.12.3. Information about the role of the primary care provider (PCP);

17.1.12.4. Information about choosing and changing a PCP;

17.1.12.5. Appointment procedures;

17.1.12.6. [Intentionally left blank.]

17.1.12.7. Description of all available benefits and services, including information on out-of-network providers;Information on how to access services, including EPSDT services, non-emergency transportation services, and maternity and family planning services. The handbook should also explain that the MCO cannot require a member to receive prior approval prior to choosing a family planning provider;

17.1.12.8. An explanation of any service limitations or exclusions from coverage;

17.1.12.9. A notice stating that the MCO shall be liable only for those services authorized by or required of the health plan;

17.1.12.10. Information on where and how members may access benefits not available from or not covered by the MCO;

17.1.12.11. The Necessity definitions used in determining whether services will be covered;

17.1.12.12. Detailed information regarding the amount, duration, and scope of benefits so that enrollees understand the benefits to which they are entitled.

17.1.12.13. A description of all pre-certification, prior authorization, or other requirements for treatments and services;

17.1.12.14. Information regarding prior authorization in the event the member chooses to transfer to another MCO and the member's right to continue to utilize a provider specified in a prior authorization regardless of whether the provider is participating in the MCO network;

17.1.12.15. The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;

17.1.12.16. Information on how to obtain services when the member is out of the State and for after-hours coverage;

17.1.12.17. Cost-sharing requirements;

17.1.12.18. Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including an inclusion of the MCO's toll-free telephone line and website;

17.1.12.19. A description of Utilization Review policies and procedures used by the MCO;

17.1.12.20. A description of those member rights and responsibilities, described in 17.3 of this Agreement, but also including but not limited to notification that:

17.1.12.20.1. Oral interpretation is available for any language, and information as to how to access those services;

17.1.12.20.2. Written translation is available in prevalent languages, and information as to how to access those services;

17.1.12.20.3. Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and information as to how to access those services;

17.1.12.21. The policies and procedures for disenrollment;

17.1.12.22. Information on Advance Directives;

17.1.12.23. A statement that additional information, including information on the structure and operation of the MCO plan and provider incentive plans, shall be made available upon request;

17.1.12.24.Member rights and protections;

17.1.12.25.Information on the Grievance, Appeal, and Fair Hearing procedures and timeframes in a DHHS-approved description, including:

17.1.12.25.1.The right to file grievances and appeals;

17.1.12.25.2.The requirements and timeframes for filing a grievance or appeal;

17.1.12.25.3.The availability of assistance in the filing process;

17.1.12.25.4.The right to request a State fair hearing after the MCO has made a determination on an enrollee's appeal which is adverse to the enrollee; and

17.1.12.25.5.An enrollee's right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however if the enrollee receives an adverse decision then the enrollee may be required to pay for the cost of service furnished while the appeal or State fair hearing is pending as specified in 42 CFR 438.10(g)(2);

17.1.12.26.Member's right to a second opinion from a qualified health care professional within the network, or one outside the network arranged by the MCO at no cost to the member. [42 CFR 438.206(b)(3)].

17.1.12.27.The extent to which, and how, after hours and emergency coverage are provided including:

17.1.12.27.1.What constitutes an emergency and emergency medical care; and

17.1.12.27.2.The fact that prior authorization is not required for emergency services; and

17.1.12.27.3.The enrollee's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)];

17.1.12.28.Information on how to access the New Hampshire Office of the Long Term Care Ombudsman;

17.1.12.29. Information on how to access auxiliary aids and services, including additional information in alternative formats or languages;

17.1.12.30. Information and guidance as to how the enrollee can effectively use the managed care program as described in 42 CFR 438.10(g)(2);

17.1.12.31. Information on how to report suspected fraud or abuse;

17.1.12.32. Information on how to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center who can provide all enrollees and potential enrollees choice counseling and information on managed care; and

17.1.12.33. Disenrollment information.

17.1.13. The MCO shall produce a revised member handbook, or an insert informing members of changes to covered services, upon DHHS notification of any change in covered services, and at least thirty (30) calendar days prior to the effective date of such change. In addition to changes to documentation, the MCO shall notify all existing members of the covered services changes at least thirty (30) calendar days prior to the effective date of such changes.

17.1.14. The MCO shall mail the handbook to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment [42 CFR 438.10(g)(1)].

17.1.15. The MCO shall notify all enrollees of their disenrollment rights, at a minimum, annually [42 CFR 438.10 (f)].

17.1.16. [Intentionally left blank.]

17.1.17. The MCO shall notify all enrollees, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the plan's website. The member information appearing on the website shall include the following, at a minimum:

17.1.17.1. Information contained in the Member Handbook

17.1.17.2. The following information on the MCO's provider network:

17.1.17.2.1. Names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English languages (including American Sign Language) spoken by current contracted providers, including identification of providers that are not accepting new patients. This shall include, at a minimum: information on PCPs, specialists, Family Planning Providers, pharmacies, Federally

Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals;

17.1.17.2.2. Any restrictions on the member's freedom of choice among network providers; and

17.1.17.2.3. How to file an appeal and/or a grievance.

17.1.18. For any change that affects member rights, filing requirements, time frames for grievances, appeals, and State fair hearing, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each member written notice of the change at least thirty (30) days before the intended effective date of the change.

17.1.19. The MCO shall notify members of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the enrollee can access those services. [42 CFR 438.102(b)(1)(ii)(B) and 42 CFR 438.10].

17.1.20. The MCO shall submit a copy of all information intended for members to DHHS for approval ten (10) business days prior to distribution.

17.2. Language and Format of Member Information

17.2.1. The MCO shall develop all member materials at or below a sixth (6th) grade reading level, as measured by the appropriate score on the Flesch reading ease test.

17.2.2. The MCO shall use the DHHS developed definitions consistently throughout its user manual, notices, and in any other form of client communication.

17.2.3. The MCO shall develop enrollee notices in accordance with the DHHS model notices.

17.2.4. The MCO shall provide all enrollment notices, information materials, and instructional materials relating to members and potential members in a manner and format that may be easily understood in a font size no smaller than 12 point [42 CFR 438.10(d) / SMD Letter 2/20/98].

17.2.5. The MCO's written materials shall be developed to meet all applicable Cultural Considerations requirements in Section 18 so that they are communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The MCO shall inform members that information is available in alternative formats and how to access those formats [42 CFR 438.10(d)(6)].

17.2.6. The MCO shall make all written member information available in English, Spanish, and the commonly encountered languages of New Hampshire. All written member information shall include at the bottom a tagline explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the MCO's Customer Service Center. The MCO shall also provide all written member information in large print with a font size no smaller than 18 point upon request [42 CFR 438.10(d)(3)].

17.2.6.1. Written member information shall include at a minimum provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.

17.2.7. The MCO shall also make oral interpretation services available free of charge to each member or potential member for MCO covered services. This applies to all non-English languages, not just those that DHHS identifies as languages of other Major Population Groups. The beneficiary shall not to be charged for interpretation services. The MCO shall notify members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services [42 CFR 438.10(d)].The MCO shall provide auxiliary aids such as TTY/TDY and American Sign Language interpreters available free of charge to each member or potential member who requires these services [42 CFR 438.10(d)].

17.3. Member Rights

17.3.1. The MCO shall have written policies which shall be included in the member handbook and posted on the MCO website regarding member rights [42 CFR 438.100] including:

17.3.1.1. Each managed care member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;

17.3.1.2. Each managed care member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

17.3.1.3. Each managed care member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment;

17.3.1.4. Each managed care member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

17.3.1.5. Each managed care member is guaranteed the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 42 CFR 438.100; and

17.3.1.6. Each managed care member has a right to a second opinion. [42 CFR 438.206].

17.3.2. Each member is free to exercise his/her rights, and that the MCO shall assure that the exercise of those rights shall not adversely affect the way the MCO and its providers or DHHS treat the member [42 CFR 438.100(c)].

17.3.3. Each managed care member has the right to request and receive any MCO's written physician incentive plans.

17.4. Member Call Center

17.4.1. The MCO shall operate a NH specific call center Monday through Friday, except for state approved holidays. The call center shall be staffed with personnel who are knowledgeable about the MCOs plan in NH to answer member inquiries.

17.4.2. At a minimum, the call center shall be operational:

17.4.2.1. Two days per week: 8:00 am EST to 5:00 pm EST;

17.4.2.2. Three days per week: 8:00 am EST to 8:00 pm EST; and

17.4.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

17.4.3. The member call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

17.4.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

17.4.3.2. Average Speed of Answer: Ninety percent (90%) of calls will be answered with live voice within thirty (30) seconds; and

17.4.3.3. Voicemail messages shall be responded to no later than the next business day.

17.4.4. The MCO shall develop a means of coordinating its call center with the DHHS Customer Service Center.

17.4.5. The MCO shall develop a warm transfer protocol for members who may call the incorrect call center to speak to the correct representative and provide monthly reports to DHHS on the number of warm transfers made and the program to which the member was transferred.

17.5. Member Information Line

17.5.1. The MCO shall establish a member hotline that shall be an automated system that operates outside of the call center standard hours, Monday through Friday, and at all hours on weekends and holidays.

17.5.2. The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for callers to leave messages.

17.5.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages.

17.5.4. A representative of the MCO shall return messages no later than the next business day.

17.6. Marketing

17.6.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing to potential members [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.2. The MCO shall submit all MCO marketing material to DHHS for approval before distribution [§1932(d)(2)(A)(1) of the SSA; 42 CFR 438.104(b)(1)(i); SMD letter 12/30/97]. DHHS will identify any required changes to the marketing materials within fifteen (15) business days. If DHHS has not responded to a request for review by the fifteenth (15th) business day, the MCO may proceed to use the submitted materials.

17.6.3. The MCO shall comply with federal requirements for provision of information that ensures the potential member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

17.6.4. The MCO marketing materials shall not contain false or materially misleading information.

17.6.5. The MCO shall not offer other insurance products as inducement to enroll.

17.6.6. The MCO shall ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients of DHHS [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.7. The MCO's marketing materials shall not contain any written or oral assertions or statements that:

17.6.7.1. The recipient must enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

17.6.7.2. That the MCO is endorsed by CMS, the Federal or State government, or similar entity [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101]

17.6.8. The MCO shall distribute marketing materials to the entire state in accordance with §1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1 and SMM 2101. The MCO's marketing materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.7. Member Engagement Strategy

17.7.1. The MCO shall develop and facilitate an active member advisory board that is composed of members who represent its member population. At least twenty-five percent (25%) of the members of the advisory board should be receiving an LTSS service or be a support person, who is not a paid service provider or employed as an advocate, to a member receiving an LTSS service. Representation on the consumer advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. The advisory board shall meet at least quarterly. The advisory board shall meet in-person or through interactive technology including but not limited to a conference call or webinar and provide a member perspective to influence the MCO's quality improvement program, program changes and decisions. All costs related to the member advisory board shall be the responsibility of the MCO.

17.7.2. The MCO shall hold in-person regional member meetings for two-way communication where members can provide input and ask questions and the MCO can ask questions and obtain feedback from members. Regional meetings shall be held at least twice each Agreement year. The MCO shall make efforts to provide video conferencing opportunities for members to attend the regional meetings. If video conferencing is not available then, the MCO shall use alternate technologies as available for all meetings.

17.7.3. The MCO shall report on the activities of the meetings required in Sections 17.7.1 and 17.7.2 including meeting dates, board members, topics discussed and actions

taken in response to Board contributions to DHHS in the Medicaid Care Management Program Comprehensive Annual Report.

17.7.4. The MCO shall conduct a member satisfaction survey at least annually in accordance with National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) requirements to gain a broader perspective of member opinions. The MCO survey instrument is subject to DHHS approval. The results of these surveys shall be made available to DHHS to be measured against criteria established by DHHS, and to the MCO's membership [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.10(f)(6); 42 CFR 438.10(g); 42 CFR 438.6(h)].

17.7.5. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

17.8. Provider Directory

17.8.1. The MCO shall publish a Provider Directory that shall be approved by DHHS prior to publication and distribution. The MCO shall submit the draft directory and all substantive changes to DHHS for approval.

17.8.2. The Provider Directory shall include names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English language (including American Sign Language) spoken by, current contracted providers. This shall include, at a minimum; information on PCPs, specialists, Family Planning Providers, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals.

17.8.3. The Provider Directory shall provide all information according to the requirements of 42 CFR 438.10(h).

17.8.4. The MCO shall send a letter to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the member to the Provider Directory on the MCO's website and informing the member of the right to a printed version of provider directory information upon request [42 CFR 438.10(h)].

17.8.5. The MCO shall notify all members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the plan's website in a machine readable file and format as specified by the Secretary. The MCO shall update the paper copy of the Provider Directory at least monthly and shall update no later than thirty (30) calendar days after the MCO receives updated information. [42 CFR 438.10(h)(4)].

17.8.6. The MCO shall post on its website a searchable list of all contracted providers. At a minimum, this list shall be searchable by provider name, specialty, and location.

17.8.7. Thirty (30) calendar days after contract effective date or ninety (90) calendar days prior to the Program start date, whichever is later, the MCO shall develop and submit the draft Provider Directory template to DHHS for approval and thirty (30) calendar days prior to each Program Start Date the MCO shall submit the final provider directory.

17.8.8. Upon the termination of a contracted provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify enrollees who received their primary care from, or was seen on a regular basis by, the terminated provider.

17.9. Program Website

17.9.1. The MCO shall develop and maintain, consistent with DHHS standards and other applicable Federal and State laws, a website to provide general information about the MCO's program, its provider network, the member handbook, its member services, and its grievance and appeals process.

17.9.2. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes.

17.9.3. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory. The Provider Directory shall identify all providers, including primary care, specialty care, behavioral health, substance abuse, home health, home care, rehabilitation, hospital, LTSS, and other providers, and include the following information for each provider:

17.9.3.1. Address of all practice/facility locations;

17.9.3.2. Gender;

17.9.3.3. Office hours;

17.9.3.4. Telephone numbers;

17.9.3.5. Website (if applicable);

17.9.3.6. Accommodations provided for people with disabilities;

17.9.3.7. Whether the provider has completed cultural competence training;

17.9.3.8. Hospital affiliations, if applicable;

17.9.3.9. Open/close status for MCO members;

17.9.3.10. Languages spoken (including American Sign Language) in each provider location;

17.9.3.11. Medical Specialty; and

17.9.3.12. Board certification, when applicable.

17.9.3.13. The MCO program content included on the website shall be:

17.9.3.14. Written in English, Spanish, and any other of the commonly encountered languages in the State;

17.9.3.15. Culturally appropriate;

17.9.3.16. Written for understanding at the 6th grade reading level; and

17.9.3.17. Geared to the health needs of the enrolled MCO program population.

17.9.4. The MCO shall maintain an updated list of formulary drug lists on its website. Such information shall include:

17.9.4.1. Which medications are covered (both generic and name brand); and

17.9.4.2. Which tier each medication is on.

17.9.5. The MCO's NH Medicaid Care Management website shall be compliant with the Federal Department of Justice "Accessibility of State and Local Government Websites to people with disabilities".

18. Culturally and Linguistically Competent Services

18.1. Cultural Competency Plan

18.1.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how the MCO shall ensure that services are provided in a culturally and linguistically competent manner to all Medicaid members, including those with Limited English Proficiency (LEP). The Cultural Competency Plan shall describe how the providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. The MCO shall work with DHHS Office of Minority Heath & Refugee Affairs and the New Hampshire Medical Society to address cultural and linguistic considerations as defined in the section.

18.2. General Provisions

18.2.1. The MCO shall participate in efforts to promote the delivery of services in a culturally and linguistically competent manner to all members and their families, including those with LEP and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)].

18.2.2. The MCO shall develop appropriate methods of communicating and working with its members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

18.2.3. The MCO shall develop appropriate methods for identifying and tracking members' needs for communication assistance for health encounters including preferred spoken language for health encounters, need for interpreter, and preferred language for written health information.

18.2.4. The MCO shall collect data regarding member's race, ethnicity, and spoken language in accordance with the current best practice standards from the Office of Management and Budget and/or the 2011 final standards for data collection as required by Section 4302 of the Affordable Care Act from the federal Department of Health and Human Services.

18.2.5. The MCO shall not use children or minors to provide interpretation services.

18.2.6. If the member declines offered free interpretation services, there must be a process in place for informing the member of the potential consequences of declination with the assistance of a competent interpreter to assure the member's understanding, as well as a process to document the member's declination. Interpreter services must be re-offered at every new contact. Every declination requires new documentation of the offer and decline.

18.2.7. The MCO shall respect members whose lifestyle or customs may differ from those of the majority of members.

18.2.8. The MCO shall ensure interpreter services are available to any member who requests them, regardless of the prevalence of the member's language within the overall program for all health plan and MCO services exclusive of inpatient services. The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e., will provide meaningful access) for all members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and will be based upon the unique needs and circumstances of each individual. Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the provider of the encounter service.

18.2.9. The MCO shall bear the cost of interpretive services, including American Sign Language (ASL) interpreters and translation into Braille materials available to hearing- and vision-impaired members.

18.2.10. The Member Handbook shall include information on the availability of oral and interpretive services.

18.2.11. The MCO shall communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care.

18.2.12. As a condition of receipt of Federal financial assistance, the MCO acknowledges and agrees that it must comply with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin (42 U.S.C. 2000d et seq.).

18.2.13. As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of Limited English Proficiency (LEP). To ensure compliance with Title VI, the MCO must take reasonable steps to ensure that LEP persons have meaningful access to the MCO's programs. The MCO shall provide the following assistance, including, but not limited to:

18.2.13.1. Offer language assistance to individuals who have LEP and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

18.2.13.2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

18.2.13.3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

18.2.13.4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

18.2.14. Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. MCOs are encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. For assistance and information regarding MCO LEP obligations, go to **http://www.lep.gov**.

19. Grievances and Appeals

19.1. General Requirements

19.1.1. The MCO shall develop, implement and maintain a Grievance System under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance and which includes a grievance process, an appeal process, and access to the State's fair hearing system. The MCO shall ensure that the Grievance System is in compliance with 42 CFR 438 Subpart F, and N.H. Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

19.1.2. The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS' review and approval prior to the first readiness review. Any proposed changes to the Grievance System must be approved by DHHS prior to implementation.

19.1.3. The Grievance System shall be responsive to any grievance or appeal of dual- eligible members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accord with this Agreement. In the event the MCO, after review, determines that the dual-eligible member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the member to the State's SHIP program, which is currently administered by Service Link Aging and Disability Resource Center.

19.1.4. The MCO shall be responsible for ensuring that the Grievance System (grievance process, appeal process, and access to the State's fair hearing system) complies with the following general requirements. The MCO must:

19.1.4.1. Give members any reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the member in providing written consent for appeals;

19.1.4.2. Acknowledge receipt of each grievance and appeal (including oral appeals), unless the enrollee or authorized provider requests expedited resolution;

19.1.4.3. Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making;

19.1.4.4. Ensure that decision makers take into account all comments, documents, records, and other information submitted by the enrollee of their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination; and

19.1.4.4.1. If deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the member's condition or disease:

a. An appeal of a denial based on lack of medical necessity;

b. A grievance regarding denial of expedited resolutions of an appeal; or

c. A grievance or appeal that involves clinical issues.

19.1.5. The MCO shall send written notice to members and providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

19.1.6. The MCO shall provide information as specified in 42 CFR § 438.10(g) about the Grievance System to providers and subcontractors at the time they enter into a contact or subcontract. The information shall include, but is not limited to:

19.1.6.1. The member's right (or provider acting on their behalf) to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

19.1.6.2. The member's right to file grievances and appeals and their requirements and timeframes for filing;

19.1.6.3. The availability of assistance with filing;

19.1.6.4. The toll-free numbers to file oral grievances and appeals;

19.1.6.5. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

19.1.6.6. Any State-determined provider appeal rights to challenge the failure of the MCO to cover a service.

19.1.7. The MCO shall make available training to providers in supporting and assisting members in the Grievance System.

19.1.8. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the member, the dates received, the dates of each review, the dates of the grievance or appeal, and the date of resolution.

19.1.9. The MCO shall provide a report of all actions, grievances, and appeals, including all matters handled by delegated entities, to DHHS on a monthly basis.

19.1.10. The MCO shall review Grievance System information as part of the State quality strategy and in accord with this Agreement and 42 CFR 438.402. The MCO shall make such information accessible to the State and available upon request to CMS.

19.1.11. The MCO shall provide any and all provider complaint and appeal logs to DHHS.

19.2. Grievance Process

19.2.1. The MCO shall develop, implement, and maintain a grievance process that establishes the procedure for addressing member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.2.2. The grievance process shall address member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. An enrollee or the enrollee's authorized representative with written consent may file a grievance at any time.

19.2.3. Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated, may file a complaint with the MCO in accordance with He-M 204.

19.2.4. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR part 438, subpart K may file a grievance.

19.2.5. The MCO shall have policies and procedures addressing the grievance process, which comply with the requirements of this Agreement. The MCO shall submit in advance to DHHS for its review and approval, all grievance process policies and procedures and related notices to members regarding the grievance process. Any proposed changes to the grievance process must be approved by DHHS prior to implementation.

19.2.6. The MCO shall allow a member, or the member's authorized representative with the member's written consent to file a grievance with the MCO either orally or in writing [42 CFR 438.402(c)].

19.2.7. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance for at least one hundred percent (100%) of members filing a grievance. If the enrollee requests disenrollment, then the MCO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment.

19.2.8. The MCO shall notify members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues must be in writing.

19.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

19.3. Appeal Process

19.3.1. The MCO shall develop, implement, and maintain an appeal process that establishes the procedure for addressing member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.3.2. The MCO shall allow a member, or the member's authorized representative, or a provider acting on behalf of the member and with the member's written consent, to request an appeal orally or in writing of any MCO action [42 CFR 438.402(c)].

19.3.3. The MCO shall include as parties to the appeal, the member and the member's authorized representative, or the legal representative of the deceased member's estate.

19.3.4. For appeals of standard service authorization decisions, the MCO shall allow a member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. This shall also apply to a member's request for an expedited appeal. An oral appeal must be followed by a written, signed appeal.

19.3.5. The MCO shall ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the member or the authorized provider requests expedited resolution. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution.

19.3.6. If DHHS receives a request to appeal an action of the MCO, DHHS will forward relevant information to the MCO and the MCO will contact the member and acknowledge receipt of the appeal.

19.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

19.3.8. The MCO shall allow the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO shall inform the member of the limited time available for this in the case of expedited resolution.

19.3.9. The MCO shall provide the member and the member's representative opportunity, to receive the member's case file, including medical records, and any other documents and records considered during the appeal process free of charge prior to the hearing.

19.3.10. The MCO shall resolve at least one hundred percent (100%) of member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. The date of filing shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest. Or, in the case of a provider filing an appeal on behalf of the member, the date of filing shall be considered the date upon which the MCO receives authorization from the member for the provider to file an appeal on the member's behalf.

19.3.11. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the enrollee is deemed to have exhausted the MCO's appeals process, and the enrollee may initiate a state fair hearing.

19.3.12. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR 42 CFR part 438, subpart K may file an appeal.

19.4. Actions

19.4.1. The MCO shall allow for the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

19.4.1.1. Denial or limited authorization of a requested service, including the type or level of service;

19.4.1.2. Reduction, suspension, or termination of a previously authorized service;

19.4.1.3. Denial, in whole or in part, of payment for a service;

19.4.1.4. Failure to provide services in a timely manner, as defined by the State;

19.4.1.5. Untimely service authorizations;

19.4.1.6. Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

19.4.1.7. At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one MCO, the denial of a member's request to obtain services outside the network, in accord with 42 CFR 438.52(b)(2)(ii).

19.5. Expedited Appeal

19.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the member, or a provider request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

19.5.1.1. The MCO must inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals.

19.5.1.2. The MCO shall make a decision on the member's request for expedited appeal and provide notice, as expeditiously as the member's health condition requires, within 72 hours after the MCO receives the appeal. The MCO may extend the 72 hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest. The MCO shall also make reasonable efforts to provide oral notice. The first date shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest.

19.5.1.3. If the MCO extends the timeframes not at the request of the enrollee, it must:

19.5.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.5.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision;

19.5.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.5.1.4. The MCO shall meet the timeframes in 19.5.1.2 for at least one hundred percent (100%) of requests for expedited appeals.

19.5.1.5. The MCO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

19.5.1.6. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

19.5.1.7. The member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the member of his/her right and the procedures to file a grievance in the notice of denial.

19.6. Content of Notices

19.6.1. The MCO shall notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing.

19.6.2. Each notice of adverse action shall conform with 42 CFR 431.210, contain and explain:

19.6.2.1. The action the MCO or its subcontractor has taken or intends to take;

19.6.2.2. The reasons for the action;

19.6.2.3. The member's or the provider's right to file an appeal;

19.6.2.4. Procedures for exercising member's rights to appeal or grieve;

19.6.2.5. Circumstances under which expedited resolution is available and how to request it; and

19.6.2.6. The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits.

19.6.3. The MCO shall ensure that all notices of adverse action be in writing and must meet the following language and format requirements:

19.6.3.1. Written notice must be translated for the individuals who speak one of the commonly encountered languages spoken in New Hampshire (as defined by the State per 42 CFR 438.10(d));

19.6.3.2. Notice must include language clarifying that oral interpretation is available for all languages and how to access it; and

19.6.3.3. Notices must use easily understood language and format, and must be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All members and potential members must be informed that information is available in alternative formats and how to access those formats.

19.6.4. The MCO shall mail the notice of adverse benefit determination by the date of the action when any of the following occur:

19.6.4.1 The enrollee has died;

19.6.4.2 The enrollee submits a signed written statement requesting service termination;

19.6.4.3 The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction will result;

19.6.4.4 The enrollee has been admitted to an institution where he or she is ineligible under the state plan for further services;

19.6.4.5 The enrollee's address is determined unknown based on returned mail with no forwarding address;

19.6.4.6 The enrollee is accepted for Medicaid services by another state, territory, or commonwealth;

19.6.4.7 A change in the level of medical care is prescribed by the enrollee's physician;

19.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act;

19.6.4.9 The transfer or discharge from a facility will occur in an expedited fashion.

19.7. Timing of Notices

19.7.1. Termination, suspension or reduction of services - The MCO shall provide members written notice at least ten (10) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services, except the period of advance notice shall be five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the member.

19.7.2. Denial of payment - The MCO shall provide members written notice on the date of action when the action is a denial of payment or reimbursement.

19.7.3. Standard service authorization denial or partial denial- The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

19.7.3.1. The member or the provider requests the extension; or

19.7.3.2. The MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.3.3. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

19.7.4. Expedited process - For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

19.7.4.1. The MCO may extend the three (3) business days' time period by up to seven (7) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.5. Untimely service authorizations - The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations.

19.8. Continuation of Benefits

19.8.1. The MCO shall continue the member's benefits if:

19.8.1.1. The appeal is filed timely, meaning on or before the later of the following:

19.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action; or

19.8.1.1.2. The intended effective date of the MCO's proposed action.

19.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

19.8.1.3. The services was ordered by an authorized provider;

19.8.1.4. The authorization period has not expired; and

19.8.1.5. The member requests extension of benefits, orally or in writing.

19.8.2. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

19.8.2.1. The member withdraws the appeal, in writing;

19.8.2.2. The member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision;

19.8.2.3. A State fair hearing decision adverse to the member is made; or

19.8.2.4. The authorization expires or authorization service limits are met.

19.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the member the amount paid for the services provided to the member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

19.9. Resolution of Appeals

19.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within the following timeframes:

19.9.1.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within thirty (30) calendar days after receipt of the appeal, unless the MCO notifies the member that an extension is necessary to complete the appeal.

19.9.1.2. The MCO may extend the timeframes up to fourteen (14) calendar days if:

19.9.1.2.1. The member requests an extension, orally or in writing; or

19.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the member's best interest.

19.9.1.3. If the MCO extends the timeframes not at the request of the enrollee then it must:

19.9.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.9.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

19.9.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.9.1.4. Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request.

19.9.2. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

19.9.3. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting provider or member may obtain the Utilization Management clinical review or decision-making criteria.

19.9.4. For notice of an expedited resolution, the MCO shall make reasonable efforts to provide oral notice.

19.9.5. For appeals not resolved wholly in favor of the member, the notice shall:

19.9.5.1. Include information on the member's right to request a State fair hearing;

19.9.5.2. How to request a State fair hearing;

19.9.5.3. Include information on the member's right to receive services while the hearing is pending and how to make the request; and

19.9.5.4. Inform the member that the member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action.

19.10. State Fair Hearing

19.10.1. The MCO shall inform members and providers regarding the State fair hearing process, including but not limited to, members right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F. The Parties to the State fair hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

19.10.2. The MCO shall ensure that members are informed, at a minimum, of the following:

19.10.2.1. That members must exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

19.10.2.2. That if a member does not agree with the MCO's resolution of the appeal, the member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date on the MCO's notice of the resolution of the appeal.

19.10.3. If the member requests a fair hearing, the MCO shall provide to DHHS and the member, upon request, and within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

19.10.4. The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit. The MCO shall consult with DHHS regarding the State fair hearing process In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate and at no additional cost. In the event the State fair hearing decision is appealed by the member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost. The Office of the Attorney General or designee shall represent the State on an appeal from a fair hearing decision by a member.

19.10.5. DHHS shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

19.11. Effect of Adverse Decisions of Appeals and Hearings

19.11.1. If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

19.11.2. If the MCO or DHHS reverses a decision to deny authorization of services, and the member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services.

19.12. Survival

19.12.1. The obligations of the MCO pursuant to Section 19 to fully resolve all grievances and appeals including, but not limited to, providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

20. Access

20.1. Network

20.1.1. The MCO shall provide documentation to DHHS showing that it is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 20 and 21.

20.1.2. The MCO's network shall have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the geographic standards in Section 20.2, the timely provision of services requirements in Section 20.4, Equal Access, and reasonable choice by members to meet their needs.

20.1.3. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the readiness review for the enrollment of NHHPP members.

20.1.4. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the first readiness review for each phase of Step 2.

20.1.5. The MCO shall submit documentation to DHHS to demonstrate that it maintains an adequate network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)]:

20.1.5.1. At the second readiness review prior to the Program start date;

20.1.5.2. Forty-five (45) calendar days following the end of the semi-annual period; and

20.1.5.3. At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to:

20.1.5.3.1. Changes in services, benefits, geographic service area, or payments

20.1.5.3.2. Enrollment of a new population in the MCO [42 CFR 438.207(c)]

20.1.6. The MCO shall submit documentation quarterly to DHHS to demonstrate Equal Access to services for Step 1, 2 and NHHPP populations.

20.1.7. The MCO shall be subject to annual, external independent reviews of the timeliness of, and access to the services covered under this Agreement [42 CFR 438.204].

20.1.8. For Step 1 Implementation, the anticipated number of members in Sections 20.1.1 and 20.1.2 shall be based on the "NH Medicaid Care Management Fifty Percent Population Estimate by Zip code" report provided by DHHS.

20.2. Geographic Distance

20.2.1. The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and Equal Access to its members.

Provider/Service	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
SUD Councilors (MLDAC)	One (1) within forty-five (45) minutes or fifteen (15) miles
SUD Programs (Comprehensive, Outpatient, Methadone Clinics)	One (1) within sixty (60) minutes or forty-five (45) miles.

20.3. NH Ins 2701.06 Standards for Geographic Accessibility

20.3.1. The MCO may request exceptions from these standards after demonstrating its efforts to create a sufficient network of providers to meet these standards. DHHS reserves the right at its discretion to approve or disapprove these requests, approval shall not be unreasonably withheld.

20.3.1.1. Should the MCO, after good faith negotiations, be unable to create a sufficient number of providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with the help of DHHS, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) days after start date Section 34.7.1 shall not apply.

20.3.1.2. Except for the provisions of 20.3.1.1, should the MCO, after good faith negotiations, be unable to create a sufficient number of providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with the help of DHHS, continue to be unable to meet geographic and timely access to service delivery standards DHHS may, at its discretion, provide temporary exemption to the MCO from Section 34.7.1.

20.3.2. At any time the provisions of this section may apply, the MCO will work with DHHS to ensure that members have access to needed services.

20.3.3. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the provider network to ensure that necessary admissions can be made.

20.4. Timely Access to Service Delivery

20.4.1. The MCO shall make services available for members twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR 438.206(c)(1)(iii)].

20.4.2. The MCO shall require that all network providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial, and FFS patients. [42 CFR 438.206(c)(1)(ii)].

20.4.3. The MCO shall encourage its PCPs to offer after-hours office care in the evenings and on weekends.

20.4.4. The MCO's network shall meet the following minimum timely access to service delivery standards [42 CFR 438.206(c)(1)(i)]

20.4.4.1. Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

20.4.4.2. The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

20.4.4.2.1. Transitional healthcare by a provider shall be available from a primary or specialty provider for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

20.4.4.2.2. Transitional home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the member's primary care or specialty care provider or as part of the discharge plan.

20.4.4.2.3. Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

20.4.4.2.4. Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

20.4.4.2.5. Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and don't meet the definition of Emergency Medical Condition.

20.4.4.2.6. Emergency medical, SUD and psychiatric care shall be available twenty-four (24) hours per day, seven (7) days per week.

20.4.4.2.7. Behavioral health care shall be available as follows:

a. care within six (6) hours for a non-life threatening emergency;

b. care within forty-eight (48) hours for urgent care; or

c. an appointment within ten (10) business days for a routine office visit.

20.4.4.2.8. For members receiving Step 2 covered services, transitional care shall be readily available and delivered, after discharge from a nursing facility, inpatient or institutional care, in accordance with the member's discharge plan or as ordered by the member's primary care or specialty care provider. Transfers and discharges shall be done in accordance with RSA 151:21 and RSA 151:26.

20.4.5. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide a semi-annual report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v).

20.4.6. The MCO shall develop a Corrective Action Plan if there is a failure to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

20.4.7. The MCO shall monitor waiting times for appointments at approved community mental health providers and report case details on a semi-annual basis.

20.5. Women's Health

20.5.1. The MCO shall provide female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

20.5.2. The MCO shall provide access to family planning services to members without the need for a referral or prior-authorization. Additionally, members shall be able to access these services by providers whether they are in or out of the MCO's network.

20.5.2.1. Family Planning Services shall include, but not be limited to, the following:

20.5.2.1.1. Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

20.5.2.1.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

20.5.2.1.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

20.5.2.1.4. Referral of members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

20.5.2.1.5. Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and HPV vaccine

20.5.2.2. Enrollment in the MCO shall not restrict the choice of the provider from whom the member may receive family planning services and supplies [42 CFR 431.51(b)(2)].

20.5.2.3. The MCO shall only provide for abortions in the following situations:

20.5.2.3.1. If the pregnancy is the result of an act of rape or incest; or

20.5.2.3.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed [42 CFR 441.202].

20.5.3. The MCO shall not provide abortions as a benefit, regardless or funding, for any reasons other than those identified in this Agreement [42 CFR 441.202].

20.6. Access to Special Services

20.6.1. The MCO shall ensure members have access to DHHS-designated Level I and Level II trauma centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.

20.6.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, hospice programs, and licensed long term care facilities with Medicare-certified skilled nursing beds. To the extent that the above specialty services are available within New Hampshire, the plan shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable.

20.6.3. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude New Hampshire providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

20.7. Out-of-Network Providers

20.7.1. If the MCO's network is unable to provide necessary medical, behavioral, SUD and LTSS services covered under the Agreement to a particular member, the MCO shall adequately and in a timely manner cover these services for the member through out-of-network sources [42 CFR 438.206(b)(4)]. The MCO shall inform the out-of-network provider that the member cannot be balance billed.

20.7.2. The MCO shall coordinate with out-of-network providers regarding payment. For payment to out-of-network, or non-participating providers, the following requirements apply:

20.7.2.1. If the MCO offers the service through an in-network provider(s), and the member chooses to access non-emergent services from an out-of-network provider, the MCO is not responsible for payment.

20.7.2.2. If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the MCO and the out-of-network provider.

20.7.3. The MCO shall ensure that cost to the member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

20.8. Second Opinion

20.8.1. The MCO shall provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no greater cost to the member than allowed by DHHS [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a second opinion in its Member Handbook.

20.9. Provider Choice

20.9.1. The MCO shall allow each member to choose his or her health professional to the extent possible and appropriate [42 CFR 438.3(l)].

21. Network Management

21.1. Provider Network

21.1.1. The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered medical, behavioral health, SUD, psychosocial and LTSS needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

21.1.1.1. Current and anticipated New Hampshire Medicaid enrollment;

21.1.1.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the covered New Hampshire population;

21.1.1.3. The number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services;

21.1.1.4. The number of network providers not accepting new or any New Hampshire Medicaid patients;

21.1.1.5. The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by New Hampshire members;

21.1.1.6. Accessibility of provider practices for members with disabilities [42 CFR 438.206(b)(1)];

21.1.1.7. Adequacy of the primary care network to offer each member a choice of at least two appropriate primary care providers that are accepting new Medicaid patients; and

21.1.1.8. Required access standards identified in this Agreement

21.1.2. In developing its network, the MCO's provider selection policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

21.1.3. The MCO shall not employ or contract with providers excluded from participation in federal health care programs.

21.1.4. The MCO shall not employ or contract with providers who fail to provide Equal Access to services.

21.1.5. The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of all members including those with LEP and those with unique cultural needs.

21.1.6. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory, as specified in Section 17.9 of this Agreement.

21.2. Network Requirements

21.2.1. The MCO shall ensure its providers and subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement.

21.2.2. All providers shall be licensed and or certified in accordance with the laws of the state in which they provide the covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program. All provider types that may obtain a National Provider Identifier (NPI) shall have an NPI in accordance with 45 CFR Part 162, Subpart D.

21.2.3. All providers in the MCO's network are required to be enrolled as New Hampshire Medicaid providers. DHHS may waive this requirement for good cause on a case-by-case basis.

21.2.4. In all contracts with health care professionals, the MCO shall comply with requirements in 42 CFR 438.214, NCQA standards, and RSA 420-J:4, which includes selection and retention of providers, credentialing and re-credentialing requirements, and non-discrimination (42 CFR 438.12(a)(2); 42 CFR 438.214].

21.2.5. The MCO shall not require a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

21.2.6. The MCO's Agreement with health care providers shall be in writing, shall be in compliance with applicable federal and state laws and regulations, and shall include the requirements in this Agreement.

21.2.7. The MCO shall submit all model provider contracts to DHHS for review during the Readiness Review process. The MCO shall resubmit the model provider contracts any time it makes substantive modifications to such Agreements. DHHS retains the right to reject or require changes to any provider Agreement.

21.2.8. The MCO shall negotiate rates with providers in accordance with Section 9 of this Agreement, unless otherwise specified in this Agreement.

21.2.9. The MCO shall reimburse private duty nursing agencies for private duty nursing services provided on or after April 1, 2016 at the fee-for-for service rate established by DHHS. The MCO shall provide the following information to determine if access to private duty nursing services is increasing:

21.2.9.1. The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

21.2.9.2. The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

21.2.10.The MCO shall submit model provider contracts related to the implementation of NHHPP to DHHS prior to the beginning of enrollment in NHHPP. The contract will provide for:

21.2.10.1. An in-state provider of services included in Step 1 must provide services to both the MCO's Step 1 and NHHPP members, except for SUD providers and chiropractors; provided, however, that exceptions to this requirement may be made upon a request by the MCO and approved by DHHS for providers that only want to provide coverage for Step 1 Services.

21.2.10.2. The provider shall provide equal availability of services and access to both Step 1 and NHHPP members unless an exception to the requirement in section 21.2.10.1 was approved for the provider and the provider is not required to provide coverage for NHHPP Services.

21.2.10.3. The MCO shall pay the provider for services at a rate not more than nor less than the amounts established according to Section 21.2.10.4.

21.2.10.4. The MCO shall reimburse providers for NHHPP services according to the NHHPP Provider Fee Schedule posted at **https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms** as of August 15, 2017 and incorporated herein. DHHS shall provide the MCO sixty (60) days notice prior to any change to the Schedule. Services falling outside the published NHHPP Provider Fee Schedule shall be paid at a rate determined by the Department and enforced in the sixty (60) calendar day notification period.

21.2.10.5. The MCO shall allow a participating provider thirty (30) days to review contract modifications to an existing contract relating to the implementation of the NHHPP.

21.2.11.The MCO provider Agreement shall require providers in the MCO network to accept the member's Medicaid ID Card as proof of enrollment in the MCO until the member receives his/her MCO ID Card.

21.2.12.The MCO shall maintain a provider relations presence in New Hampshire as approved by DHHS.

21.2.13.The MCO shall prepare and issue Provider Manual(s) upon request to all Network Providers, including any necessary specialty manuals (e.g., behavioral health). For newly contracted and credentialed providers, the MCO shall issue copies of the Provider Manual(s) no later than seven (7) calendar days after inclusion in the network. The provider manual shall be available on the web and updated no less than annually.

21.2.14.The MCO shall provide training to all providers and their staff regarding the requirements of this Agreement including the grievance and appeal system. The MCO's provider training shall be completed within thirty (30) calendar days of entering into a contract with a provider. The MCO shall provide ongoing training to new and existing providers as required by the MCO, or as required by DHHS.

21.2.15.Provider materials shall comply with state and federal laws and DHHS and NHID requirements. The MCO shall submit any Provider Manual(s) and provider training materials to DHHS for review and approval sixty (60) calendar days prior to any substantive revisions. Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

21.2.16.The MCO shall operate a toll-free telephone line for provider inquiries from 8 a.m. to 5 p.m. EST, Monday through Friday, except for State-approved holidays. The provider toll free line shall be staffed with personnel who are knowledgeable about the MCO's plan in New Hampshire. The provider call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

21.2.16.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

21.2.16.2. Average Speed of Answer: Eighty percent (80%) of calls will be answered with live voice within thirty (30) seconds; and

21.2.16.3. Ninety percent (90%) of voicemail messages shall be responded to no later than the next business day.

21.2.17.The MCO shall maintain a Transition Plan providing for continuity of care in the event of Agreement termination, or modification limiting service to members, between the MCO and any of its contracted providers, or in the event of site closing(s) involving a primary care provider with more than one location of service.

The Transition Plan shall describe how members will be identified by the MCO and how continuity of care will be provided.

21.2.18. The MCO shall ensure that after regular business hours the provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a member. The MCO shall have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent medical, behavioral health or LTSS related condition or an emergency medical or behavioral health condition.

21.2.19. The MCO shall notify DHHS and affected current members in writing of a provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. Within three (3) calendar days following the effective date of the termination the MCO shall have a Transition Plan in place for all affected members.

21.2.20. If a member is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the MCO shall notify the member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a Transition Plan for the affected members.

21.2.21. The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the provider network. As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued member access to needed service and how the MCO will maintain compliance with its contractual obligations for member access to needed services. A significant change is defined as:

21.2.21.1. A decrease in the total number of PCPs by more than five percent (5%);

21.2.21.2. A loss of all providers in a specific specialty where another provider in that specialty is not available within sixty (60) minutes or forty-five (45) miles;

21.2.21.3. A loss of a hospital in an area where another contracted hospital of equal service ability is not available within forty-five (45) miles or sixty (60) minutes; or

21.2.21.4. Other adverse changes to the composition of the network, which impair or deny the members' adequate access to in-network providers.

21.2.22. The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its network, the MCO shall give the affected providers written notice of the reason for its decision. [42 CFR 438.12(a)(1) ; 42 CFR 438.214(c); SMD letter 02/20/98)].

21.2.23. The requirements in 42 CFR 438.12 (a) may not be construed to:

21.2.23.1. Require the MCO to contract with providers beyond the number necessary to meet the needs of its member;

21.2.23.2. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

21.2.23.3. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)].

21.3. Screening and Enrollment

21.3.1. No later than January 1, 2018, the MCO shall ensure that all of its network providers are enrolled with DHHS Medicaid.

21.3.2. No later than November 1, 2017, the MCO shall provide to DHHS all identifying information for its enrolled network providers including:

21.3.2.1. Name;

21.3.2.2. Specialty;

21.3.2.3. Date of Birth;

21.3.2.4. Social Security number;

21.3.2.5. National Provider identifier;

21.3.2.6. Federal taxpayer identification number; and

21.3.2.7. State license or certification number of the provider.

21.4. Provider Credentialing and Re-Credentialing

21.4.1. The MCO shall demonstrate to DHHS that its providers are credentialed according to the requirements of 42 CFR 438.206(b)(6), current NCQA standards, Code of Administrative Rules He-M 403, and RSA 420-J:4.

21.4.2. The MCO shall submit to DHHS its credentialing standards relating to the implementation of Choices for Independence waiver services.

21.4.3. The MCO shall have written policies and procedures to review, approve and at least every three (3) years recertify the credentials of all participating physician and all other licensed providers who participate in the MCO's network [42 CFR 438.214(a); 42 CFR 438.214(b) (1&2); RSA 420-J:4]. At a minimum, the scope and structure of a MCO's credentialing and re-credentialing processes shall be consistent NCQA standards and NHID, and relevant state and federal regulations relating to provider credentialing and notice. The MCO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with NCQA delegated credentialing requirements and any comparable requirements defined by DHHS.

21.4.4. The MCO shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: within thirty (30) calendar days for primary care providers; within forty-five (45) calendar days for specialists, SUD providers, chiropractors, Nursing Facilities and CFI service providers. [RSA 420-J:4). The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying the provider of the MCO's decision.

21.4.5. The re-credentialing process shall occur in accordance with NCQA guidelines. The re-credentialing process shall take into consideration provider performance data including, but not be limited to: member complaints and appeals, quality of care, and appropriate utilization of services.

21.4.6. The MCO shall maintain a policy that mandates board certification levels that, at a minimum, meets the ninety (90) percentile rates indicated in NCQA standards (HEDIS Medicaid All Lines of Business National Board Certification Measures as published by NCQA in Quality Compass) for PCPs and specialty physicians in the provider network. The MCO shall make information on the percentage of board-certified PCPs in the provider network and the percentage of board-certified specialty physicians, by specialty, available to DHHS upon request.

21.4.7. The MCO shall provide that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number [42 CFR 493.1 and 42 CFR 493.3].

21.4.8. The MCO shall not employ or contract with providers, business managers, owners or others excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or 42 CFR 1000.

21.4.9. The MCO shall ensure that providers whose Medicare certification is a precondition of participation in the Medicaid program obtain certification within one year of enrollment in MCO's provider network.

21.4.10. The MCO shall notify DHHS when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

21.5. Provider Engagement

21.5.1. The MCO shall, at a minimum, develop and facilitate an active provider advisory board that is composed of a broad spectrum of provider types. Representation on the provider advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. This advisory board shall include representation from CFI service providers. This advisory board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the meetings shall be provided to DHHS within thirty (30) calendar days of the meeting.

21.5.2. The MCO shall conduct a provider satisfaction survey, approved by DHHS and administered by a third party, on a statistically valid sample of each major provider type; PCP, specialists, hospitals, pharmacies, DME and Home Health providers, Nursing Facilities and CFI service providers. DHHS shall have input to the development of the survey. The survey shall be conducted semi-annually the first year after the program start date and at least once an Agreement year thereafter to gain a broader perspective of provider opinions. The results of these surveys shall be made available to DHHS and published on the DHHS website.

21.5.3. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

21.6. Anti-Gag Clause for Providers

21.6.1. The MCO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

21.6.1.1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

21.6.1.2. For any information the member needs in order to decide among all relevant treatment options;

21.6.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

21.6.1.4. For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [§1923(b)(3)(D) of the SSA; 42 CFR 438.102(a)(1)(i), (ii), (iii), and (iv); SMD letter 2/20/98].

21.7. Reporting

21.7.1. Provider Participation Report: Provide provider participation reports on an annual basis by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of member access to health care.

21.7.2. Provider Quality Report Card: Ability to provide dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc.

22. Quality Management

22.1. General Provisions

22.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO shall work in collaboration with members and providers to actively improve the quality of care provided to members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate into the MCO's quality improvement activities.

22.1.2. The MCO shall support and comply with the most current version of the Quality Strategy for the New Hampshire Medicaid Care Management Program.

22.1.3. The MCO shall have an ongoing quality assessment and performance improvement program for the operations and the services it furnishes for members [42 CFR 438.330(b); and SMM 2091.7].

22.1.4. The MCO shall approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and shall:

22.1.4.1. Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

22.1.4.2. Foster data-driven decision-making;

22.1.4.3. Solicit member and provider input on the prioritization and strategies for QAPI activities;

22.1.4.4. Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and member and provider satisfaction;

22.1.4.5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements;

22.1.4.6. Support re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions as appropriate; and

22.1.4.7. The MCO shall undertake a member experience of care survey;

22.1.4.7.1. The MCO shall deploy the CMS Home and Community Based Care Service Experience of Care Survey, Testing Experience and Functional Tools (TEFT) as early as 6 months but not later than 9 months from Step 2 Phase 2 start date, if ready for deployment.

22.1.4.7.2. The MCO shall deploy an in-person patient experience survey (PES) if the CMS Home and Community Based Care Service Experience of Care Survey is not ready for deployment with this same timeframe.

22.1.4.7.3. The MCO shall use a DHHS approved, external vendor and statistically sound methodology to conduct the member experience of care survey.

22.1.5. The MCO shall have mechanisms that detect both underutilization and overutilization of services.

22.1.6. The MCO shall develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the requirements of this Agreement. The MCOs shall also meet the requirements of for the QAPI Program [42 CFR 438.330; SMM 2091.7].

22.1.7. The MCO shall submit a QAPI Program Annual Summary in a format and timeframe specified by DHHS or its designee for its approval. The MCO shall keep participating physicians and other Network Providers informed and engaged in the QAPI Program and related activities. The MCO shall include in provider contracts a requirement securing cooperation with the QAPI.

22.1.8. The MCO shall maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO shall designate a senior executive responsible for the QAPI Program and the Medical Director shall have substantial involvement in QAPI Program activities. At a minimum, the MCO shall ensure that the QAPI Program structure:

22.1.8.1. Is organization-wide, with clear lines of accountability within the organization;

22.1.8.2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;

22.1.8.3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

22.1.8.4. Evaluates the effectiveness of clinical and non-clinical initiatives.

22.1.9. If the MCO sub-contracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO shall maintain detailed files documenting work performed by the sub-contractor. The file shall be available for review by DHHS or its designee upon request.

22.1.10. The MCO shall integrate behavioral health and LTSS into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services and LTSS provided to members. The MCO shall collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from the integration and coordination of physical and behavioral health services and LTSS.

22.1.11. The MCO shall conduct any performance improvement projects required by CMS and a minimum of four (4) performance improvement projects, subject to DHHS approval, per year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one (1) of these projects shall have a behavioral health focus. At least one (1) of these projects shall have an LTSS focus. The MCO shall report the status and results of each project to DHHS as requested and shall report on the status results of the CMS performance improvement projects described in 42 CFR 438.330.

22.1.12. The performance improvement projects shall involve the following:

22.1.12.1. Measurement of performance using statistically valid, national recognized objective quality indicators;

22.1.12.2. Implementation of system interventions to achieve improvement in the access to and quality of care;

22.1.12.3. Evaluation of the effectiveness of the interventions based on any performance measures required by CMS as outlined in 42 CFR 438.330(c); and

22.1.12.4. Planning and initiation of activities for increasing or sustaining improvement; and

22.1.12.5. Reporting on the status and results to DHHS on an annual basis.

22.1.13. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

22.1.14. The MCO shall have a plan to assess and report the quality and appropriateness of care furnished to members with special needs in order to identify any ongoing special conditions of a member that require a course of treatment or regular care monitoring The plan must be submitted to DHHS for review and approval. The assessment mechanisms must use appropriate health care professionals.[42 CFR 438.208(c)(2); 42 CFR 438.330].

22.1.15. The MCO's Medical Director and Quality Improvement Director will participate in quarterly Quality Improvement meetings with DHHS and the other MCOs contracted with DHHS to discuss quality related initiatives and how those initiatives could be coordinated across the MCOs.

22.1.16. The MCOs shall be required to be accredited by NCQA, including all applicable Medicaid Standards and Guidelines and the MCOs must authorize NCQA to provide DHHS a copy of its most recent accreditation review, including:

22.1.16.1. Accreditation status, survey type, and level (as applicable);

22.1.16.2. Accreditation results, including recommended actions or improvements, corrective actions plans, and summaries of findings; and

22.1.16.3. Expiration date of the accreditation.

22.2. Practice Guidelines and Standards

22.2.1. The MCO shall adopt evidence-based clinical practice guidelines built upon high quality data and strong evidence. Such practice guidelines shall consider the needs of the MCO's members, be adopted in consultation with Network Providers, and be reviewed and updated periodically, as appropriate.

22.2.2. The MCO shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

22.2.3. The MCO shall make practice guidelines available, including, but not limited to, the web, to all affected providers and, upon request, to members and potential members.

22.2.4. The MCO's decisions regarding utilization management, member education, and coverage of services shall be consistent with the MCO's clinical practice guidelines [42 CFR 438.236(d)].

22.3. External Quality Review Organization

22.3.1. The MCO shall collaborate with DHHS's External Quality Review Organization (EQRO) as outlined in 42 CFR 438.358 to assess the quality of care and services provided to members and to identify opportunities for MCO improvement. To

facilitate this process, the MCO shall supply data, including but not limited to claims data and medical records, to the EQRO.

22.4. Evaluation

22.4.1. The MCO shall prepare a written report within ninety (90) calendar days at the end of each Agreement year on the QAPI that describes:

22.4.1.1. Completed and ongoing Quality management activities, including all delegated functions;

22.4.1.2. Performance trends on QAPI measures to assess performance in quality of care and quality of service;

22.4.1.3. An analysis of whether there have been any demonstrated improvements in the quality of care or service; and

22.4.1.4. An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement

22.4.2. The annual evaluation report shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

22.4.3. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, members, and appropriate MCO staff, as well as posted on the web. The MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

22.5. Quality Measures

22.5.1. MCO shall report annually, according to the then current industry/regulatory standard definitions, the following quality measure sets:

22.5.1.1. CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP;

22.5.1.2. CMS Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid;

22.5.1.3. NCQA Medicaid Accreditation HEDIS/CAHPS Measures, which shall be validated by submission to NCQA; and

22.5.1.4. All available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment; and

22.5.1.5. Any CMS mandated measures outlined in 42 CFR 438.330(c)(1)(i).

22.5.2. If additional measures are added to the NCQA or CMS measure sets, MCO shall include those new measures. For measures that are no longer part of the measures sets, DHHS may at its option continue to require those measures.

22.5.3. In addition MCO shall submit other quality measures as specified by DHHS in Exhibit O in a format to be specified by DHHS.

22.5.4. DHHS shall provide the MCO with ninety (90) calendar days notice of any additions or modifications to the quality measures as specified by DHHS in Exhibit O.

22.5.5. Each Data Year as defined by NCQA HEDIS specifications, or other twelve (12) month period determined by DHHS, at DHHS discretion, DHHS may select four (4) measures to be included in the Quality Incentive Program (QIP). DHHS shall notify the MCO of the four (4) measures to be included in the QIP no later than three (3) months prior to the start of the period for which data will be collected to evaluate the program.

22.5.6. For each measure selected by DHHS for the QIP, DHHS will monitor MCO performance to determine baseline measures and levels of improvement.

22.5.7. Should DHHS choose QIPs and implement withholds for QIP performance, in the event of changes to the Medicaid Care Management program or material circumstances beyond DHHS or the MCOs' control, which DHHS determines would unduly limit all MCOs' ability to reasonably perform and achieve the withhold return threshold, DHHS will evaluate the impact of the circumstances and make such changes as required, at the discretion of DHHS.

22.5.8. At such time DHHS provides access to Medicare data sets to the MCOs, the MCO shall integrate expanded Medicare data sets into its Care Coordination and Quality Programs and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual members. The MCO shall:

22.5.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from care coordination of the dual members;

22.5.8.2. Include Medicare data in DHHS quality reporting; and

22.5.8.3. Sign data use agreements and submit data management plans as required by CMS.

23. Utilization Management

23.1. Policies & Procedures

23.1.1. The MCO's policies and procedures related to the authorization of services shall be in compliance with 42 CFR 438.210 and NH RSA Chapter 420-E:2.

23.1.2. The MCO shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services [42 CFR 438.210(b)(1)].

23.1.3. The MCO shall submit its written utilization management policies, procedures, and criteria to DHHS for approval as part of the first readiness review. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.4. The MCO shall submit its written utilization management policies, procedures, and criteria specific to each phase of Step 2 to DHHS for approval as part of the first readiness review. Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs (not just those for LTSS) and a subsequent person-centered planning process. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.5. The MCO's written utilization management policies, procedures, and criteria shall, at a minimum, conform to the standards of NCQA.

23.1.6. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)].

23.1.7. The MCO's written utilization management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Further such policies, procedures and criteria shall address, at a minimum, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information.

23.1.8. The MCO's written utilization management policies, procedures, and criteria shall be:

23.1.8.1. Developed with input from appropriate actively practicing practitioners in the MCO's service area;

23.1.8.2. Updated at least biennially and as new treatments, applications, and technologies emerge;

23.1.8.3. Developed in accordance with the standards of national accreditation entities;

23.1.8.4. Based on current, nationally accepted standards of medical practice;

23.1.8.5. If practicable, evidence-based; and

23.1.8.6. Be made available upon request to DHHS, providers and members.

23.1.9. The MCOs shall work in good faith with DHHS develop prior authorization forms with consistent information and documentation requirements from providers wherever feasible. Providers shall be able to submit the prior authorizations forms electronically, by mail, or fax. The MCOs shall submit a proposed plan for the development of common prior authorization processes within ninety (90) calendar days of the NHHPP Program Start Date.

23.1.10. The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including, but not limited to, interrater reliability monitoring, and consult with the requesting provider when appropriate and at the request of the provider submitting the authorization [42 CFR 438.210(b)(2)].

23.1.11. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)(3)].

23.1.12. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member [42 CFR 438.210(e)].

23.1.13. Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

23.1.14. When a member receiving State Plan Home Health Services and Step 1 services chooses to change to another MCO, the new MCO shall be responsible for the member's claims as of the effective date of the member's enrollment in the new MCO except as specified in Section 31.2.17. Upon receipt of prior authorization information from DHHS, the new MCO shall honor prior authorizations in place by the former MCO for fifteen (15) calendar days or until the expiration of previously issued prior authorizations, whichever comes first. The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 23.4.2.1.

23.1.15. Prior authorizations in place for long term services and supports at the time a member transitions to an MCO will be honored until the earliest of (a) the authorization's expiration date, (b) the member's needs changes, (c) the provider loses its Medicaid status or (d) otherwise approved by DHHS. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO. In the event that the prior authorization specifies a specific provider, that MCO will continue to utilize that provider regardless of whether the provider is participating in the MCO network until such time as services are available in the MCO's network. The MCO will ensure that the member's needs are met continuously and will continue to cover services under the previously issued prior authorization until the MCO issues new authorizations that address the member's needs.

23.1.16. Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire.

23.2. Medical Necessity Determination

23.2.1. The MCO shall specify what constitutes "medically necessary services" in a manner that:

23.2.1.1. Is no more restrictive than the State Medicaid program; and

23.2.1.2. Addresses the extent to which the MCO is responsible for covering services related to the following [42 CFR 438.210(a)]:

23.2.1.2.1. The prevention, diagnosis, and treatment of health impairments;

23.2.1.2.2. The ability to achieve age-appropriate growth and development; and

23.2.1.2.3. The ability to attain, maintain, or regain functional capacity.

23.2.2. For members twenty-one (21) years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are [He-W 530.01(f)]:

23.2.2.1. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

23.2.2.2. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

23.2.2.3. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

23.2.2.4. Not experimental, investigative, cosmetic, or duplicative in nature.

23.2.3. For EPSDT services the following definition of medical necessity shall be used: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service He-W546.01(f).

23.2.4. The MCO must provide the criteria for medical necessity determinations for mental health or substance use disorder benefits to any enrollee, potential enrollee, or contracting provider upon request.

23.3. Necessity Determination

23.3.1. For long term services and supports (including CFI Waiver services) the following definition of necessity shall be used: "Necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term services and supports within the limits of current waivers, statutes, administrative rules, and/or Medicaid State Plan amendments.

23.4. Notices of Coverage Determinations

23.4.1. The MCO shall provide the requesting provider and the member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

23.4.2. The MCO shall make utilization management decisions in a timely manner. The following minimum standards shall apply:

23.4.2.1. Urgent determinations: The determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for ninety-eight percent (98%) of requests, unless the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the MCO shall notify the member or member's representative within twenty-four (24) hours of receipt of the request and shall advise the member or member's representative of the specific information necessary to make a determination. The member or member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information.

23.4.2.2. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

23.4.2.3. Routine determinations: The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but in no event exceed the following timeframes for ninety-five percent (95%) of requests:

23.4.2.3.1. Fourteen (14) calendar days after the receipt of a request:

a. An extension of up to fourteen (14) calendar days is permissible if:

i. the member or the provider requests the extension; or

ii. the MCO justifies a need for additional information and that the extension is in the member's interest;

23.4.2.3.2. Two (2) calendar days for diagnostic radiology.

23.4.2.4. The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

23.4.2.5. The member or the provider requests the extension; or

23.4.2.6. The MCO justifies a need for additional information and how the extension is in the member's interest.

23.4.2.7. If such an extension is necessary due to a failure of the member or member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the member or member's representative shall be given at least forty- five (45) calendar days from receipt of the notice within which to provide the specified information. Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

23.4.2.8. Determination for Services that have been delivered: The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the member fails to provide sufficient information to determine the request, the MCO shall notify the member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the member shall be given at least forty-five (45) calendar days to provide the required information. The thirty (30) calendar day period for determination shall be tolled until such time as the member submits the required information.

23.4.3. Whenever there is an adverse determination, the MCO shall notify the ordering provider and the member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

23.5. Advance Directives

23.5.1. The MCO shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489.

23.5.2. The MCO shall adhere to the definition of advance directives as defined in 42 CFR 489.100.

23.5.3. The MCO shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCO [42 CFR 422.128].

23.5.4. The MCO shall not condition the provision of care or otherwise discriminate against an enrollee or potential enrollee based on whether or not the individual has executed an advance directive.

23.5.5. The MCO shall provide information in the member handbook with respect to the following:

23.5.5.1. The member's rights under the state law. The information provided by the MCO shall reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change [42 CFR 438.3(j)(3) and (4)].

23.5.5.2. The MCO's policies respecting the implementation of those rights including a statement of any limitation regarding the implementation of advance directives as a matter of conscience

23.5.5.3. That complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State Agency [42 CFR 438.3(;)(1); 42 CFR 438.10(g)(2); 42 CFR 422.128; 42 CFR 489 (subpart I); 42 CFR 489.100].

24. MCIS

24.1. System Functionality

24.1.1. The MCO Managed Care Information System (MCIS) shall include, but not be limited to:

24.1.1.1. Management of Recipient Demographic Eligibility and Enrollment and History

24.1.1.2. Management of Provider Enrollment and Credentialing

24.1.1.3. Benefit Plan Coverage Management, History and Reporting

24.1.1.4. Eligibility Verification

24.1.1.5. Encounter Data

24.1.1.6. Weekly Reference File Updates

24.1.1.7. Service Authorization Tracking, Support and Management

24.1.1.8. Third Party Coverage and Cost Avoidance Management

24.1.1.9. Financial Transactions Management and Reporting

24.1.1.10. Payment Management (Checks, EFT, Remittance Advices, Banking)

24.1.1.11. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)

24.1.1.12. Call Center Management

24.1.1.13. Claims Adjudication

24.1.1.14. Claims Payments

24.1.1.15. Quality of Services (QOS) metrics

24.2. Information System Data Transfer

24.2.1. Effective communication between the MCO and DHHS will require secure, accurate, complete and auditable transfer of data to/from the MCO and DHHS management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

24.2.1.1. DHHS read access to all NH Medicaid Care Management data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

24.2.1.2. Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

24.2.1.3. Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state.

24.2.1.4. Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

24.2.1.5. MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

24.2.1.6. Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and provide for source to target or source to specification mappings;

24.2.1.7. Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

24.2.1.8. A given day's data transmissions, as specified in 24.5.9, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions will be included in the next batch transmission.

24.2.2. The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

24.2.3. The State shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.

24.3. Ownership and Access to Systems and Data

24.3.1. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data will be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

24.4. Records Retention

24.4.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than seven (7) years from the date of termination of this Agreement. Records involving matters that are the subject of litigation shall be retained for a period of not less than seven (7) years following the termination of litigation. Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

24.4.2. Upon expiration of the seven (7) year retention period and upon request, the subject records must be transferred to DHHS' possession. No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

24.5. MCIS Requirements

24.5.1. The MCO shall have a comprehensive, automated, and integrated Managed Care Information System (MCIS) that is capable of meeting the requirements listed below and throughout this Agreement and for providing all of the data and information necessary for DHHS to meet federal Medicaid reporting and information regulations.

24.5.2. All subcontractors shall meet the same standards, as described in this Section 24, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a subcontractor with respect to its provided functions.

24.5.3. Specific functionality related to the above shall include, but is not limited to, the following :

24.5.3.1. The MCIS membership management system must have the capability to receive, update, and maintain New Hampshire's membership files consistent with information provided by DHHS.

24.5.3.2. The MCIS shall have the capability to provide daily updates of membership information to sub-contractors or providers with responsibility for processing claims or authorizing services based on membership information.

24.5.3.3. The MCIS' provider file must be maintained with detailed information on each provider sufficient to support provider enrollment and payment and also meet DHHS' reporting and encounter data requirements.

24.5.3.4. The MCIS' claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system.

24.5.3.5. The MCIS' Services Authorization system shall be integrated with the claims processing system.

24.5.3.6. The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements.

24.5.3.7. The MCIS' credentialing system shall have the capability to store and report on provider specific data sufficient to meet the provider credentialing requirements, Quality Management, and Utilization Management Program Requirements.

24.5.3.8. The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in member, provider, claims and authorization files, and in order to enable encounter data to be utilized for member profiling, provider profiling, claims validation, fraud, waste and abuse monitoring activities, and any other research and reporting purposes defined by DHHS.

24.5.3.9. The encounter data system shall have a mechanism in place to receive, process, and store the required data.

24.5.3.10. The MCO system shall be compliant with the requirements of HIPAA, including privacy, security, National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format. This also includes IRS Pub 1075 where applicable.

24.5.4. MCIS capability shall include, but not be limited to the following:

24.5.4.1. Provider network connectivity to Electronic Data Interchange (EDI) and provider portal systems;

24.5.4.2. Documented scheduled down time and maintenance windows as agreed upon with DHHS for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

24.5.4.3. DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes, and procedures (approved by the State) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

24.5.4.4. DHHS access to user acceptance test environment for externally accessible systems including websites and secure portals;

24.5.4.5. Documented instructions and user manuals for each component; and

24.5.4.6. Secure access.

24.5.5. MCIS Up-time

24.5.5.1. Externally accessible systems, including telephony, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours per day, seven (7) days per week, three-hundred-sixty-five (365) days per year, except for scheduled maintenance upon notification of and pre-approval by DHHS. Maintenance period cannot exceed four (4) consecutive hours without prior DHHS approval.

24.5.5.2. MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions will result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

24.5.6. Systems operations and support shall include, but not be limited to the following:

24.5.6.1. On-call procedures and contacts

24.5.6.2. Job scheduling and failure notification documentation

24.5.6.3. Secure (encrypted) data transmission and storage methodology

24.5.6.4. Interface acknowledgements and error reporting

24.5.6.5. Technical issue escalation procedures

24.5.6.6. Business and member notification

24.5.6.7. Change control management

24.5.6.8. Assistance with User Acceptance Testing (UAT) and implementation coordination

24.5.6.9. Documented data interface specifications – data imported and extracts exported including database mapping specifications.

24.5.6.10. Disaster Recovery and Business Continuity Plan

24.5.6.11. Journaling and internal backup procedures. Facility for storage MUST be class 3 compliant.

24.5.6.12. Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

24.5.7. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

24.5.7.1. Network diagram that fully defines the topology of the MCO's network.

24.5.7.2. State/MCO connectivity

24.5.7.3. Any MCO/subcontractor locations requiring MCIS access/support

24.5.7.4. Web access for DHHS staff, providers and recipients

24.5.8. Data transmissions from DHHS to the MCO will include, but not be limited to the following:

24.5.8.1. Provider Extract (Daily)

24.5.8.2. Recipient Eligibility Extract (Daily)

24.5.8.3. Recipient Eligibility Audit/Roster (Monthly)

24.5.8.4. Medical and Pharmacy Service Authorizations (Daily)

24.5.8.5. Commercial and Medical Third Party Coverage (Daily)

24.5.8.6. Claims History (Bi-Weekly)

24.5.8.7. Capitation payment data

24.5.9. Data transmissions from the MCO to DHHS shall include but not be limited to:

24.5.9.1. Member Demographic changes (Daily)

24.5.9.2. MCO Provider Network Data (Daily)

24.5.9.3. Medical and Pharmacy Service Authorizations (Daily)

24.5.9.4. Beneficiary Encounter Data including paid, denied, adjustment transactions by pay period (Weekly)

24.5.9.5. Financial Transaction Data

24.5.9.6. Updates to Third Party Coverage Data (Weekly)

24.5.9.7. Behavioral Health Certification Data (Monthly)

24.5.10.The MCO shall provide DHHS staff with access to timely and complete data:

24.5.10.1. All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS.

24.5.10.2. The MCO shall work collaboratively with DHHS, DHHS' MMIS fiscal agent, the New Hampshire Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement.

24.5.10.3. The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/subcontractor locations supporting the New Hampshire program.

24.5.10.4. The MCO shall utilize data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

24.5.10.5. The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including encounter data

24.5.10.6. The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this document (24.2.1.8).

24.5.10.7. Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable state and federal law.

24.5.10.8. Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

24.5.11.The MCIS shall include web access for use by and support to enrolled providers and members. The services shall be provided at no cost to the provider or members. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

24.5.11.1. The MCO shall create secure web access for Medicaid providers and members and authorized DHHS staff to access case-specific information.

24.5.11.2. The MCO shall manage provider and member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist providers and members with gaining access and utilizing the web portal.

24.5.11.3. Providers will have the ability to electronically submit service authorization requests and access and utilize other utilization management tools.

24.5.11.4. Providers and members shall have the ability to download and print any needed Medicaid MCO program forms and other information.

24.5.11.5. Providers shall have an option to e-prescribe as an option without electronic medical records or hand held devices.

24.5.11.6. MCO shall support provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es).

24.5.11.7. Providers shall have access to drug information.

24.5.11.8. The website shall provide an e-mail link to the MCO to allow providers and members or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website.

24.5.11.9. The website shall be secure and HIPAA compliant in order to ensure the protection of Protected Health Information and Medicaid recipient confidentiality. Access shall be limited to verified users via passwords and any other available industry standards. Audit logs must be maintained reflecting access to the system and random audits will be conducted.

24.5.11.10.The MCO shall have this system available no later than the Program Start Date.

24.5.11.11.Support Performance Standards shall include:

24.5.11.11.1.Email inquiries – one (1) business day response

24.5.11.11.2.New information posted within one (1) business day of receipt

24.5.11.11.3.Routine maintenance

24.5.11.11.4.Standard reports regarding portal usage such as hits per month by providers/members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports.

24.5.11.11.5.Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO must redirect user to site to install appropriate browser.

24.5.12.Critical systems within the MCIS support the delivery of critical medical services to members and reimbursement to providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

24.5.12.1. The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to New Hampshire within twenty-four (24) hours of incident onset.

24.5.12.2. The MCO shall ensure that the New Hampshire PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements as defined in Section 24.5.13.

24.5.12.3. The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction. Archiving processes shall not modify the data composition of DHHS' records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

24.5.12.4. The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between providers, provider billing agents/clearing houses, or DHHS and the MCO. Audit logs of activities will be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

24.5.12.5. Thirty (30) calendar days prior to the beginning of each State Fiscal Year, the MCO shall submit the following documents and corresponding checklists for DHHS' review and approval:

24.5.12.5.1.Disaster Recovery Plan

24.5.12.5.2.Business Continuity Plan

24.5.12.5.3.Security Plan

24.5.12.5.4.The MCO shall provide the following documents. If after the original documents are submitted the MCO modifies any of them, the revised documents and corresponding checklists shall be submitted to DHHS for review and approval:

a. Risk Management Plan

b. Systems Quality Assurance Plan

c. Confirmation of 5010 compliance and Companion Guides

d. Confirmation of compliance with IRS Publication 1075

e. Approach to implementation of ICD-10 and ultimate compliance

24.5.13.Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements shall be part of the change management process:

24.5.13.1. The complete system shall have proper configuration management/change management in place (to be reviewed and approved by DHHS). The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

24.5.13.2. The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent. DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

24.5.13.3. The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day. The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

24.5.13.4. A New Hampshire program centralized electronic repository shall be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

24.5.13.5. The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any member.

24.5.13.6. The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

24.5.14. DHHS, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

24.5.14.1. The System Readiness Review may include a desk review and/or an onsite review.

24.5.14.2. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

24.5.14.3. If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency.

24.5.15. Systems enhancements developed specifically, and data accumulated, as part of the New Hampshire Care Management program remain the property of the State of New Hampshire.

24.5.15.1. Source code developed for this program shall remain the property of the vendor but will be held in escrow.

24.5.15.2. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

24.5.15.3. The MCO shall not destroy or purge DHHS' data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be

retrievable for review and or reporting by DHHS in the timeframe set forth by DHHS.

24.5.16. The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute ad-hoc queries to support DHHS data and information needs. DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

24.5.17. Quality of Service (QOS) Metrics:

24.5.17.1. System Integrity: The system shall ensure that both user and provider portal design, and implementation is in accordance with Federal, standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

24.5.17.2. The security of the care management processing system must minimally provide the following three types of controls to maintain data integrity that directly impacts QOS . These controls shall be in place at all appropriate points of processing:

24.5.17.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

24.5.17.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

24.5.17.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

24.5.17.2.4. System Administration: Ability to comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with Agreement terms and conditions. Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions at no additional cost.

25. Data Reporting

25.1. General Provisions

25.1.1. The MCO shall make all collected data available to DHHS upon request and upon the request of CMS [42 CFR 438.242(b)(4)].

25.1.2. The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility [42 CFR 438.242(a)].

25.1.3. The MCO shall collect data on member and provider characteristics as specified by DHHS and on services furnished to members through a MCIS system or other methods as may be specified by DHHS [42 CFR 438.242(b)(2)].

25.1.4. The MCO shall ensure that data received from providers are accurate and complete by:

25.1.4.1. Verifying the accuracy and timeliness of reported data;

25.1.4.2. Screening the data for completeness, logic, and consistency; and

25.1.4.3. Collecting service information in standardized formats to the extent feasible and appropriate [42 CFR 438.242(b)(3)].

25.2. Encounter Data

25.2.1. The MCO shall submit encounter data in the format and content, timeliness, completeness, and accuracy as specified by the DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS.

25.2.2. All encounter data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

25.2.2.1. The MCO shall provide support to DHHS to substantiate the validity, integrity and reconciliation of DHHS reports that utilize the MCO encounter data.

25.2.3. Submission of encounter data to DHHS does not eliminate the MCO's responsibility under state statute to submit member and claims data to the Comprehensive Healthcare Information System [NH RSA 420-G:1,1 II. (a)]

25.2.4. The MCO shall ensure that encounter records are consistent with the DHHS requirements and all applicable state and federal laws.

25.2.5. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

25.2.6. The MCO shall use appropriate member identifiers as defined by DHHS.

25.2.7. The MCO shall maintain a record of both servicing and billing information in its encounter records.

25.2.8. The MCO shall also use appropriate provider identifiers for encounter records as directed by DHHS.

25.2.9. The MCO shall have a computer and data processing system sufficient to accurately produce the data, reports, and encounter record set in formats and timelines prescribed by DHHS as defined in this Agreement.

25.2.10. The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

25.2.11. The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS. The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

25.2.12. The MCO's systems that are required to use or otherwise contain the applicable data type shall conform with current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards:

25.2.12.1. Health Care Common Procedure Coding System (HCPCS)

25.2.12.2. CPT codes

25.2.12.3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the U.S. Department of Health and Human Services (HHS).

25.2.12.4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

25.2.12.5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.

25.2.12.6. National Drug Codes (NDC): The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

25.2.12.7. Code on Dental Procedures and Nomenclature (CDT): The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

25.2.12.8. Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains point of service (POS) codes used throughout the health care industry.

25.2.12.9. Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

25.2.12.10. Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the Medicaid Management Information System (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

25.2.13. All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format.

25.2.14. All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and as applicable the Medicare paid amount, other insurance paid amount and expected member co-payment amount.

25.2.15. The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

25.2.16.The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

25.2.17.The MCO shall collect, and submit to the State's fiscal agent, member service level encounter data for all covered services. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

25.2.18.The MCO shall conform to all current and future HIPAA-compliant standards for information exchange. Batch and Online Transaction Types are as follows:

25.2.18.1. Batch transaction types

25.2.18.1.1.ASC X12N 820 Premium Payment Transaction

25.2.18.1.2.ASC X12N 834 Enrollment and Audit Transaction

25.2.18.1.3.ASC X12N 835 Claims Payment Remittance Advice Transaction

25.2.18.1.4.ASC X12N 837I Institutional Claim/Encounter Transaction

25.2.18.1.5.ASC X12N 837P Professional Claim/Encounter Transaction

25.2.18.1.6.ASC X12N 837D Dental Claim/Encounter Transaction

25.2.18.1.7.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.18.2. Online transaction types

25.2.18.2.1.ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

25.2.18.2.2.ASC X12N 276 Claims Status Inquiry

25.2.18.2.3.ASC X12N 277 Claims Status Response

25.2.18.2.4.ASC X12N 278/279 Utilization Review Inquiry/Response

25.2.18.2.5.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.19.Submitted encounter data shall include all elements specified by DHHS including, but not limited to, those specified in Exhibit N and detailed in the Medicaid Encounter Submission Guidelines.

25.2.20.The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims. Any exceptions will be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception. The MCO shall also use the provider identifiers as directed by DHHS for both Encounter and fee-for-service claims submissions, as applicable.

25.2.21.The MCO shall provide as a supplement to the encounter data submission a member file, which shall contain appropriate member identification numbers, the primary care provider assignment of each member, and the group affiliation of the primary care provider.

25.2.22.The MCO shall submit complete encounter data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

25.2.23.The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

25.2.24.The MCO shall provide complete and accurate encounters to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards:

25.2.24.1. Completeness

25.2.24.1.1.The MCO shall submit encounters that represent at least ninety-nine percent (99%) of the covered services provided by the MCO's network and non-network providers. All data submitted by the providers to the MCO shall be included in the encounter submissions.

25.2.24.2. Accuracy

25.2.24.2.1.Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits.

25.2.24.2.2.Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

25.2.24.2.3.One-hundred percent (100%) of member identification numbers shall be accurate and valid.

25.2.24.2.4.Ninety-eight percent (98%) of servicing provider information will be accurate and valid.

25.2.24.2.5.Ninety-eight percent (98%) of member address information shall be accurate and valid.

25.2.24.3. Timeliness

25.2.24.3.1. Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment. All encounters shall be submitted, both paid and denied claims. The paid claims shall include the MCO paid amount.

25.2.24.3.2. The MCO shall be subject to remedies as specified in Section 34 for failure to timely submit encounter data, in accordance with the accuracy standards established in this Agreement.

25.2.24.4. Error Resolution

25.2.24.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice. For all ongoing claim encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fifteen (15) calendar days after such notice. If the MCO fails to do so, DHHS will require a Corrective Action Plan and assess liquidated damages as described in Section 34. MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

25.2.24.4.2. All sub-contracts with providers or other vendors of service shall have provisions requiring that encounter records are reported or submitted in an accurate and timely fashion.

25.2.24.5. Survival

25.2.24.5.1. All encounter data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

25.3. Data Certification

25.3.1. All data submitted to DHHS by the MCO shall be certified by one of the following:

25.3.1.1. The MCO's Chief Executive Officer;

25.3.1.2. The MCO's Chief Financial Officer; or

25.3.1.3. An individual who has delegated authority to sign for, and who reports directly to, the MCO's Chief Executive Officer or Chief Financial Officer.

25.3.2. The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, encounter data, and other information contained in contracts, proposals. The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data. The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

25.4. Data System Support for QAPI

25.4.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI requirements described in Section 21. The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of MCO providers, member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

25.5. Data Requirements for CFI Waiver Program

25.5.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the reporting requirements described in New Hampshire's home and community-based care 1915(c) waivers and applicable federal and state statutes and rules. The reporting system shall be able to support and provide data needed for the Annual Report on Home and Community-Based Services Waivers (CMS Form HCFA-372(S)) each reporting period or lag reporting period, which includes but not limited to:

25.5.1.1. The unduplicated number of persons who participated in the waiver during the waiver year;

25.5.1.2. The total expenditures for waiver services;

25.5.1.3. The number of participants who utilized each waiver service;

25.5.1.4. The amount expended for each waiver service and for all waiver services in total;

25.5.1.5. The average annual per participant expenditures for waiver service;

25.5.1.6. The total number of days of waiver coverage for all waiver participants and the average length of stay (ALOS) on the waiver;

25.5.1.7. Expenditures under the Medicaid State Plan for non-waiver services (including expanded EPSDT services when the waiver serves children) that

were made on behalf of waiver participants and average per participant expenditures for such services (based on the number of participants who utilized such services);

25.5.1.8. Information about the impact of the waiver on the health and welfare of waiver participants;

25.5.1.9. Total number of members who utilized nursing facility services;

25.5.1.10. Total expenditures for the members identified in 25.5.1.9, broken out by waiver, institutional and acute care expenditures;

25.5.1.11. The average expenditure per member, broken out by waiver, non-waiver and total expenditures;

25.5.1.12. The total number of days of nursing long term care coverage for the members identified in 25.5.1.9; and

25.5.1.13. Measures in Exhibit O.

26. Fraud Waste and Abuse

26.1. Program Integrity Plan

26.1.1. The MCO shall have a Program Integrity Plan in place that has been approved by DHHS and that shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse. The MCO is expected to be familiar with, comply with, and require compliance with, all state and federal regulations related to Medicaid Program Integrity, whether or not those regulations are listed herein, and as required in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008, and Section 1902(a)(68) of the Social Security Act.

26.1.1.1. The MCO shall retain all data, information, and documentation described in 42 CFR 438.604, 438.606, 438.608, and 438.610 for period no less than ten (10) years.

26.1.1.2. Fraud, waste and abuse investigations are targeted reviews of a provider or member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services. Cases which would be considered investigations are as follows, but not limited to:

26.1.1.2.1. review of instances which may range from outliers identified through data mining;

26.1.1.2.2. pervasive or persistent findings of routine audits to specific allegations that involve or appear to involve intentional misrepresentation in an effort to receive an improper payment;

26.1.1.2.3. notification of potential fraud, waste, and abuse through member verification of services, or complaint filed; and.

26.1.1.2.4. any reviews as defined by CMS as fraud, waste, and abuse investigation.

26.1.1.3. Routine claims audits are random reviews conducted for the purpose of verifying provider compliance with contractual requirements including, but not limited to, quality standards, reimbursement guidelines, and/or medical policies.

26.2. Fraud, Waste and Abuse Prevention Procedures

26.2.1. The MCO shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud, waste and abuse. The MCO procedures shall include, at a minimum, the following:

26.2.1.1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;

26.2.1.2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

26.2.1.3. Effective training and education for the compliance officer and the MCO's employees;

26.2.1.4. Effective lines of communication between the compliance officer and the MCO's employees;

26.2.1.5. Enforcement of standards through well-publicized disciplinary guidelines;

26.2.1.6. Provisions for internal monitoring and auditing;

26.2.1.7. Provisions for the MCO's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23; and

26.2.1.8. Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's Agreement [42 CFR 438.608(a) and (b)]

26.2.2. The MCO shall establish a Program Integrity Unit within the MCO comprised of:

26.2.2.1. Experienced Fraud, Waste and Abuse reviewers who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein; and

26.2.2.2. An experienced Fraud, Waste, and Abuse Coordinator who is qualified by having appropriate background, training, education, and experience in health care provider fraud, waste and abuse.

26.2.3. .This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud, Waste and Abuse that may be committed by providers that are paid by the MCO and/or their subcontractors. The MCO Program Integrity Plan shall also include the prevention, detection, investigation and reporting of suspected fraud by the MCO, the MCO's employees, subcontractors, subcontractor's employees, or any other third parties with whom the MCO contracts. The MCO shall refer all suspected provider fraud to the DHHS Program Integrity Unit upon discovery. The MCO shall refer all suspected member fraud to DHHS Special Investigations Unit.

26.3. Reporting

26.3.1. The MCO shall promptly report provider fraud, waste and abuse information to DHHS' Program Integrity Unit, which is responsible for such reporting to federal oversight agencies pursuant to [42 CFR 455.1(a)(1) and 42 CFR438.608].

26.3.1.1. The MCO shall perform a preliminary investigation of all incidents of suspected fraud, waste and abuse internally. The MCO shall not take any of the following actions as they specifically relate to claims involved with the investigation unless prior written approval is obtained from DHHS' Program Integrity Unit, utilizing the MCO Request to Open Investigation form:

26.3.1.1.1. Contact the subject of the investigation about any matters related to the investigation, either in person, verbally or in writing, hardcopy, or electronic;

26.3.1.1.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

26.3.1.1.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

26.3.2. The MCO shall promptly report to DHHS' Division of Client Services all information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including but not limited to:

26.3.2.1. Changes in the enrollee's residence; and

26.3.2.2. Death of an enrollee.

26.3.3. The MCO shall promptly report to DHHS' Office of Medicaid Services and the Program Integrity Unit all changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

26.3.4. The MCO shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (five (5) percent or greater) in the MCO, or any sub-contractor in which the MCO has a five percent (5%) or greater ownership interest [42 CFR 438.608(c)(2)].

26.3.5. [Intentionally left blank.]

26.3.6. The MCO shall provide written disclosure of any prohibited affiliation under §438.610 and as described in subparagraph 4.3.2 of this Agreement [42 CFR 438.608(c)(1)].The MCO shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State.

26.3.7. As an integral part of the Program Integrity function, and in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438, the MCO shall provide DHHS or its designee real time access to all of the MCO electronic encounter and claims data from the MCO's current claims reporting system. The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in section 24.5.16.

26.3.7.1. MCOs shall provide any additional data access upon written request from DHHS for any potential fraud, waste, or abuse investigation or for MCO oversight review. The additional access shall be provider within 3 business days of the request.

26.3.8. The MCO shall make claims and encounter data available to DHHS (and other State staff) using a reporting system that is compatible with DHHS' system(s).

26.3.9. The MCO, their subcontractors, their contracted providers, their subcontractor's providers, and any subcontractor's subcontractor's providers shall cooperate fully with Federal and State agencies and contractors in any program integrity related investigations and subsequent legal actions. The MCO, their subcontractors and their contracted providers, subcontractor's providers, and any subcontractor's subcontractor's providers shall, upon written request and as required by this Agreement or state and/or federal law, make available any and all administrative, financial and medical records relating to the delivery of items or services for which MCO monies are expended. In addition, and as required by this Agreement or state and/or federal law, such agencies shall, also be allowed access to the place of business and to all MCO records of any contractor, their subcontractor or their contracted provider, subcontractor's providers, and any subcontractor's subcontractor's providers.

26.3.9.1. The MCO is responsible for program integrity oversight of its subcontractors. In accordance with federal regulations, CMS requires MCO contracts to contain provisions giving states' Program Integrity Units audit and access authority over MCOs and their subcontractors to include direct on site access to ordinal policies and procedures, claims processing, and provider credentialing for validation purposes at the expense of the MCO.

26.3.10. The MCO shall have a written process approved by DHHS for Recipient Explanation of Medicaid Benefits, which shall include tracking of actions taken on responses, as a means of determining and verifying that services billed by providers were actually provided to members. The MCO shall provide DHHS with a quarterly EOB activity report, including, but not limited to, tracking of all responses received, action taken by the MCO, and the outcome of the activity. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the MCO.

26.3.11. The MCO shall maintain an effective fraud, waste and abuse-related provider overpayment identification, recovery and tracking process. This process shall include

a methodology for a means of estimating overpayment, a formal process for documenting communication with providers, and a system for managing and tracking of investigation findings, recoveries, and underpayments related to fraud, waste and abuse investigations. DHHS and the AG Medicaid Fraud Unit shall have unrestricted access to information and documentation related to the NH Medicaid program for use during annual MCO Program Integrity audits and on other occasions as needed as a means of verifying and validating MCO compliance with the established policies, procedures, methodologies, and investigational activity regarding provider fraud, waste and abuse.

26.3.12. The MCO shall provide DHHS with a monthly report of all Program Integrity, in process and completed during the month, including fraud, waste and abuse by the MCO, the MCO's employees, subcontractors, subcontractor's employees, and contracted providers. [42 CFR 455.17]. The MCO will supply at a minimum:

26.3.12.1. provider name/ID number,

26.3.12.2. source of complaint,

26.3.12.3. type of provider,

26.3.12.4. nature of complaint,

26.3.12.5. review activity, and

26.3.12.6. approximate dollars involved,

26.3.12.7. Provider Enrollment Safeguards related to Program Integrity;

26.3.12.8. Overpayments, Recoveries, and Claim Adjustments;

26.3.12.9. Audits/Investigations Activity;

26.3.12.10. MFCU Referrals;

26.3.12.11. Involuntary Provider Terminations; and

26.3.12.12. Provider Appeal/Hearings Activity resulting from, or related to, Program Integrity.

26.3.13. All fraud, waste and abuse reports submitted to DHHS shall be mutually developed and agreed upon between DHHS and the MCO. The reports will be submitted to DHHS in a format and mode of delivery, mutually agreed upon between DHHS and the MCO.

26.3.14.In the event DHHS is unable to produce a desired Ad Hoc report through its access to the MCO's data as provided herein, DHHS shall request in writing such Ad hoc report from the MCO and, within three (3) business days of receipt of such request, the MCO shall notify DHHS of the time required by the MCO to produce and deliver the Ad hoc report to DHHS, at no additional cost to DHHS.

26.3.15.The MCO shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the MCO discovers wasteful and or abusive incorrect billing trends with a particular provider/provider type, specific billing issue trends, or quality trends, it is the MCO's responsibility, as part of the provider audit/investigative process, to recover any inappropriately paid funds, and as part of the resolution and outcome, for the MCO to determine the appropriate remediation, such as reaching out to the provider to provide individualized or group training/education regarding the issues at hand. Within sixty (60) days of discovery, the MCO shall report overpayments identified during investigations to DHHS Program Integrity and shall include them on the monthly investigation activity report. The MCO shall still notify Program Integrity unit to request approval to proceed with a suspected fraud or abuse investigation.

26.3.16. [Intentionally left blank.]

26.3.17.Annually, the MCO shall submit to DHHS a report of the overpayments it recovered and certify by its Chief Financial Officer that this information is accurate to the best of his or her information, knowledge, and belief [42 CFR 438.606].DHHS reserves the right to conduct peer reviews of final program integrity investigations completed by the MCO.

26.3.18.DHHS will perform an annual program integrity audit, conducted on-site at the MCO (at the expense of the MCO) to verify and validate the MCO's compliance. The review will include, but not limited to, the plan's established policies and methodologies, credentialing, provider and staff education/training, provider contracts, and case record reviews to ensure that the MCO is making proper payments to providers for services under their agreements, and pursuant to 42 CFR 438 6(g). The review will include direct access to MCO system while on site and hard copy of documentation while on site as requested. Any documentation request at the end of the on site shall be delivered to Program Integrity within 3 business days of request. The MCO shall provide DHHS staff with access to appropriate on-site private work space to conduct DHHS's program integrity contract management reviews.

26.3.19.The MCO shall meet with DHHS monthly, or as determined by DHHS, to discuss audit and investigation results and make recommendations for program improvements. DHHS shall meet with both MCOs together quarterly, or as determined by DHHS, to discuss areas of interest for past, current and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities, and to discuss and share provider audit information and results.

26.3.20.The MCO shall provide DHHS with an annual report of all investigations in process and completed during the Agreement year within thirty (30) calendar days of the end of the Agreement year. The report shall consist of, at a minimum, an aggregate of the monthly reports, as well as any recommendations by the MCO for future reviews, changes in the review process and reporting process, and any other findings related to the review of claims for fraud, waste and abuse.

26.3.21.The MCO shall provide DHHS with a final report within thirty (30) calendar days following the termination of this Agreement. The final report format shall be developed jointly by DHHS and the MCO, and shall consist of an aggregate compilation of the data received in the monthly reports.

26.3.22.The MCO shall refer all suspected provider Medicaid fraud cases to DHHS upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.

26.3.23.The MCO shall institute a Pharmacy Lock-In Program for members which has been reviewed and approved by DHHS.

26.3.23.1. If the MCO determines that a member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to members regarding the Pharmacy Lock-In determination.

26.3.24.MCOs may, with prior approval from DHHS, implement Lock-In Programs for other medical services.

26.3.25.The MCO shall provide DHHS with a monthly report regarding the Pharmacy Lock-In Program. Report format, content, design, and mode of transmission shall be mutually agreed upon between DHHS and the MCO.

26.3.26.DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit or DHHS Special Investigations Unit.

26.3.27.Subject to applicable state and federal confidentiality/privacy laws, upon written request, the MCO will allow access to all NH Medicaid medical records and claims information to State and Federal agencies or contractors such as, but not limited to Medicaid Fraud Control Unit, Recovery Audit Contractors (RAC) the Medicaid Integrity Contractors (MIC), or DHHS Special Investigations Unit.

26.3.27.1. The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency (State and Federal) or their contractors, whether administrative, civil, or criminal. Such cooperation shall include providing, upon written request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in

medical or pharmaceutical questions or in any matter related to an investigation.

26.3.28. The MCO's MCIS system shall have specific processes and internal controls relating to fraud, waste and abuse in place, including, but not limited to the following areas:

26.3.28.1. Prospective claims editing;

26.3.28.2. NCCI edits;

26.3.28.3. Post-processing review of claims; and

26.3.28.4. Ability to pend any provider's claims for pre-payment review if the provider has shown evidence of credible fraud [42 CFR 455.21] in the Medicaid Program.

26.3.29. The MCO and their subcontractors shall post and maintain DHHS approved information related to Fraud, Waste and Abuse on its website, including but not limited to provider notices, updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

26.3.30. The MCO and their subcontractors shall be subject to on-site reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests as a result of an annual or targeted on-site review (at the expense of the MCO).

26.3.31. DHHS shall conduct investigations related to suspected provider fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for any and all types of claims older than six months for which the MCO does not have an active investigation.

26.3.32. DHHS shall validate the MCO and their subcontractors' performance on the program integrity scope of services to ensure the MCO and their subcontractors are taking appropriate actions to identify, prevent, and discourage improper payments made to providers, as set forth in 42 CFR 455 – Program Integrity.

26.3.33. DHHS shall establish performance measures to monitor the MCO compliance with the Program Integrity requirements set forth in this Agreement.

26.3.34. DHHS shall notify the MCO of any policy changes that impact the function and responsibilities required under this section of the Agreement.

26.3.35. DHHS shall notify the MCO of any changes within its agreement with its fiscal agent that may impact this section of this Agreement as soon as reasonably possible.

26.3.36.The MCO(s) shall report to DHHS all identified providers prior to being investigated, to avoid duplication of on-going reviews with the RAC, MIC, MFCU and, using the MCO Request to Open Investigation Form. DHHS will either approve the MCO to proceed with the investigation, or deny the request due to potential interference with an existing investigation.

26.3.37.The MCO(s) shall maintain appropriate record systems for services to members pursuant to 42 CFR 434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff, or its designee, to MCO(s) NH Medicaid related data files. Such information shall include, but not be limited to:

26.3.37.1. Recipient – First Name, Last Name, DOB, gender, and identifying number;

26.3.37.2. Provider Name and number (rendering, billing and Referring);

26.3.37.3. Date of Service(s) Begin/End;

26.3.37.4. Place Of Service;

26.3.37.5. Billed amount/Paid amount;

26.3.37.6. Paid date;

26.3.37.7. Standard diagnosis codes (ICD-9-CM and ICD-10-CM), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim);

26.3.37.8. Paid, denied, and adjusted claims;

26.3.37.9. Recouped claims and reason for recoupment;

26.3.37.10.Discharge status;

26.3.37.11.Present on Admission (POA);

26.3.37.12.Length of Stay;

26.3.37.13.Claim Type;

26.3.37.14.Prior Authorization Information;

26.3.37.15.Detail claim information;

26.3.37.16.Provider type;

26.3.37.17.Category of Service;

26.3.37.18.Admit time and discharge date;

26.3.37.19.Admit code;

26.3.37.20.Admit source;

26.3.37.21.Covered days;

26.3.37.22.TPL information;

26.3.37.23.Units of service;

26.3.37.24.EOB;

26.3.37.25.MCO ID#;

26.3.37.26.Member MCO enrollment date;

26.3.37.27.If available, provider time in and time out for the specific service(s) provided;

26.3.37.28.Data shall be clean, not scrubbed; and

26.3.37.29.And any other data deemed necessary by DHHS

26.3.38.The MCO shall provide DHHS with the following monthly reports as required by CMS:

26.3.38.1. Date of Death.

26.3.39.The MCO shall provide DHHS with any new reports as identified and required by state and federal regulation. The timing, format, content and mode of transmission will be mutually agreed upon between DHHS and the MCO.

27. Third Party Liability

DHHS and the MCO will cooperate in implementing cost avoidance and cost recovery activities. The rights and responsibilities of the parties relating to members and Third Party Payors are as follows:

27.1. MCO Cost Avoidance Activities

27.1.1. The MCO shall have primary responsibility for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans, and workers compensation. The MCO must attempt to avoid initial payment of claims, whenever possible, when federal or private health insurance resources are available. To support that responsibility, the MCO must implement a file transfer protocol between the DHHS MMIS and the MCO's MCIS to receive Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138. MCO shall require its subcontractors to promptly and consistently report COB daily information to the MCO.

27.1.2. The MCO shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

27.1.3. The number of claims cost avoided by the MCO's claims system, including the amount of funds, the amounts billed, the amounts not collected, and the amounts denied, must be reported weekly to DHHS in delimited text format.

27.1.4. The MCO shall maintain records of all COB collection efforts and results and report such information either through monthly electronic data transfers or access rights for DHHS to the MCO's data files. The data extract shall be in the delimited text format. Data elements may be subject to change during the course of the Agreement. The MCO shall accommodate changes required by DHHS and DHHS shall have access to all billing histories and other COB related data.

27.1.5. The MCO shall provide DHHS with a detailed claim history of all claims for a member, including adjusted claims, on a monthly basis based on a specific service date parameter requested for accident and trauma cases. This shall be a full replacement file each month for those members requested. These data shall be in the delimited text format. The claim history shall have, at a minimum, the following data elements:

27.1.5.1. Member name;

27.1.5.2. Member ID;

27.1.5.3. Dates of service;

27.1.5.4. Claim unique identifier (transaction code number);

27.1.5.5. Claim line number;

27.1.5.6. National Diagnosis Code;

27.1.5.7. Diagnosis code description;

27.1.5.8. National Drug Code;

27.1.5.9. Drug code description;

27.1.5.10. Amount billed by the provider;

27.1.5.11. Amount paid by the MCO;

27.1.5.12. Amount of other insurance recovery, name or Carrier ID;

27.1.5.13. Date claim paid;

27.1.5.14. Billing provider name; and

27.1.5.15. Billing provider NPI.

27.1.6. The MCO shall provide DHHS with a monthly file of COB collection effort and results. These data shall be in a delimited text format. The file should contain the following data elements:

27.1.6.1. Medicaid member name;

27.1.6.2. Medicaid member ID;

27.1.6.3. Insurance Carrier, other public payer, PBM, or benefit administrator ID;

27.1.6.4. Insurance Carrier, other public payer, PBM, or benefit administrator name;

27.1.6.5. Date of Service;

27.1.6.6. Claim unique identifier (transaction code number);

27.1.6.7. Date billed to the insurance carrier, other public payer, PBM, or benefit administrator;

27.1.6.8. Amount billed;

27.1.6.9. Amount recovered;

27.1.6.10. Denial reason code;

27.1.6.11. Denial reason description; and

27.1.6.12. Performing provider.

27.1.7. The MCO and its subcontractors shall not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations nor bill or pursue collection from a member for services. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third Party Liability is established at the time the claim is adjudicated.

27.2. DHHS Cost Avoidance and Recovery Activities

27.2.1. DHHS shall be responsible for:

27.2.1.1. Medicare and newly eligible members' initial insurance verification and submitting this information to the MCO;

27.2.1.2. Cost avoidance and pay and chase of those services that are excluded from the MCO;

27.2.1.3. Accident and trauma recoveries;

27.2.1.4. Lien, Adjustments and Recoveries and Transfer of Assets pursuant to § 1917 of the SSA;

27.2.1.5. Mail order co-pay deductible pharmacy program for Fee for Service and HIPP (Health Insurance Premium Payment) program;

27.2.1.6. Veterans Administration benefit determination;

27.2.1.7. Health Insurance Premium Payment Program; and

27.2.1.8. Audits of MCO collection efforts and recovery.

27.3. Post-Payment Recovery Activities

27.3.1. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources.

27.3.2. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts.

27.3.3. Other resources with regard to Third Party Liability include but are not limited to: recoveries from personal injury claims, liability insurance, first party automobile medical insurance, and accident indemnity insurance.

27.4. MCO Post Payment Activities

27.4.1. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources, including a claim involving Workers' Compensation or where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible or collection through either legal action or traditional subrogation and collection procedures.

27.4.2. The MCO shall be responsible for Reviewing claims for accident and trauma codes as required under 42 C.F.R. §433.138 (e). The MCO shall specify the guideline used in determining accident and trauma claims and establish a procedure to send the DHHS Accident Questionnaire to Medicaid members, postage pre-paid, when such potential claim is identified. The MCO shall instruct members to return the Accident Questionnaire to DHHS. The MCO shall provide the guidelines and procedures to DHHS for review and approval. Any changes to procedures must be submitted to DHHS at least thirty days for approval prior to implementation.

27.4.3. Due to potential time constraints involving accident and trauma cases and due to the large dollar value of many claims which are potentially recoverable by DHHS, the MCO must identify these cases before a settlement has been negotiated. Should DHHS fail to identify and establish a claim prior to settlement due to the MCO's untimely submission of notice of legal involvement where the MCO has received such notice, the amount of the actual loss of recovery shall be assessed against the MCO. The actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by DHHS.

27.4.4. The MCO has the latter of eighteen (18) months from the date of service or twelve (12) months from the date of payment of health-related insurance resources to initiate recovery and may keep any funds that it collects. The MCO must indicate its intent to recover on health-related insurance by providing to DHHS an electronic file of those cases that will be pursued. The cases must be identified and a file provided to DHHS by the MCO within thirty (30) days of the date of discovery of the resource.

27.4.5. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a Medically Necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

27.5. DHHS Post Payment Recovery Activity

27.5.1. DHHS retains the sole and exclusive right to investigate, pursue, collect and retain all Other Resources, including accident and trauma. DHHS is assigned the MCO's subrogation rights to collect the "Other Resources" covered by this provision. Any correspondence or Inquiry forwarded to the MCO (by an attorney, provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forward to DHHS.

27.5.2. The MCO may neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by DHHS under the scope of these "Other Resources" shall be retained by DHHS.

27.5.3. DHHS may pursue, collect and retain recoveries of all health-related insurance cases; provided, however, that if the MCO has not notified DHHS of its intent to pursue a case identified for recovery before the latter of eighteen (18) months after the date of service or twelve (12) months after the date of payment, such cases not identified for recovery by the MCO will become the sole and exclusive right of DHHS to pursue, collect and retain. The MCO must notify DHHS through the prescribed electronic file process of all outcomes for those cases identified for pursuit by the MCO.

27.5.4. Should DHHS lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in billing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable Claim shall be assessed against the MCO.

28. Compliance with State and Federal Laws

28.1. General

28.1.1. The MCO, its subcontractors, and the providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

28.1.2. The MCO 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].

28.1.3. The MCO shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

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

28.1.3.2. Related rules: Title 42 Chapter IV;

28.1.3.3. 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);

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

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

28.1.3.6. Regulations promulgated thereunder: 42 CFR 457;

28.1.3.7. Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

28.1.3.8. Patient Protection and Affordable Care Act of 2010;

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

28.1.3.10. State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26; and

28.1.3.11. American Recovery and Reinvestment Act.

28.1.4. The MCO will not release and make public statements or press releases concerning the program without the prior consent of DHHS.

28.1.5. The MCO shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and the MCO, 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.

28.2. Non-Discrimination

28.2.1. The MCO shall require its providers and 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 or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

28.2.2. ADA Compliance

28.2.2.1. The MCO shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA.

28.2.2.1.1. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

28.2.2.2. The MCO shall submit to DHHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the MCO's knowledge. The MCO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by the MCO and shall be available for inspection by the DHHS. The MCO warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA. Where applicable, the MCO shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

28.2.2.3. The MCO shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all members who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

28.2.2.4. The MCO shall forward to DHHS copies of all grievances alleging discrimination against members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability for review and appropriate action within three (3) business days of receipt by the MCO.

28.2.3. Non-Discrimination in employment:

28.2.3.1. The MCO shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. The MCO 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. The MCO 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.

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

28.2.3.3. The MCO 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 the MCO'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.

28.2.3.4. The MCO 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.

28.2.3.5. The MCO 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.

28.2.3.6. In the event of the MCO'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 the MCO 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.

28.2.3.7. The MCO 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. The MCO 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 the MCO

becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

28.2.4. Non-Discrimination in Enrollment

28.2.4.1. The MCO shall and shall require its providers and subcontractors to accept assignment of an member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

28.2.4.2. The MCO shall and shall require its providers and subcontractors to not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

28.2.5. Non-Discrimination with Respect to Providers

28.2.5.1. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's members, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the MCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

28.3. Changes in Law

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

29. Administrative Quality Assurance Standards

29.1. Claims Payment Standards

29.1.1. The MCO shall pay or deny ninety-five percent (95%) of clean claims within thirty (30) days of receipt, or receipt of additional information [42 CFR 447.46; 42 CFR 447.45(d)(2), (d)(3), (d)(5), and (d)(6)].

29.1.2. The MCO shall pay interest on any clean claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

29.1.3. The MCO shall pay or deny all claims within sixty (60) calendar days of receipt.

29.1.4. Additional information necessary to process incomplete claims shall be requested from the provider within thirty (30) days from the date of original claim receipt.

29.1.5. For purposes of this requirement, New Hampshire DHHS has adopted the claims definitions established by CMS under the Medicare program, which are as follows:

29.1.5.1. "clean" claim: a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and

29.1.5.2. "incomplete" claim: a claim that is denied for the purpose of obtaining additional information from the provider.

29.1.6. Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or electronic funds transfer is issued to the service provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

29.2. Quality Assurance Program

29.2.1. The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS on a monthly basis.

29.2.2. Monthly reporting shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

29.2.3. The MCO shall implement Corrective Action Plans to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

29.3. Claims Financial Accuracy

29.3.1. Claims financial accuracy measures the accuracy of dollars paid to providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

29.4. Claims Payment Accuracy

29.4.1. Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay ninety-seven percent (97%) of claims accurately.

29.5. Claims Processing Accuracy

29.5.1. Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process ninety-five percent (95%) of all claims correctly.

30. Privacy and Security of Members

30.1. General Provisions

30.1.1. The MCO shall be in compliance with privacy policies established by governmental agencies or by State or federal law.

30.1.2. The MCO shall provide sufficient security to protect the State and DHHS data in network, transit, storage, and cache.

30.1.3. In addition to adhering to privacy and security requirements contained in other applicable laws and statutes, the MCO shall execute as part of this Agreement a Business Associates Agreement governing the permitted uses and disclosure and security of Protected Health Information.

30.1.4. The MCO shall ensure that it uses and discloses individually identifiable health information in accordance with HIPAA privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable [42 CFR 438.224]; complies with federal statutes and regulations governing the privacy of drug and alcohol abuse patient records (42 CFR, Part 2), and all applicable state statutes and regulations, including but not limited to: R.S.A. 167:30: protects the confidentiality of all DHHS records with identifying medical information in them.

30.1.5. With the exception of submission to the Comprehensive Healthcare Information System or other requirements of State or federal law, claims and member data on New Hampshire Medicaid members may not be released to any party without the express written consent of DHHS.

30.1.6. The MCO shall ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information [42 CFR 438.208(b)].

31. Finance

31.1. Financial Standards

31.1.1. In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with New Hampshire Insurance Department regulations, and any other relevant laws and regulations.

31.1.2. Capitation Rates for State Fiscal Year 2018. Any increase in the capitation rates for each of the rating categories for the MCM program for the extension period between July 1, 2017 to June 30, 2018 shall not result in a total average increase for all rating categories combined in excess of 3.8% over the capitation rates in effect at the end of State Fiscal Year 2017, which average increase shall be calculated: a) based on the membership in the MCM program at the time the State Fiscal Year 2018 capitation rates are developed and b) net of the cost impact of any program changes that will take effect in State Fiscal Year 2018; provided, however, that the capitation rate proposed for each rating category for State Fiscal Year 2018 must be sufficient to be certified as actuarially sound per 42 CFR 438.4 and approvable by the Centers for Medicare and Medicaid Services.

31.1.3. The MCO shall maintain a risk-based capital (RBC) ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

31.1.4. With the exception of payment of a claim for a medical product or service that was provided to a member, and that is in accordance with a written Agreement with the provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

31.1.4.1. RBC ratio was less than 2.0 for the most recent year filing, per R.S.A. 404-F:14 (III); and

31.1.4.2. MCO was not in compliance with the NHID solvency requirement.

31.1.5. The MCO shall notify DHHS within ten (10) calendar days when its Agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

31.1.6. The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

31.1.7. The MCO shall not be responsible for DSH/GME (IME/DME) payments to hospitals. DSH and GME amounts are not included in capitation payments.

31.1.8. The MCO shall submit data on the basis of which DHHS determines that the MCO has made adequate provision against the risk of insolvency.

31.2. Capitation Payments

31.2.1. Preliminary capitation rates for non NHHPP members for the agreement period through June 30, 2018 are shown in Exhibit B. For each of the subsequent years of the Agreement actuarially sound per member, per month capitated rates will be calculated and certified by the DHHS's actuary.

31.2.2. Capitation rates for NHHPP members are shown in Exhibit B and were determined as part of Agreement negotiations, any best and final offer process, and the DHHS actuary's soundness certification.

31.2.3. Capitation rate cell is determined as of the first day of the capitation month and does not change during the entire month regardless of member changes (e.g., age).

31.2.4. DHHS will make a monthly payment to the MCO for each member enrolled in the MCO's plan. Capitation payments shall only be made for Medicaid-eligible enrollees and be retained by the MCOs for those enrollees. The capitation rates, as set forth in Exhibit B, will be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis as follows:

31.2.4.1. The Chronic Illness and Disability Payment System and/or Medicaid Rx risk adjuster (CDPS + Rx, Medicaid Rx) will be used to risk adjust MCO capitation payments;

31.2.4.2. A risk score will be developed for members with six (6) months or more months of Medicaid eligibility (either FFS or managed care) inclusive of three (3) months of claims run out in the base experience period. For members with less than six (6) months of eligibility, a score equal to the average of those scored beneficiaries in each cohort will be used; and

31.2.4.3. The MCO risk score for a particular rate cell will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population enrolled in the Care Management program. For rate cells with an opt-out provision, the MCO risk score will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population that is eligible to enroll in the Care Management program (FFS eligibles + MCO members).

31.2.4.4. [Intentionally left blank.]

31.2.5. DHHS reserves the right to terminate or implement the use of a risk adjustment process for specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates. For example, the risk adjustment process

may need to be modified when Long Term Services and Supports (LTSS) are added to the capitation rates.

31.2.6. The capitation payment for Medicaid Managed Care members will be made retrospectively with a two (2) month delay. For example, a payment will be made within five (5) business days of the first day in October 2012 for services provided in July 2012.

31.2.7. Section 31.2.6 notwithstanding, capitation payments for NHHPP members will be paid in the month of service.

31.2.8. Capitation payment settlements will be made at three (3) month intervals. DHHS will recover capitation payments made for deceased members, or members who were later determined to be ineligible for Medicaid and/or for Medicaid managed care or need rate cell or kick payment corrections. DHHS will pay MCO for retroactive member assignments, corrections to kick payments, behavioral health certification level correction or other rate assignment corrections.

31.2.9. Capitation payments for members who became ineligible for services in the middle of the month will be prorated based on the number of days eligible in the month.

31.2.10. The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement [42 CFR 438.608(c)(3)].

31.2.11. For each live birth, DHHS will make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all maternity expenses, including all delivery and postpartum care. In the event of a multiple birth DHHS will only make only one maternity kick payment. A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

31.2.12. For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2012 and August 2012 for a baby born any time in July 2012. Enrolled babies will be covered under the MCO capitated rates thereafter.

31.2.13. The MCO shall submit information on maternity and newborn events to DHHS. The MCO shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

31.2.14. Beginning July 1, 2018, one percent (1.0%) of each member's capitation payment to the MCO will be withheld annually to support DHHS's payment reform incentive program. Details of the Incentive Program are described in Section 9.

31.2.15. DHHS will inform the MCO of any required program revisions or additions in a timely manner. DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

31.2.16. When requested by DHHS, the MCO shall submit base data to DHHS to ensure actuarial soundness in development of the capitated rates.

31.2.17. The MCO's Chief Financial Officer shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate [42 CFR 438.606].

31.2.18. In the event an enrolled Medicaid member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive full capitation payment for that member. The entity responsible for coverage of the member at the time of admission as an inpatient, i.e. either DHHS or another MCO, shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

31.2.19. Payment for behavioral health rate cells shall be determined based on a member's CMHC behavioral certification level and a member having had an encounter at a CMHC in the last 6 months. Changes in the certification level for a member shall be reflected as of the first of each month and does not change during the month.

31.2.20. For Applied Behavioral Analysis (ABA) services incurred on or after September 1, 2015 the MCO shall not be financially responsible for claims for ABA services provided that the MCO obtained prior approval from DHHS of prior authorizations for the services. DHHS shall make payments to the MCO based on DHHS's Medicaid fee schedule for those ABA services approved by DHHS.

31.2.21. Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the New Hampshire Insurance Administrative Fund (Fund) pursuant to R.S.A. 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NH Insurance Department.

31.2.22. For any member with claims exceeding five hundred thousand dollars ($500,000) for the fiscal year, after applying any third party insurance off set, DHHS will reimburse fifty percent (50%) of the amount over five hundred thousand dollars ($500,000) after all claims have been recalculated based on the DHHS fee schedule for the services.

For a member whose services may be projected to exceed five hundred thousand dollars ($500,000) in MCO claims, the MCO shall advise DHHS. Prior approval from the Medicaid Director is required for subsequent services provided to the member.

31.3. Medicaid Loss Ratio

31.3.1. The MCO shall determine the Medicaid Loss Ratio ("MLR") experienced in accordance with 42 CFR 438.8.

31.3.2. The MCO shall submit MLR summary reports quarterly to DHHS, which shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year. Specifically, the MCO shall provide separate summary reports for NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program. The MCO must attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. Such summary reports shall be based on a template provided and developed by DHHS within sixty (60) days of the effective date of this Agreement.

31.3.3. The MCO and its subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

31.4. NHHPP Risk Protection Structure

31.4.1. DHHS will implement risk adjustment and risk corridors for the NHHPP Medically Frail and NHHPP Transitional populations.

31.4.1.1. Risk adjustment – (MCO Revenue Reallocation) – Similar to the risk adjustment process for the current Medicaid Step 1 population under the MCM program, risk adjustment will shift revenue from MCOs with lower acuity populations to MCOs with higher acuity populations. The risk adjustment component will only apply to the NHHPP Medically Frail population. The risk adjustment process is revenue neutral. The NHHPP Transitional population is expected to have very short enrollment duration and therefore will not be risk adjusted.

31.4.2. Risk adjustment – Methodology – Acuity will be measured using the CDPS+Rx, a diagnosis and pharmacy based risk adjuster that will also be used for the current Medicaid population. Key differences in the risk adjustment process for the NHHPP Medically Frail population include:

31.4.2.1. DHHS will use concurrent risk adjustment for the NHHPP Medically Frail population. DHHS will use SFY 2018 claims and the standard CDPS+Rx concurrent risk weights to estimate SFY 2018 acuity (as opposed to prospective models that use a prior year's claims to estimate current acuity).

31.4.2.2. Risk adjustment transfer payments will be made as part of the contract period settlement, not as prospective payments.

31.4.3. Risk corridors – DHHS will establish a target medical loss ratio (MLR) of 89.3% based on NHHPP pricing assumptions and perform a separate calculation for the NHHPP Medically Frail and NHHPP Transitional populations:

31.4.3.1. Administrative and margin allowance of 8.9% of the capitation rate prior to state premium tax.

31.4.3.2. New Hampshire state premium tax of 2%.

31.4.3.3. DHHS and each MCO will share the financial risk of actual results that are above or below the MLR target as shown in the table below:

New Hampshire Department of Health and Human Services New Hampshire Health Protection Program Population Risk Corridor Program		
Actual MLR Compared to Target MLR	**MCO Share**	**DHHS Share**
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

31.4.3.4. The NHHPP Medically Frail risk corridor calculation will be applied after the risk adjustment calculation.

31.4.4. For SFY 2018, risk protection settlement will occur after the SFY 2018 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.4.1. June 30, 2018: End of NHHPP contract period

31.4.4.2. December 31, 2018: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.4.3. January 31, 2019: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.4.4. April 30, 2019: DHHS releases settlement payment report to MCOs

31.4.4.5. May 31, 2019: DHHS makes / receives final settlement payments to / from MCOs

31.4.5. For SFY 2017, risk protection settlement will occur after the SFY 2017 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.5.1. June 30, 2017: End of NHHPP contract period

31.4.5.2. December 31, 2017: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2017 dates of service paid through December 31, 2017)

31.4.5.3. January 31, 2018: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.5.4. April 30, 2018: DHHS releases settlement payment report to MCOs

31.4.5.5. May 31, 2018 DHHS makes / receives final settlement payments to / from MCOs

31.4.6. For SFY 2016, risk protection settlement will occur after the SFY 2016 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.6.1. June 30, 2016: End of NHHPP contract period

31.4.6.2. December 31, 2016: Cutoff date for encounter data to be used in the risk protection settlement calculations (January 2016 – June 2016 dates of service paid through December 31, 2016)

31.4.6.3. January 31, 2017: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.6.4. April 30, 2017: DHHS releases settlement payment report to MCOs

31.4.6.5. May 31, 2017: DHHS makes / receives final settlement payments to / from MCOs

31.4.7. For September 2014 – December 2015 risk protection settlement:

31.4.7.1. August 31, 2016: DHHS intends to release settlement payment report to MCOs

31.4.7.2.September 30, 2017: DHHS intends to make / receive final settlement payments to / from MCOs.

31.5. Financial Responsibility for Dual-Eligibles

31.5.1. The MCO shall pay any Medicare coinsurance and deductible amount up to what New Hampshire Medicaid would have paid for that service, whether or not the Medicare provider is included in the MCO's provider network. These payments are included in the calculated capitation payment.

31.6. Premium Payments

31.6.1. DHHS is responsible for collection of any premium payments from members. If the MCO inadvertently receives premium payments from members, it shall inform the member and forward the payment to DHHS.

31.7. Sanctions

31.7.1. If the MCO fails to comply with the financial requirements in Section 31, DHHS may take any or all of the following actions:

31.7.1.1. Require the MCO to submit and implement a Corrective Action Plan

31.7.1.2. Suspend enrollment of members to the MCO after the effective date of sanction

31.7.1.3. Terminate the Agreement upon forty-five (45) calendar days written notice

31.7.1.4. Apply liquidated damages according to Section 34

31.8. Medical Cost Accruals

31.8.1. The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims.

31.9. Audits

31.9.1. The MCO shall allow DHHS and/or the NHID to inspect and audit any of the financial records of the MCO and its subcontractors. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)].

31.9.2. The MCO shall file annual and interim financial statements in accordance with the standards set forth below. This Section 31.9.2 will supersede any conflicting requirements in Exhibit C of this Agreement.

31.9.3. Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners ("NAIC"), annual audited financial statements that have been audited by an independent Certified Public Accountant. Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

31.9.4. The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the Insurance Department.

31.9.5. The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

31.10.Member Liability

31.10.1.The MCO shall not hold its Medicaid members liable for:

31.10.1.1. The MCO's debts, in the event of the MCO's insolvency [42 CFR 438.116(a); SMM 2086.6];

31.10.1.2. The covered services provided to the member, for which the State does not pay the MCO;

31.10.1.3. The covered services provided to the member, for which the State, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or

31.10.1.4. Payments for covered services furnished under an Agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided those services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(a), (b) and (c); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.2.Subcontractors and referral providers may not bill members any amount greater than would be owed if the entity provided the services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.3.The MCO shall cover continuation of services to members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency [SMM 2086.6B].

31.11.Denial of Payment

31.11.1.Payments provided for under the Agreement will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in [§1903(m)(5)(B)(ii) of the SSA; 42 CFR 438.726(b); 42 CFR 438.730(e)].

31.12.Federal Matching Funds

31.12.1.Federal matching funds are not available for amounts expended for providers excluded by Medicare, Medicaid, or Children's Health Insurance Program (CHIP), except for emergency services [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and §1903(i)(2) of the SSA; SMD letter 12/30/97]. Payments made to such providers are subject to recoupment from the MCO by DHHS.

31.13.Health Insurance Providers Fee

31.13.1.Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposed an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

31.13.1.1. To the extent such fees exist:

31.13.1.1.1.The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement no later than 120 days following its review and acceptance of the Contractor's Adjusted Fee.

31.13.1.1.2. To claim reimbursement for the Contractor's Adjusted Fee, the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment

for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:

Attn: Medicaid Finance Director

New Hampshire Medicaid Managed Care Program

129 Pleasant Street

Concord, NH 03304

32. Termination

32.1. Transition Assistance

32.1.1. Upon receipt of notice of termination of this Agreement by DHHS, the MCO 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 vendor or to perform the work itself.

32.1.1.1. Transition Plan

32.1.1.1.1. MCO must prepare a Transition Plan which is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date.

32.1.1.2. Data

32.1.1.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, 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.

32.1.1.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO shall transmit the information and records required 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.

32.2. Service Authorization

32.2.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received. Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS.

32.2.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

32.3. Claims Responsibilities

32.3.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

32.3.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

32.4. Termination for Cause

32.4.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if the MCO [42 CFR 438.610(c)(3); 42 CFR 434.6(a)(6)]:

32.4.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any member, including significant marketing abuses;

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

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

32.4.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS' notice and written request for compliance;

32.4.1.5. Violates state or federal law or regulation;

32.4.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

32.4.1.7. Becomes insolvent;

32.4.1.8. Fails to meet applicable requirements in sections §1932, §1903 (m) and §1905(t) of the SSA [42 CFR 438.708]. In the event of a termination by DHHS pursuant to 42 CFR 438.708, DHHS shall provide the MCO with a pre-termination hearing in accordance with 42 CFR 438.710;

32.4.1.9. 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

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

32.4.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance.

32.4.2. If DHHS terminates this Agreement for cause, the MCO 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 MCO. 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 reasonable attributable to the MCO's failure to perform any service in accordance with the terms of this Agreement.

32.5. Termination for Other Reasons

32.5.1. Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for sixty (60) calendar days after written notice thereof by the other party.

32.5.2. In the event the MCO gives written notice that it does not accept the actuarially sound capitation rates established by DHHS for Year 2 or later of the program, the MCO and DHHS will have thirty (30) days from the date of such notice or thirty (30) calendar days from the expiration of the rates indicated in Exhibit B, whichever comes later, to attempt to resolve the matter without terminating the agreement. If no resolution is reached in the above thirty (30) calendar days period, then the contract will terminate ninety (90) calendar days thereafter, or at the time that all members have been disenrolled from the MCO's plan, whichever date is earlier. In the event of such termination, the MCO shall accept the lesser of the most recently agreed to capitation rates or the new annual capitation rate for each rating category as payment in full for Covered Services and all other services required under this Agreement delivered to Members until all Members have been disenrolled from the MCO's plan consistent with any mutually agreed upon transition plans to protect Members.

32.6. Final Obligations

32.6.1. DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Amounts due to MCO for unpaid premiums, risk settlement, ABA therapies, High Dollar Stop Loss, shall be paid to MCO within one year of date of termination.

32.7. Survival of Terms

32.7.1. 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:

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

32.7.1.2. 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.

32.8. Notice of Hearing

32.8.1. Except because of change in circumstances or in the event DHHS terminates this Agreement pursuant to subsections (1), (2), (3) or (10 of Section 32.3.1, DHHS shall give the MCO ninety (90) days advance, written notice of termination of this Agreement and shall provide the MCO with an opportunity to protest said termination and/or request an informal hearing in accordance with 42 CFR 438.710. This notice shall specify the applicable provisions of this Agreement and the effective date of termination, which shall not be less than will permit an orderly disenrollment of members to the Medicaid FFS program or transfer to another MCO.

33. Agreement Closeout

33.1. Period

33.1.1. A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day the MCO is responsible for coverage of specific beneficiary groups or operating under this Agreement. During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS. Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

33.2. Data

33.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new MCO and/or DHHS shall define the information required during this period and the time frames for submission.

33.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO 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.

33.2.3. The MCO shall be responsible for continued submission of data to the Comprehensive Healthcare Information System during and after the transition in accordance with NHID regulations.

33.3. Service Authorizations

33.3.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with the new MCO to process service authorization requests received. Disputes between the MCO and the new MCO regarding service authorizations shall be resolved by DHHS.

33.3.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

33.4. Claims Responsibilities

33.4.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

33.4.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

34. Remedies

34.1. Reservation of Rights and Remedies

34.1.1. 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 MCO 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.

34.2. Liquidated Damages

34.2.1. DHHS and the MCO agree that it will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards indicated below throughout the life of this Agreement. Any breach by the MCO will delay and disrupt DHHS's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable.

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

34.2.3. DHHS shall make all assessments of liquidated damages. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify the MCO as specified in Section 34.9 of this Agreement.

34.2.4. The MCO shall submit a written Corrective Action Plan to DHHS, within five business days of notification, for review and approval prior to implementation of corrective action.

34.2.5. The MCO agrees that as determined by DHHS, failure to provide services meeting the performance standards below will result in liquidated damages as specified. The MCO agrees to abide by the Performance Standards and Liquidated Damages specified, provided that DHHS has given the MCO data required to meet performance standards in a timely manner. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

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

34.2.7. Liquidated damages may be assessed for each day, incidence or occurrence, as applicable, of a violation or failure.

34.2.8. The amount of liquidated damages assessed by DHHS to the MCO shall not exceed three percent (3%) of total expected yearly capitated payments, based on average annual membership from start date, for the MCO.

34.2.9. Liquidated damages related to timely processing of membership, claims and or/encounters shall be waived until such time as DHHS's file transfer systems and processes are operational.

34.3. Category 1

34.3.1. Liquidated damages up to $100,000 per violation or failure may be imposed for Category 1 events. Category 1 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.3.1.1. Acts that discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll an enrollee, except as permitted under law or under this Agreement, or any practice that would reasonably be expected to discourage enrollment by an enrollee whose medical condition or history indicates probable need for substantial future medical services. [42 CFR 700(b)(3) and 42 CFR 704(b)(2)].

34.3.1.2. A determination by DHHS that a recipient was not enrolled because of a discriminatory practice; $15,000 for each recipient subject to the $100,000 overall limit in 42 CFR 704(b)(2).

34.3.1.3. A determination by DHHS that a member found eligible for CFI services was relocated to a Nursing Facility due to MCO's failure to arrange for adequate in-home services in compliance with this Agreement and He-E801.09.

34.3.1.4. Misrepresentations of actions or falsifications of information furnished to CMS or the State.

34.3.1.5. Failure to comply with material requirements in this Agreement.

34.3.1.6. [Intentionally left blank.]

34.3.1.7. Failure to meet the Administrative Quality Assurance Standards specified in Section 29 of this Agreement.

34.3.1.8. Failure of the MCO to assume full operation of its duties under this Agreement in accordance with the implementation and transition timeframes specified herein.

34.4. Category 2

34.4.1. Liquidated damages up to $25,000 per violation or failure may be imposed for Category 2 events. Category 2 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.4.1.1. Misrepresentation or falsification of information furnished to a member, potential member, or health care provider.

34.4.1.2. Distribution, directly, or indirectly, through any agent or independent MCO, marketing materials that have not been approved by the State or that contain false or materially misleading information.

34.4.1.3. Violation of any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

34.4.1.4. Imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program; a maximum of $25,000 or double the amount of the charges, whichever is greater. The State will deduct the amount of the overcharge and return it to the affected member.

34.4.1.5. Failure to resolve member Appeals and Grievances within the timeframes specified in Section 19 of this Agreement.

34.4.1.6. Failure to ensure client confidentiality in accordance with 42 CFR 166 and 45 CFR 164; an incident of non-compliance shall be assessed as per member and/or per HIPAA regulatory violation.

34.4.1.7. Violation of a subcontracting requirement in this Agreement.

34.4.1.8. Failure to provide medically necessary services that the MCO is required to provide under law, or under this Agreement, to a member covered under this Agreement.

34.5. Category 3

34.5.1. Liquidated damages up to $10,000 per violation or failure may be imposed for Category 3 events. Category 3 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.5.1.1. Late, inaccurate, or incomplete turnover or termination deliverables.

34.6. Category 4

34.6.1. Liquidated damages up to $5,000 per violation or failure may be imposed for Category 4 events. Category 4 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.6.1.1. Failure to meet staffing requirements as specified in Section 6.

34.6.1.2. Failure to submit reports not otherwise addressed in this Section within the required timeframes.

34.7. Category 5

34.7.1. Liquidated damages as specified below may be imposed for Category 5 events. Category 5 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.7.1.1. Failure to provide a sufficient number of providers in order to ensure member access to all covered services and to meet the geographic access standards and timely access to service delivery specified in this Agreement:

34.7.1.1.1. $1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan;

34.7.1.1.2. $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan.

34.7.1.2. Failure to submit readable, valid health care data derived from Claims, Pharmacy or Encounter data in the required form or format, and timeframes required by the terms of this Agreement:

34.7.1.2.1. $5,000 for each day the submission is late;

34.7.1.2.2. for submissions more than thirty (30) calendar days late, DHHS reserves the right to withhold five percent (5%) of the aggregate

capitation payments made to the MCO in that month until such time as the required submission is made.

34.7.1.3. Failure to implement the Disaster Recovery Plan (DRP):

34.7.1.3.1. Implementation of the DRP exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2.

34.7.1.3.2. Implementation of the DRP exceeds the proposed time by more than two (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per day beginning with day 3 and up to day 5.

34.7.1.3.3. Implementation of the DRP exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days: twenty five thousand dollars ($25,000) per day beginning with day 6 and up to day 10.

34.7.1.3.4. Implementation of the DRP exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per day beginning with day 11.

34.7.1.4. Unscheduled system unavailability occurring during a continuous five (5) business day period:

34.7.1.4.1. Greater than or equal to two (2) and less than twelve (12) hours cumulative; up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof.

34.7.1.4.2. Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative; up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof.

34.7.1.4.3. Greater than or equal to twenty-four (24) hours cumulative; up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

34.7.1.5. Failure to correct a system problem not resulting in system unavailability within the allowed timeframe:

34.7.1.5.1. One (1) to fifteen (15) calendar days late; two hundred and fifty dollars ($250) per calendar day for days 1 through 15.

34.7.1.5.2. Sixteen (16) to thirty (30) calendar days late; five hundred dollars ($500) per calendar day for days 16 through 30.

34.7.1.5.3. More than thirty (30) calendar days late; one thousand dollars ($1,000) per calendar day for days 31 and beyond.

34.7.1.6. Failure to meet telephone hotline performance standards:

34.7.1.6.1. One thousand dollars ($1,000) for each percentage point that is below the target answer rate of ninety percent (90%) in thirty (30) seconds.

34.7.1.6.2. One thousand dollars ($1,000) for each percentage point that is above the target of a one percent (1%) blocked call rate.

34.7.1.6.3. One thousand dollars ($1,000) for each percentage point that is above the target of a five percent (5%) abandoned call rate.

34.7.1.7. The MCO shall resolve at least ninety-eight percent (98%) of member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO

34.8. Suspension of Payment

34.8.1. Payment of capitation payments shall be suspended when:

34.8.1.1. The MCO fails to cure a default under this Agreement within thirty (30) days of notification;

34.8.1.2. Failing to act on identified Corrective Action Plan;

34.8.1.3. Failure to implement approved program management or implementation plans;

34.8.1.4. Failure to submit or act on any transition plan, or corrective action plan, as specified in this Agreement; or

34.8.1.5. Upon correction of the deficiency or omission, capitation payments shall be reinstated.

34.9. Administrative and Other Remedies

34.9.1. In addition to other liquidated damages described in Category 1-5 events, DHHS may impose the following other remedies:

34.9.1.1. Appointment of temporary management of the MCO, as provided in 42 CFR 438.706, if DHHS finds that the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

34.9.1.2. Suspending enrollment of new members and/or changing auto-assignment of new members to the MCO.

34.9.1.3. Granting members the right to terminate enrollment without cause and notifying affected members of their right to disenroll.

34.9.1.4. Suspension of payment to the MCO for members enrolled after the effective date of the remedies and until CMS or DHHS is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur.

34.9.1.5. Termination of the Agreement if the MCO 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.

34.9.1.6. Civil monetary fines in accordance with 42 CFR 438.704.

34.9.1.7. Additional remedies allowed under State statute or regulation that address area of non-compliance specified in 42 CFR 438.700.

34.10. Notice of Remedies

34.10.1. Prior to the imposition of either liquidated damages or any other remedies under this Agreement, including termination for breach, with the exception of requirements related to the Implementation Plan, DHHS will issue written notice of remedies that will include, as applicable, the following:

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

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

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

34.10.1.4. Request for a Corrective Action Plan;

34.10.1.5. The timeframe and procedure for the MCO to dispute DHHS's determination. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

34.10.1.6. If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor.

35. Dispute Resolution Process

35.1. Informal Dispute Process

35.1.1. In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) days following the action or decision, the MCO may protest such action or decision by the delivery of a notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. The MCO 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 of the time, format and location of the presentations. At the conclusion of the presentations, the Director will consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation. The Director may appoint a designee to hear and determine the matter.

35.2. No Waiver

35.2.1. The MCO's exercise of its rights under Section 34.1 shall not limit, be deemed a waiver of, or otherwise impact the parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A or any applicable provisions of the N.H. Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

36. Confidentiality

36.1. Confidentiality of Records

36.1.1. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Agreement shall be confidential and shall not be disclosed by the MCO, 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 Agreement; 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 MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

36.2. MCO Owned or Maintained Data or Information

36.2.1. 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 the MCO. Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. The MCO acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense. If the MCO fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2017 – June 30, 2018
Capitation Payment

Eligibility Category	Capitation Rates
Low Income Children and Adults - Age 2-11 Months	$230.25
Low Income Children and Adults - Age 1-18 Years	130.78
Low Income Children and Adults - Age 19+ Years	398.96
Foster Care / Adoption	320.15
Breast and Cervical Cancer Program	1,612.84
Severely Disabled Children	1,162.00
Elderly and Disabled Adults	1,050.22
Dual Eligibles	227.70
Newborn Kick Payment	3,215.44
Maternity Kick Payment	3,168.61

NF Resident and Waiver Rate Cell	Capitation Rates
Nursing Facility Residents – Medicaid Only – Under 65	$2,118.93
Nursing Facility Residents – Medicaid Only – 65+	1,295.89
Nursing Facility Residents – Dual Eligibles – Under 65	247.69
Nursing Facility Residents – Dual Eligibles – 65+	85.64
Community Residents – Medicaid Only – Under 65	3,068.03
Community Residents – Medicaid Only – 65+	1,430.97
Community Residents – Dual Eligibles – Under 65	1,209.45
Community Residents – Dual Eligibles – 65+	399.92
Developmentally Disabled Adults – Medicaid Only	878.44
Developmentally Disabled Adults – Dual Eligibles	248.76
Developmentally Disabled and IHS Children	1,227.94
Acquired Brain Disorder – Medicaid Only	1,356.89
Acquired Brain Disorder – Eligibles Dual	311.11

Behavioral Health Population Rate Cells	Capitation Rates
Severe / Persistent Mental Illness – Medicaid Only	$2,232.40
Severe / Persistent Mental Illness – Dual Eligibles	1,699.66
Severe Mental Illness – Medicaid Only	1,504.34
Severe Mental Illness – Dual Eligibles	992.34
Low Utilizer – Medicaid Only	1,402.41
Low Utilizer – Dual Eligibles	566.73
Serious Emotionally Disturbed Child	919.20

July 1, 2017 – June 30, 2018
Capitation Payment – NH Health Protection Program, Alternative Benefit Plan for Medically Frail

Eligibility Category	Capitation Rate
Medically Frail	$ 1,207.45

July 1, 2017 – June 30, 2018
Capitation Payment – NH Health Protection Program, Transitional Population

Eligibility Category	Capitation Rate
NHHPP Transitional Population	$ 429.28
Maternity Kick Payment	$ 3,499.83

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for State Fiscal Year 2018, to be served among all contracts is 1,588,466. Accordingly, the price limitation for SFY18 among all contracts, for State Fiscal Year 2018, based on the projected members per month is $617,356,040.

3. Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement within 30 days following its review and acceptance of the Contractor's Adjusted Fee.

To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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G+C Approved
6-21-17 Tabled #18

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

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

Jeffrey A. Meyers
Commissioner

Deborah H. Fournier
Medicaid Director

May 24, 2017

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend the existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 529 Main Street, Suite 500, Charlestown, MA 02129, in order to reflect SFY 2018 rates prior to the beginning of SFY 2018. This amendment effects a SFY 2018 price limitation of $619,281,945.00 to the contracts for a cumulative contract value of $2,904,421,069.01 for all Medicaid Care Management contracts effective upon Governor and Executive Council approval through June 30, 2018. Funds to support this request are available in the following accounts in SFY 2018 and are anticipated to be available in SFY 2018 upon availability and continued appropriation of funds in future operating budgets.

Governor and Executive Council approved the original agreements on May 9, 2012, Item #54A, and approved subsequent amendments on June 19, 2013, Item #, 67A, February 12, 2014, Item #25, April 9, 2014, Item #44, June 18, 2014, Item #65A, July 16, 2014, Late Item "A", December 23, 2014, Item #11, June 24, 2015, Item #30, August 5, 2015, Tabled Item "A", December 16, 2015, Late Item "A3", January 27, 2016, Item #7B, March 9, 2016, Item #10A, June 29, 2016, Late Item "A2", and October 5, 2016, Item #12A. Funds are 50% Federal and 50% General Funds for the currently eligible Medicaid population, and NH Health Protection Program services are 95% Federal and 5% Other Funds in Calendar Year 2017, and 94% Federal and 6% Other Funds for Calendar Year 2018.

Funds to support this request are anticipated to be available in the following accounts in SFY 2018, upon the availability and continued appropriation of funds in the future operating budgets.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18	Total
Medicaid Care Mgmt. 010-047-79480000-101	$0	$250,000,000.00	$460,000,000.00	$490,897,701.00	$538,801,671.35	$540,813,917.00	$2,280,313,289.35
New Hampshire Health Protection Program: 010-047-3099-102	$0	$0.00	$193,000,000.00	$218,624,347.94	$134,015,403.72	$78,468,028.00	$624,107,779.66
Total	$0	$250,000,000.00	$653,000,000.00	$709,522,048.94	$672,817,075.17	$619,281,945.00	$2,904,421,069.01

EXPLANATION

The purpose of this amendment is to set the SFY 2018 Medicaid Managed Care capitation rates and to modify the contract to reflect certain requirements of the Centers for Medicare and Medicaid Services (CMS) Managed Care Final Rule (CMS 2390-F). These requirements do not extend the contract beyond the current expiration date of June 30, 2018. There is currently pending legislation that would require a re-procurement of the Medicaid managed care program for acute-care medical services as well as nursing facility services and home and community based services for seniors and people living with disabilities known as Choices for Independence, (CFI). Depending on the outcome of that proposed legislation, the Department may later this year bring an extension of the current contract, for consideration by the council, to the date established by the legislature regarding re-procurement in order to ensure continuity of care in the event a re-procurement yields vendors different than the incumbents.

CMS requires the state of NH to establish actuarially sound rates of reimbursement to the Managed Care Organizations (MCOs) on an annual basis. This contract amendment is the vehicle for bringing forward the rates for the next fiscal year. The rates apply to our standard Medicaid population as well as those who are medically frail and are transitional in the New Hampshire Health Protection eligibility group and served through the managed care delivery system. Exhibit A also reflects necessary changes that bring the contract into compliance with existing federal requirements in Title XIX of the Social Security Act, 42 CFR 438, including requirements incorporated into the CMS Managed Care Final Rule that will be effective July 1, 2017. Per CMS requirements, the Department has strengthened contract language specific to beneficiary supports and protections, clarified the grievance and appeal process, and provided for the calculation and reporting of the Medical Loss Ratio (MLR) in accordance with the Final Rule.

The capitation rates listed in Exhibit B reflect compliance with the Managed Care Final rule as well as program changes made by the Department of Health and Human Services, including continued improvement of mental health services under the Community Mental Health Agreement (CMHA), removal of mental health prior authorization prohibition, and the removal of the exclusion of coverage for gender dysphoria surgery.

Exhibit O to the Agreement has changed to reflect reporting requirements in support of Exhibit A requirements per the CMS Managed Care Final Rule. For example, the Department has modified, in accordance with the Final Rule, the Exhibit O to consolidate annual reporting requirements, provided for improved appeals and grievance reporting, and tracking of care management requirements for special needs populations.

The Department commenced the Medicaid Managed Care (MMC) Program in December 2013, providing acute-care medical services primarily to low-income children and adults, people living with disabilities, pregnant women, newborns, and those receiving breast and cervical cancer treatments. While not all Medicaid-eligible individuals are required to obtain their health care coverage through the MMC Program, at the present time, approximately 133,190 individuals receive their health care through this program.

The Medicaid managed care authorizing legislation SB 147, enacted in 2011, contemplated a five year agreement between the state and participating Medicaid managed care health plans. However, as noted above, the administration of Medicaid through the managed care delivery system did not begin until December of 2013. The continuation of the program into SFY18 allows the operational span of the program to reflect the intent of the authorizing legislation for the program to run for five years.

Tables 1 and 2 provide a summary of the impact of the program changes and calculate a 2.14% rate increase from SFY 2017 rates. The SFY2018 rates also assume efficiencies from a maturing relationship between the MCOs and the community mental health centers as well as progress that the Integrated Delivery Networks (IDNs) participating in the Building Capacity for Transformation Demonstration, are expected to make during SFY18 relative to improving the integration of physical and behavioral health care for Medicaid participants.

Table 1
New Hampshire Department of Health and Human Services
SFY 2018 Capitation Rate Change
Based on Projected SFY 2018 MCO Enrollment by Rate Cell

Population	SFY 2017 Capitation Rate	SFY 2018 Capitation Rate	Percentage Change
Base Population Rate Cells	$250.72	$252.74	0.80%
NF Resident and Waiver Population Rate Cells	547.71	575.98	5.16%
Behavioral Health Population Rate Cells	1,205.80	1,248.90	3.57%
Grand Total	**$349.20**	**$356.68**	**2.14%**

Table 2
New Hampshire Department of Health and Human Services
Medicaid Care Management Program Capitation Rates
Summary of SFY 2018 Capitation Rate Change Components

Rate Component	Rate Change	Annualized Dollar Impact
Impact of new managed care initiatives	-0.90%	($4,752,000)
Reduction of margin allowance from 2.0% to 1.5% of MCO revenue	-0.61%	(3,254,000)
Rate change for trend and other assumptions	2.68%	14,197,000
Rate change prior to program changes	**1.17%**	**6,191,000**
SFY 2018 program changes:		
Increase in funding for mental health services under the CMHA	1.19%	6,293,000
Removal of mental health formulary restriction under HB 1680	-0.70%	(3,731,000)
Implementation of gender dysphoria benefit	0.05%	286,000
Impact of increased SMI and SUD service capacity under HB 400	0.44%	2,305,000
Rate change due to SFY 2018 program changes	**0.97%**	**5,153,000**

There are no changes to the information technology components of these Agreements. As a result, an approval letter from the Department of Information Technology's Chief Information Officer is not included, and the Department has instead provided written notification of the amendment to the Chief Information Officer for his records.

The May 24, 2017, Governor and Council submission has been attached to this request as background information. Please note that only one copy of Exhibit A, Exhibit B, and Exhibit O have been attached as the Exhibits were voluminous, but were identical for both vendors.

Area Served: Statewide.

Source of funds: Federal financial participation rates for the currently eligible population will be 50% Federal Funds as appropriated by Congress for the entire period of this amendment, and 50% General Funds. Federal financial participation rates for the New Hampshire Health Protection services are 95% Federal Funds and 5% Other Funds in Calendar Year 2017, and 94% Federal Funds and 6% Other Funds in Calendar Year 2018, as appropriated by Congress.

In the event that Federal Funds become no longer available or are decreased below the 95% level in CY 2017 and the 94% level for the New Hampshire Health Protection population in CY 2018, consistent with RSA 126-A:5-b&c General Funds will not be requested to support this program; and medical services for the new adult population would end consistent with RSA126-A:5-b&c and the Special Terms and Conditions of the Premium Assistance Program Demonstration.

Respectfully submitted;

Deborah Fournier
Medicaid Director

Approved:

Jeffrey A. Meyers
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #14 to the
Medicaid Care Management Contract

This 14th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment Fourteen") dated this 23 day of May, 2017, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Granite State Health Plan, Inc., (hereinafter referred to as "the Contractor"), a New Hampshire Corporation with a place of business at 2 Executive Park Drive, Bedford, NH 03110.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013, Item #, 67A, Amendment #2 February 12, 2014, Item #25, Amendment #3 April 9, 2014, Item #44, Amendment #4 June 18, 2014, Item #65A, Amendment #5 July 16, 2014, Late Item "A", Amendment #6 December 23, 2014, Item #11, Amendment #7 June 24, 2015, Item #30, Amendment #8 August 5, 2015, Tabled Item "A", Amendment #9 December 16, 2015, Late Item "A3", Amendment #10 January 27, 2016, Item #7B, Amendment #11 March 9, 2016, Item #10A, Amendment #12 June 29, 2016, Late Item "A2", and Amendment #13 October 5, 2016, Item #12A, 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to increase the price limitation, and modify the scope of services to support continued delivery of these services, 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:

1. Amend Form P-37, Block 1.8, to decrease the Price Limitation by ($53,335,130.07) from $2,957,756,199.08 to read: $2,904,421,069.01 for a cumulative contract value for all Medicaid Care Management contracts.

2. Amend Form P-37, Block 1.9, to read Jonathan V. Gallo, Esq., Interim Director of Contracts and Procurement.

3. Amend Form P-37, Block 1.10 to read 603-271-9246.

4. Delete Exhibit A Amendment #11 in its entirety and replace with Exhibit A Amendment #12.

5. Delete Exhibit B Amendment #13 in its entirety and replace with Exhibit B Amendment #14.

6. Delete Exhibit O Amendment #7 in its entirety and replace with Exhibit O Amendment #8.

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

5.25.17
Date

Name: Deborah H. Fournier
Title: Medicaid Director

Granite State Health Plan, Inc.

5-24-17
Date

Name: Jennifer Wenzel
Title: Interim President & CEO

Acknowledgement of Contractor's signature:

State of New Hampshire County of Merrimack on 5/24/17, before the undersigned officer, personally appeared the person identified directly 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.

Lisa Marie Malanga
Signature of Notary Public or Justice of the Peace

LISA MARIE MALANGA, Notary Public
My Commission Expires February 6, 2018
Name and Title of Notary or Justice of the Peace

My Commission Expires: _____

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

OFFICE OF THE ATTORNEY GENERAL

5/25/17
Date

Name: Nicole A. Lapp
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:

State of New Hampshire
Department of Health and Human Services
Amendment #14 to the
Medicaid Care Management Contract

This 14th Amendment to the Medicaid Care Management contract (hereinafter referred to as "Amendment Fourteen") dated this 23 day of May, 2017, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Boston Medical Center Health Plan, Inc., (hereinafter referred to as "the Contractor"), a Massachusetts nonprofit corporation with a place of business at 529 Main Street, Suite 500, Charlestown, MA 02129.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 9, 2012, Item #54A, and approved subsequent amendments as follows: Amendment #1 June 19, 2013, Item #, 67A, Amendment #2 February 12, 2014, Item #25, Amendment #3 April 9, 2014, Item #44, Amendment #4 June 18, 2014, Item #65A, Amendment #5 July 16, 2014, Late Item "A", Amendment #6 December 23, 2014, Item #11, Amendment #7 June 24, 2015, Item #30, Amendment #8 August 5, 2015, Tabled Item "A", Amendment #9 December 16, 2015, Late Item "A3", Amendment #10 January 27, 2016, Item #7B, Amendment #11 March 9, 2016, Item #10A, Amendment #12 June 29, 2016, Late Item "A2", and Amendment #13 October 5, 2016, Item #12A, 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, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the parties agree to increase the price limitation, and modify the scope of services to support continued delivery of these services, 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:

1. Amend Form P-37, Block 1.8, to decrease the Price Limitation by ($53,335,130.07) from $2,957,756,199.08 to read: $2,904,421,069.01 for a cumulative contract value for all Medicaid Care Management contracts.

2. Amend Form P-37, Block 1.9, to read Jonathan V. Gallo, Esq., Interim Director of Contracts and Procurement.

3. Amend Form P-37, Block 1.10 to read 603-271-9246.

4. Delete Exhibit A Amendment #11 in its entirety and replace with Exhibit A Amendment #12.

5. Delete Exhibit B Amendment #13 in its entirety and replace with Exhibit B Amendment #14.

6. Delete Exhibit O Amendment #7 in its entirety and replace with Exhibit O Amendment #8.

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

5.25.17
Date

Name: Deborah H. Fournier
Title: Medicaid Director

Boston Medical Center Health Plan, Inc.

May 23, 2017
Date

Name: Susan Cooley
Title: President

Acknowledgement of Contractor's signature:

State of Massachusetts, County of Suffolk on 5/23/17, before the undersigned officer, personally appeared the person identified directly 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

Kim Graham, Executive Administrator
Name and Title of Notary or Justice of the Peace

My Commission Expires: 3/11/2022

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

OFFICE OF THE ATTORNEY GENERAL

5/25/17
Date

Name: Mega A. Yola
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

Medicaid Care Management Contract
Exhibit A - Amendment 12

Table of Contents

1. Introduction

1.1. Purpose

1.1.1. The purpose of this Agreement is to set forth the terms and conditions for the MCO's participation in the NH Medicaid Care Management Program.

1.2. Type of Agreement

1.2.1. This is a comprehensive full risk prepaid capitated contract. The MCO is responsible for the timely provision of all medically necessary services as defined under this Agreement. In the event the MCO incurs costs that exceed the capitation payments, the State of New Hampshire and its agencies are not responsible for those costs and will not provide additional payments to cover such costs.

1.3. Agreement Period

1.3.1. The Department of Health and Human Services (DHHS) is extending this agreement by 12 months to June 30, 2018.

2. Glossary of Terms and Acronyms

Abuse

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. 455.2]

Administrative Review Committee

Applies appropriate risk management principles to ensure due diligence and oversight to protect the patient, community and hospital in treating high risk or high profile patients.

Acquired Brain Disorder (HCBC-ABD) Waiver

"Acquired Brain Disorder (HCBC-ABD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of services and supports to individuals age 22 years and older with traumatic brain injuries or neurological disorders who are financially eligible for Medicaid and medically qualify for institutional level of care provided with a need for specialized nursing care or specialized rehabilitation services. Covered services are identified in He-M 522.

Adequate Network of Providers

A network sufficient in numbers, types and geographic location of providers, as defined in the Agreement, to ensure that covered persons will have access to health care services without unreasonable delay.

Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of New Hampshire, relating to the provision of health care when an individual is incapacitated (42 CFR 438.6, 438.10, 422.128, and 489.100).

Agreement

"Agreement" means the entire written Agreement between DHHS and the MCO, including any Exhibits, documents, and materials incorporated by reference.

Agreement Period

Dates indicated in the P-37 of this Agreement.

Agreement Year

NH State Fiscal Year.

Appeal

"Appeal" means a request for review of an action as described in this Agreement (42 CFR 438.400(b)).

Auxiliary aids

"Auxiliary aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of programs or activities conducted by the MCO. Such aids shall include readers, Brailled materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Care coordination

"Care coordination" is the deliberate organization of patient care activities between two or more participants (including the individual) involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial, and long term services and supports. Organizing care involves the marshalling of personnel and other resources needed to carry out all required services and supports, and requires the exchange of information among participants responsible for different aspects of care. (42 CFR 438.208).

Effective care coordination includes the following:

- Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Employs evidence-based clinical practices;
- Coordinates care across health care settings and providers, including tracking referrals;
- Actively assists patients to take personal responsibility for their health care;
- Provides education regarding avoidance of inappropriate emergency room use;
- Emphasizes the importance of participating in health promotion activities; Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- Uses appropriate community resources to support individual patients, families and caregivers in coordinating care.
- Adheres to conflict of interest guidelines set forth by the health plan and contractor (State of NH)
- Ensures the patient is aware of all appeal and grievance processes including how to request a different care coordinator.

- Facilitates ready and consistent access to long term supports and services that are, to the extent possible, integrated with all other aspects of the member's health care.

Centers for Medicare and Medicaid Services (CMS)

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare program.

Children's Health Insurance Program

"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009.

Children with Special Health Care Needs

Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Choices for Independence (HCBC-CFI) Waiver

"Choices for Independence (HCBC-CFI) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities. This term is also known as home and community based care for the elderly and chronically ill (HCBC-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and covered services are identified in He-E 801.

Chronic Condition

"Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence and includes, but is not limited to: a mental health condition; a substance use disorder; asthma; diabetes; heart disease; or obesity, as evidenced by a body mass index over twenty-five.

Cold Call Marketing

"Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential member or a member with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

Communications Plan

"Communications Plan" means a written strategy for timely notification to DHHS regarding expected or unexpected interruptions or changes that impact MCO policy, practice, operations, members or providers. The Communications Plan shall define the purpose of the communication, the paths of communication, the responsible MCO party required to communicate, and the time line and evaluation of effectiveness of MCO messaging to DHHS and to affected parties. The

Communications Plan shall also provide for the MCO to communicate with DHHS and respond to correspondence received from DHHS within one (1) business day on emergent issues and five (5) business days on non-emergent issues.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under federal or state law. Confidential Information includes, but is not limited to, Personal Information.

Conflict Free Care Coordination

"Conflict Free Care Coordination" separates clinical or non-financial eligibility determination from direct service provision. Care Coordinators and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual, their paid caregivers or to anyone financially responsible for the individual; robust monitoring and oversight are in place to promote consumer-direction and beneficiaries are clearly informed about their right to appeal or submit a grievance decisions about plans of care, eligibility determination and service delivery. State level oversight is provided to measure the quality of care coordination services and to ensure meaningful stakeholder engagement. In circumstances when one entity is responsible for providing care coordination and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

Conflict Free Care Management

(see Care Coordination)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

"Consumer Assessment of Healthcare Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey used to measure member experience of health care.

Consumer Direction

"Consumer Direction", also known as participant direction or self-direction, means a service arrangement whereby the individual or representative, if applicable, directs the services and makes the decisions about how the funds available for the individual's services are to be spent. It includes assistance and resources available to individuals in order to maintain or improve their skills and experiences in living, working, socializing, and recreating.

Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through member transitions between: facilities and home; facilities; providers; service areas; managed care contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral

(mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.

Contracted Services

"Contracted Services" means covered services that are to be provided by the MCO under the terms of this Agreement.

Covered Services

"Covered Services" means health care services as defined by DHHS and State and Federal regulation.

Debarment

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Developmental Disabilities (HCBC-DD) waiver

"Developmental Disabilities (HCBC-DD) waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports in non-institutional settings to individuals of any age with mental retardation and/or developmental disabilities who are financially eligible for Medicaid and medically qualify for institutional level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Division for Children, Youth & Families (DCYF) Services

"Division of Children, Youth & Families (DCYF) Services" means community based services and residential treatment services as indicated in Section 8.2 Covered Services Matrix as DCYF..

Early, Periodic Screening, Diagnostic and Treatment (EPSDT)

"EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of services in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r), 42 CFR 441.50, and DHHS EPSDT program policy and billing instructions. Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The MCO shall be responsible for all services found to be medically necessary services during the EPSDT exam.

Eligible Members

"Eligible Members" means individuals determined eligible by DHHS and eligible to enroll for health care services under the terms of this Agreement.

Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

Emergency Services

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

Equal Access

"Equal Access" means Steps 1 and 2, and NHHPP members having the same access to providers and services for those services common to both populations.

Execution Date

Date Agreement approved by Governor and Executive Council.

External Quality Review (EQR)

"External Quality Review (EQR" means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the MCO or its subcontractors furnish to members (42 CFR 438.320).

External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358.

Fraud

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 C.F.R. 455.2]

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights (42 CFR 438.400(b)).

Grievance Process

"Grievance Process" means the procedure for addressing member grievances (42 CFR 438.400(b)).

Grievance System

"Grievance System" means the overall system that includes grievances and appeals handled by the MCO and access to the State fair hearings (42 CFR 438, Subpart F).

Healthcare Effectiveness Data and Information Set (HEDIS)

"Healthcare Effectiveness Data and Information Set (HEDIS)" means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes a standardized survey of members' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

Health Home

"Health Home" means coordinated health care provided to members with special health care needs. At minimum, health home services include:

- Comprehensive care coordination including, but not limited to, chronic disease management;
- Self-management support for the member, including parents of caregivers or parents of children and youth;
- Care coordination and health promotion;
- Multiple ways for the member to communicate with the team, including electronically and by phone;
- Education of the member and his or her parent or caregiver on self-care, prevention, and health promotion, including the use of patient decision aids;
- Member and family support including authorized representatives;
- The use of information technology to link services, track tests, generate patient registries and provide clinical data;
- Linkages to community and social support services;
- Comprehensive transitional health care including follow-up from inpatient to other settings;
- A single care plan that includes all member's treatment and self-management goals and interventions ; and
- Ongoing performance reporting and quality improvement.

Home and Community Based Care (HCBC)

"Home and Community Based Care (HCBC)", also known as Home and Community Based Services (HCBS), means the waiver of sections 1902 (a) (10) and 1915 (c) of the Social Security Act which allows the federal Medicaid funding of long term services and supports in non-institutional settings for individuals who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility. This includes services provided under the Choices for Independence Waiver (HCBC-CFI) waiver program, Developmental Disabilities (HCBC-DD) waiver program, Acquired Brain Disorders (HCBC-ABD) waiver program, and In Home Supports (HCBC-IHS) waiver program.

Implementation Period

"Implementation Period" means each period of time prior to Program Start Date for the following segments: Step 1, NHHPP, SUD Phases 1, 2 and 3, and Step 2 Phases 1, 2, 3 and 4.

Implementation Plan

"Implementation Plan" means a proposed and agreed upon written and detailed listing of all objectives, tasks, activities, time allocation, deliverables, dependencies and responsible parties required to design, develop and implement the steps and phases of the Care Management Program. The Implementation Plan(s) shall include documentation of approvals as well as document change history.

In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver

"In Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver" means the home and community-based care 1915(c) waiver program that provides a system of long term care services and supports to families with children diagnosed with autism and other developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization. Covered services are identified in He-M524.

Long Term Services and Supports (LTSS)

"Long Term Services and Supports (LTSS)" means a broad array of supportive medical, personal, and social services needed when a person's ability to care for themselves is limited due to a chronic illness, disability, or frailty. Long term services and supports include nursing facility services, all four of New Hampshire's Home and Community Based Care Waivers, and services provided to children and families through the Division for Children, Youth & Families. Other applicable terms and definitions are identified in RSA 151 E, and Administrative Rules He-E 801, 803 and 805.

Managed Care Organization (MCO)

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible DHHS members under the DHHS Care Management Program.

Marketing

"Marketing" means any communication from the MCO to a potential member or member with another DHHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the MCO or to either not enroll or end enrollment with another DHHS contracted MCO (42 CFR 438.104(a)).

Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).

Medically Frail

"Medically frail" means a member who identifies as having a physical, mental, or emotional health condition that causes limitations in activities (e.g. bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Medically Necessary Services

"Medically Necessary Services" means services that are "medically necessary" as is defined in Section 23.2.2.

Member

"Member" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having an Agreement with DHHS (42 CFR 438.10(a)).

Member Handbook

"Member Handbook" means the handbook published by the Managed Care Organization (MCO) which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Member participation in Medicaid Managed Care and which means all informing requirements as set forth in 42 CFR 438.10.

Mental Health Court

A "Mental Health Court" is a specialized court docket for certain defendants with mental illnesses that substitutes a problem solving model for traditional criminal court processing.

National Committee for Quality Assurance (NCQA)

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

Necessary Services

"Necessary Services" means services to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no

other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term service and support.

New Hampshire Community Passport (NHCP) Program or Money Follows the Person (MFP) Demonstration

"Money Follows the Person (MFP)" means a federal demonstration that assists individuals residing in nursing institutions who meet CMS eligibility requirements find suitable healthcare programs to support them in the community and then assists them to transition from nursing institution care to community care. The program's intent is to help strengthen and improve community based systems of long term care for low-income seniors and individuals with disabilities. "New Hampshire Community Passport (NHCP) Program" means the MFP program specific to New Hampshire.

New Hampshire Health Protection Program (NHHPP)

Coverage provided through the MCOs for individuals newly eligible for Medicaid based the new income levels established in Senate Bill 413, Chapter 3, Laws of 2014; provided, however, that on and after January 1, 2016, coverage under this program shall be limited to said individuals who are Medically Frail and who choose to participate in the New Hampshire Health Protection Program and those MCO members who transition from an eligibility category other than the New Hampshire Health Protection Program who have not yet begun their coverage in the Premium Assistance Program.

New Member

"New Member" means a member transferring from FFS to an MCO, or transferring from another MCO.

Non-Participating Provider

"Non-Participating Provider" means a person, health care provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with the MCO to participate in a managed care organization's provider network, but provides health care services to members.

Participating Provider

"Participating Provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice and licensure, and who is under a written contract with the MCO to provide services to members under the terms of this Agreement.

Payment Reform Plan

"Payment Reform Plan" means an MCO's plan to engage its provider network in health care delivery and payment reform activities such as pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements, and shall contain information on the anticipated impact on member health outcomes, providers affected.

Physician Group

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Provider Incentive Plan

"Provider Incentive Plan" means any compensation arrangement between the MCO and a provider or provider group that may directly or indirectly improve the delivery of healthcare services as directed by a provider under the terms of this Agreement.

Program Management Plan

"Program Management Plan" means a proposed and agreed upon written detailed plan that includes a framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program as provided for in the Agreement. Includes documentation of approvals as well as document change history.

Program Start Date

Each date when MCO is responsible for coverage of services to its members with respect to the steps and phases of the Medicaid Care Management program.

Post-stabilization Services

"Post-stabilization Services" means contracted services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition (42 CFR 438.114 and 422.113).

Primary Care Provider (PCP)

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Agreement.

Provider

"Provider " means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Referral Provider

"Referral Provider" means a provider, who is not the member's PCP, to whom a member is referred for covered services

Regulation

"Regulation" means any federal, state, or local regulation, rule, or ordinance.

Risk

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a provider incentive plan, as defined herein.

Special Needs

Special Needs include chronic physical, developmental, behavioral or emotional conditions or adverse social circumstances resulting in need for help with related services of a type or amount beyond that required by members generally. Members with Special Needs include both Children and Adults.

Start Date of the Program

Date initial member enrollment begins.

Start of Program

Date initial member enrollment begins.

State

"State" or "state" means the State of New Hampshire

Step 1

Services as indicated in Section 8.2 Covered Services Matrix as Step 1.

Step 2

Services as indicated in Section 8.1 Covered Populations Matrix and Section 8.2 Covered Services Matrix as Step 2.

Subcontract

"Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

Substance Use Disorder

"Substance Use Disorder" is marked by a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. The cluster of symptoms includes tolerance; withdrawal or

use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substance or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol, tobacco and/or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use; craving or strong desire to use. Specific diagnostic criteria are specified in "Substance-Related and Addictive Disorders", in the Diagnostic and Statistical Manual of Disorders, 5th Edition, American Psychiatric Association, 2013.

Willing Provider

"Willing Provider" is a provider credentialed according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's provider agreement, including rates, and policy manual.

2.1. Acronyms

Unless otherwise indicated acronyms used in this Agreement are as follows:

ABD	Acquired Brain Disorders Waiver
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ANB	Aid to the Needy Blind
ANSA	Adult Needs and Strengths
APTD	Aid to the Permanently and Totally Disabled
ASC	Accredited Standards Committee
ASL	American Sign Language
BCCP	Breast and Cervical Cancer Program
BMH	Bureau of Mental Health
CAD	Coronary Artery Disease
CANS	Child and Adolescent Needs and Strengths Assessment
CDC	Centers for Disease Control and Prevention
CFI	Choices for Independence Waiver
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure

CHIP	Children's Health Insurance Program
CLA	Community Living Assessment
CLAS	Cultural and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
DCYF	Division of Children, Youth & Families
DD	Developmental Disabilities Waiver
DHHS	Department of Health and Human Services (New Hampshire)
DOB	Date of Birth
DME	Durable Medical Equipment
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospitals
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EST	Eastern Standard Time
ETL	Extract Transformation Load
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HC-CSD	Home Care for Children with Severe Disabilities
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ICF	Intermediate Care Facility

IHS	In Home Supports for Children with Developmental Disabilities Waiver
IME	Indirect Medical Education
LTSS	Long term services and supports
MCO	Managed Care Organization
MCIS	Managed Care Information System
MFP	Money Follows the Person Program
MIC	Medicaid Integrity Contractor
MEAD	Medicaid for Employed Adults with Disabilities
MMIS	Medicaid Management Information System
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NHCP	New Hampshire Community Passport Program
NF	Nursing Facility
NHHPP	New Hampshire Health Protection Program
NHID	New Hampshire Insurance Department
NPI	National Provider Identifier
OAA	Old Age Assistance
OBRA	Omnibus Budget Reconciliation Act
PBM	Pharmacy Benefit Management
PCP	Primary Care Provider
PE	Presumptive Eligibility
PIN	Personal Identification Number
POA	Present on Admission
QAPI	Quality Assessment and Performance Improvement
QIP	Quality Incentive Program
QM	Quality Management
QMB	Qualified Medicare Beneficiaries

RAC	Recovery Audit Contractors
RBC	Risk-Based Capital
RFP	Request for Proposal
RHC	Rural Health Center
RIMP	Risk Identification Mitigation Plan
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse and Mental Health Services Administration
SLMB	Special Low-Income Medicare Beneficiaries
SLRC	ServiceLink Resource Center network under the New Hampshire Aging and Disability Resource Center model
SNF	Skilled Nursing Facility
SSA	Social Security Act
SSI	Supplemental Security Income
SSAE	Statement on Standards for Attestation Engagements
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TQM	Total Quality Management
USC	United States Code
VA	Veteran's Administration

3. General Terms and Conditions

3.1. Agreement Elements

The Agreement between the parties shall consist of the following:

3.1.1. P-37 Agreement General Provisions.

3.1.2. 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 MCO.

3.1.3. Exhibit B – Capitation Rates.

3.1.4. Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS that must be adhered to in addition to those outlined in the P-37.

3.1.5. Exhibit D – Certification Regarding Drug Free Workplace Requirements – MCO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988.

3.1.6. Exhibit E – Certification Regarding Lobbying – MCO's Agreement to comply with specified lobbying restrictions.

3.1.7. 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.

3.1.8. Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – MCO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act.

3.1.9. Exhibit H – Certification Regarding Environmental Tobacco Smoke – MCO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities.

3.1.10. Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the MCO in reference to the Health Insurance Portability and Accountability Act.

3.1.11. Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.

3.1.12. Exhibit K – MCO's Program Management Plan approved by DHHS in accordance with Section 7.4 of this Agreement.

3.1.13. Exhibit L – MCO's Implementation Plan approved by DHHS in accordance with Sections 7.6-7.8 of this Agreement.

3.1.14. Exhibit M – MCO's RFP (#12-DHHS-CM-01) Technical Proposal, including any addenda, submitted by the MCO.

3.1.15. Exhibit N – Encounter Data.

3.1.16. Exhibit O –Quality and Oversight Reporting.

3.1.17. Exhibit P – Substance Use Disorder (SUD) Services.

3.2. Order of Documents.

In the event of any conflict or contradiction between or among the Agreement documents, the documents shall control in the above order of precedence.

3.3. 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 unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS and NHID.

3.4. Authority of the New Hampshire Insurance Department

Wherever, by any provision of this Agreement or by the laws and rules of the State of New Hampshire the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a Managed Care Organization in the State of New Hampshire.

3.5. Errors & Omissions

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

3.6. Time of the Essence

In consideration of the need to ensure uninterrupted and continuous Medicaid Managed Care services, time is of the essence in the performance of the Scope of Work under the Agreement.

3.7. CMS Approval of Agreement & Any Amendments

This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to the prior approval of the Centers for Medicare and Medicaid Services ("CMS."). Notwithstanding any other provision of this Agreement, DHHS agrees that enrollment for any step or phase will not commence until DHHS has received required CMS approval.

3.8. **Cooperation with Other Vendors and Prospective Vendors**

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. The MCO 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.

3.9. **Renegotiation and Reprocurement Rights**

3.9.1. Renegotiation of Agreement Terms

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

3.9.2. Reprocurement of the Services or Procurement of Additional Services

3.9.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO'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 MCO under the Agreement. DHHS shall give the MCO ninety (90) calendar days notice of intent to replace another MCO participating in the Medicaid Managed Care program or to add an additional MCO to the Medicaid Managed Care program.

3.9.3. Termination Rights Upon Reprocurement.

3.9.3.1. 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, the MCO shall have the rights and responsibilities set forth in Section 32 ("Termination"), Section 33 ("Agreement Closeout") and Section 35 ("Dispute Resolution Process").

4. Organization

4.1. Organization Requirements

4.1.1. Registrations and Licenses

The MCO shall be licensed by the New Hampshire Department of Insurance to operate as an Managed Care Organization in the State as required by New Hampshire RSA 420-B, and shall have all necessary registrations and licensures as required by the New Hampshire Insurance Department and any relevant federal and state laws and regulations. An MCO must be in compliance with the requirements of this section in order to participate in any Steps and Phases of the Medicaid Care Management program.

4.2. Articles & Bylaws

4.2.1. The MCO shall provide by the beginning of each Agreement year or at the time of any substantive changes written assurance from MCO's legal counsel that the MCO 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.

4.3. Relationships

4.3.1. Ownership and Control

4.3.1.1. The MCO shall notify DHHS of any person or corporation that has five percent (5%) or more ownership or controlling interest in the MCO, parent organization, subcontractors, and/or affiliates and shall provide

a. financial statements;

b. Date of Birth in the case of an individual;

c. Social Security numbers in the case of an individual; and

d. In the case of corporations primary business address, every business location, P.O. Box address, and tax identification number 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]. The MCO shall certify by its Chief Executive Officer that this information provided to DHHS is accurate to the best of the officer's information, knowledge, and belief [42 CFR 438.606].

4.3.1.2. The MCO shall inform DHHS and the New Hampshire Insurance Department (NHID) of its intent for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of the action.

4.3.1.3. The MCO shall inform key DHHS and NHID staff by phone and by email within one business day of when any key MCO staff learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement with DHHS.

4.3.2. Prohibited

4.3.2.1. The MCO shall not knowingly have a relationship with the following:

4.3.2.1.1. 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

4.3.2.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 4.3.2.1.

4.3.2.1.3. An individual is described as follows:

a. A director, officer, or partner of the MCO;

b. A subcontractor of the MCO;

c. A person with beneficial ownership of five percent (5%) or more of the MCO's equity; or

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

4.3.3. The MCO shall retain any data, information, and documentation regarding the above described relationships for a period no less than 10 years [42 CFR 438.3(u)].

4.3.4. The MCO shall conduct background checks on all employees actively engaged in the Care Management Program. 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.

4.3.5. The MCO shall not and shall certify it does not employ or contract, directly or indirectly, with:

4.3.5.1. 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;

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

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

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

4.3.5.5. 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.

5. Subcontractors

5.1. MCO Obligations

5.1.1. The MCO remains fully responsible for the obligations, services and functions performed by its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by MCO employees, and for the purposes of this Agreement such work will be deemed performed by the MCO. DHHS reserves 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 or use of a subcontractor.

5.1.2. The MCO shall provide written policies for all employees and subcontractors describing in detail the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the SSA including information about rights of employees to be protected as whistleblowers.

5.1.3. The MCO regardless of its written agreements with any subcontractors maintains ultimate responsibility for complying with this Agreement.

5.1.4. The MCO shall inform all subcontractors at the time of entering into an agreement with the MCO about the grievance and appeal system as described in 42 CFR 438.10(g).

5.1.5. The MCO shall have a written agreement between the MCO and each subcontractor in which the subcontractor:

5.1.5.1.Agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and MCO contract provisions;

5.1.5.2.Agrees to hold harmless DHHS and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO;

5.1.5.3.Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors;[

5.1.5.4. Agrees that the State, CMS, the HHS Inspector General, or their designees shall have the right to audit, evaluate, and inspect any premises,

physical facilities, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO Managed Care activities;

5.1.5.5. Agrees that it can be audited for ten years from the final date of the contract period or from the date of any completed audit, whichever is later; and

5.1.5.6. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk [42 CFR 438.230].

5.1.4 The MCO shall notify DHHS in writing within 10 business days if a subcontractor is cited for corrective action by any federal or state regulatory authority.

5.2. Notice and Approval

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

5.2.2. The MCO 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.

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

5.2.4. DHHS may grant a written exception to the notice requirements of 5.2.1 and 5.2.2 if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period or deems that the subcontractor is not a material subcontractor.

5.2.5. The MCO shall notify DHHS within twenty four (24) hours after receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

5.2.6. The MCO shall notify DHHS of any material breach of an agreement between the MCO and the subcontractor within twenty four (24) hours of validation that such breach has occurred.

5.3. MCO's Oversight

5.3.1. The MCO shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor in accordance with 42 CFR 438.230 and SMM 2087.4, including:

5.3.1.1. The MCO shall have a written agreement between the MCO and the subcontractor that specifies the activities and responsibilities delegated to the subcontractor and its transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate as determined by the MCO or NH DHHS. In such written agreement, the subcontractor shall also agree to perform the delegated activity and related reporting responsibilities as specified in the subcontractor agreement and the applicable responsibilities in this Agreement.

5.3.1.2. All subcontracts related to any aspect of the MCO Managed Care activities shall fulfill the applicable requirements of 42 CFR Part 438for those responsibilities delegated to the subcontractor .

5.3.1.3. The MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

5.3.1.4. The MCO shall monitor the subcontractor's performance on an ongoing basis consistent with industry standards and State and Federal laws and regulations.

5.3.1.5. The MCO shall audit the subcontractor's care systems at least annually and when there is a substantial change in the scope or terms of the subcontract agreement.

5.3.1.6. The MCO shall identify deficiencies or areas for improvement, if any, with respect to which the MCO and the subcontractor shall take corrective action.

5.3.1.7. The MCO shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the Agreement between the MCO and DHHS.

5.3.1.8. If the MCO identifies deficiencies or areas for improvement are identified, the MCO shall notify DHHS and take corrective action within seven (7) calendar days of identification. The MCO shall provide DHHS with a copy of the Corrective Action Plan, which is subject to DHHS approval.

5.4. Transition Plan

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

6. Staffing

6.1. Key Personnel

6.1.1. The MCO shall commit key personnel to the New Hampshire Care Management program on a full-time basis. Positions considered to be key personnel are listed below, along with any specific requirements for each position:

6.1.1.1. Executive Director: Individual has clear authority over the general administration and day-to-day business activities of this Agreement.

6.1.1.2. Finance Officer: Individual is responsible for accounting and finance operations, including all audit activities.

6.1.1.3. Medical Director: Physician licensed by the NH Board of Medicine shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health). The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

6.1.1.4. The MCO will also have a physician available to the New Hampshire Care Management program with experience in the diagnosis and treatment of SUD.

6.1.1.5. Quality Improvement Director: Individual is responsible for all Quality Assessment and Performance Improvement (QAPI) program activities. This person shall be a licensed clinician with relevant experience in quality management for physical and/or behavioral healthcare.

6.1.1.6. Coordinators for the following five (5) functional areas shall be responsible for overseeing care coordination activities for MCO members with complex medical, behavioral health, developmental disability and long term care needs. They shall also serve as liaisons to DHHS staff for their respective functional areas:

6.1.1.6.1. Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

6.1.1.6.2. Behavioral Health Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within community mental health services.

6.1.1.6.3. Developmental Disabilities Coordinator: The individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

6.1.1.6.4. Substance Use Disorder Coordinator: The individual will have a minimum of a Master's Degree in a SUD related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to substance use disorders.

6.1.1.6.5. Long Term Services and Supports Coordinator: The individual will have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a LTSS related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care.

6.1.1.7. Network Management Director: Individual is responsible for development and maintenance of the MCO's provider network.

6.1.1.8. Member Services Manager: Individual is responsible for provision of all MCO member-services activities. The manager shall have prior experience with Medicaid or Medicare populations.

6.1.1.9. Utilization Management (UM) Director: Individual is responsible for all UM activities. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services and Necessary Services.

6.1.1.10. Systems Director/Manager: Individual is responsible for all MCO information systems supporting this Agreement including, but not limited to, continuity and integrity of operations, continuity flow of records with DHHS' information systems and providing necessary and timely reports to DHHS.

6.1.1.11. Claims/Encounter Manager: Individual is responsible for and is qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

6.1.1.12. Grievance Coordinator: Individual is responsible for overseeing the MCO's Grievance System.

6.1.1.13. Fraud, Waste, and Abuse Coordinator: Individual is responsible for tracking, reviewing, monitoring, and reducing fraud, waste, and abuse.

6.1.1.14. Compliance Officer: Individual is responsible for MCO's compliance with the provisions of this Agreement and all applicable state and federal regulations and statutes.

6.1.2. The MCO shall have an on-site presence in New Hampshire. The following key personnel shall be located in New Hampshire:

6.1.2.1. Executive Director

6.1.2.2. Medical Director

6.1.2.3. Quality Improvement Director

6.1.2.4. Special Needs Coordinator

6.1.2.5. Behavioral Health Coordinator

6.1.2.6. Developmental Disabilities Coordinator

6.1.2.7. Long Term Services and Supports Coordinator

6.1.2.8. Network Management Director

6.1.2.9. Fraud, Waste, and Abuse Coordinator

6.1.2.10. Grievance Coordinator

6.1.2.11. Substance Use Disorder Coordinator

6.1.2.12. Claim Encounter Manager

6.1.2.13. Provider Relations Manager

6.1.3. The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) days prior to start of program.

6.1.4. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.

6.1.5. DHHS may grant a written exception to the notice requirements of this Section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

6.2. General Staffing Provisions

6.2.1. The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 34.

6.2.2. The MCO shall ensure that all staff have appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

6.2.3. All key staff shall be available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

6.2.4. The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in New Hampshire with DHHS.

6.2.5. The MCO shall notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

6.2.6. If a member of the MCO's key staff is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit proposed alternate staff to DHHS for review and approval, which approval shall not be unreasonably withheld.

6.3. Staffing Contingency Plan

6.3.1. The MCO shall, deliver to DHHS a Staffing Contingency Plan within thirty (30) calendar days of signing this Agreement and after any substantive changes to the Staffing Contingency Plan. The Plan shall include but is not limited to:

6.3.1.1. The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the Agreement;

6.3.1.2. Allocation of additional resources to the Agreement in the event of inability to meet any performance standard;

6.3.1.3. Replacement of key personnel with staff with similar qualifications and experience;

6.3.1.4. Discussion of time frames necessary for obtaining replacements;

6.3.1.5. MCO's capabilities to provide, in a timely manner, replacements/additions with comparable experience; and

6.3.1.6. The method of bringing replacements/additions up-to-date regarding this Agreement.

7. Program Management and Planning

7.1. General

7.1.1. The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to members enrolled in the New Hampshire Medicaid Program and provide for all aspects of managing such program, including claims processing and operational reports. The MCO shall establish and demonstrate audit trails for all claims processing and financial reporting carried out by the MCO's staff, system, or designated agents.

7.2. Representation and Warranties

7.2.1. The MCO warrants that all Managed Care 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.

7.2.2. The MCO acknowledges that in entering this Agreement, DHHS has relied upon representations made by the MCO in its RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda, with respect to delivery of Managed Care. In reviewing and approving the program management and planning requirements of this Section, DHHS reserves the right to require the MCO to develop plans that are substantially and materially consistent with the representations made in the MCO's RFP (#12-DHHS-CM-1) or RFA (15-DHHS-CM-01), Technical and Cost Proposal, including any addenda.

7.3. Audit Requirements

7.3.1. No later than forty (40) business days after the end of the State Fiscal Year each June 30, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period. DHHS will share the report with internal and external auditors of the State of New Hampshire and federal oversight agencies. The SSAE 16 Type 2 report shall include:

7.3.1.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period.

7.3.1.2. Written assertion by the MCO's management about whether:

7.3.1.2.1. The aforementioned description fairly presents the system in all material respects;

7.3.1.2.2. The controls were suitably designed to achieve the control objectives stated in that description; and

7.3.1.2.3. The controls operated effectively throughout the specified period to achieve those control objectives.

7.3.1.3. Report of the MCO's auditor, which:

7.3.1.3.1. Expresses an opinion on the matters covered in management's written assertion; and

7.3.1.3.2. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

7.3.2. The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO. If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

7.3.3. The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

7.3.4. DHHS, CMS, the Office of the Inspector General, the Comptroller General, and their designees have the right to inspect and audit any records of the MCO, or its subcontractors and conduct on-site reviews of the MCO's operations at the MCO's expense. These on-site visits may be unannounced. The MCO shall fully cooperate with DHHS' on-site reviews. This right exists for ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

7.3.5. DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing Corrective Action Plans and review MCO compliance with requirements and standards as specified in this Agreement.

7.3.6. The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.

7.4. Program Management and Communications Plans

7.4.1. The MCO shall submit a Program Management Plan (PMP) to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Annually, thereafter, the MCO shall submit an updated PMP to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.4.1.1. The PMP shall elaborate on the general concepts outlined in the MCO's proposal and the section headings of Exhibit A;

7.4.1.2. The PMP shall describe how the MCO will operate in New Hampshire by outlining management processes such as communications, workflow, overall systems as detailed in the section headings of Exhibit A, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to member and provider experiences; and

7.4.1.3. The PMP shall outline the MCO integrated organizational structure including New Hampshire-based resources and its support from corporate, subcontractors, and workgroups or committees.

7.4.1.4. The MCO shall submit a Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the scheduled start date of the program. Thereafter, the MCO shall submit an updated Communications Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5. Emergency Response Plan

7.5.1. The MCO shall submit an Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to each Program Start Date. Thereafter, the MCO shall submit an updated Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to the commencement of each Agreement year.

7.5.2. The plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

7.5.2.1. Employee training;

7.5.2.2. Essential business functions and key employees within the organization necessary to carry them out;

7.5.2.3. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; and

7.5.2.4. Communication with staff, members, providers, subcontractors and suppliers when normal systems are unavailable;

7.5.2.5. Plans to ensure continuity of services to providers and members;

7.5.2.6. How the MCO will coordinate with and support DHHS and the other MCOs; and

7.5.2.7. How the plan will be tested, updated and maintained.

7.6. Step 1 Program Implementation Plan

7.6.1. Submission and Contents of the Plan

7.6.1.1. The MCO shall submit a "Step 1 Program Implementation Plan" (Step 1 Implementation Plan) to DHHS for review and approval no later than fourteen (14) calendar days after the signing of this Agreement. The Step 1 Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for implementation of the Plan:

7.6.1.1.1. Provider credentialing/contracting;

7.6.1.1.2. Provider payments;

7.6.1.1.3. Member Services;

7.6.1.1.4. Member Enrollment;

7.6.1.1.5. Pharmacy Management;

7.6.1.1.6. Care Coordination;

7.6.1.1.7. Utilization Management;

7.6.1.1.8. Grievance System;

7.6.1.1.9. Fraud, Waste, and Abuse;

7.6.1.1.10. Third-Party Liability;

7.6.1.1.11. MCIS ;

7.6.1.1.12. Financial management; and

7.6.1.1.13. Provider and member communications.

7.6.1.2. The Step 1 Program Implementation Plan shall become an addendum to this Agreement as Exhibit L.

7.6.2. Implementation

7.6.2.1. Upon approval of the Step 1 Implementation Plan, the MCO shall implement the Plan as approved covering the Step 1 populations and services identified in Sections 8.1 and 8.2 of this Agreement.

7.6.2.2. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.6.2.3. The MCO must obtain prior written approval from DHHS for any changes or deviations from the submitted and approved Plan.

7.6.2.4. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.6.2.4.1. Progress on Step 1 Implementation Plan;

7.6.2.4.2. Risks/Issues and mitigation strategy;

7.6.2.4.3. Modifications to the Step 1 Implementation Plan;

7.6.2.4.4. Progress on any Corrective Action Plans;

7.6.2.4.5. Program delays; and

7.6.2.4.6. Upcoming activities.

7.6.2.5. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.6.3. Readiness Reviews

7.6.3.1. DHHS intends to conduct two (2) readiness reviews of the MCO during the implementation phase prior to the Program Start Date. The first review shall take place thirty (30) days after contract effective date or scheduled after DHHS has verified that at least two MCOs have satisfied the DHHS Substantial Provider Network reporting requirements, whichever comes later, and will take place ninety(90) calendar days prior to the Program Start Date. The second review shall take place thirty (30) calendar days prior to the Program Start Date. The MCO shall fully cooperate with DHHS during these readiness reviews. During the readiness reviews, DHHS shall assess the MCO's progress towards a successful program implementation through regular reporting activities. The review shall include validation of readiness in multiple areas, including but not limited to:

7.6.3.1.1. MCO's ability to pay a claim;

7.6.3.1.2. MCO's network adequacy;

7.6.3.1.3. MCO's member transition plan;

7.6.3.1.4. MCO's system preparedness;

7.6.3.1.5. MCO's member experience procedures;

7.6.3.1.6. Grievance System; and

7.6.3.1.7. MCO subcontracts.

7.6.3.2. DHHS may adjust the timing, number and requirements of Readiness Reviews at its sole discretion.

7.6.3.3. Should the MCO fail to pass either readiness review, the MCO shall submit a Corrective Action Plan to DHHS sufficient to ensure the MCO passes the readiness review and shall complete implementation on schedule. This Corrective Action Plan shall be integrated into the overall program Step 1 Implementation Plan as a modification subject to review and approval by DHHS. DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified and/or apply liquidated damages as provided in Section 34.

7.6.3.4. During the first one hundred and eighty (180) days following the effective date of this Agreement or within ninety (90) days prior to the Program Start Date, whichever comes later, DHHS may give tentative approval of the MCO's required policies and procedures.

7.6.3.5. DHHS may at its discretion suspend application of the remedies specified in Section 34, except for those required under 42 CFR 700 and Section 1903(m) or Section 1932 of the Social Security Act, provided that the MCO is in compliance with any Corrective Action Plans developed during the readiness period, unless the MCO fails to meet the start date of the NH Medicaid Care Management program.

7.6.3.6. The start date of the Medicaid Care Management program shall be when at least two MCOs have met the readiness requirements 7.6.3.1.

7.7. Step 2 Program Implementation Plans

7.7.1. Implementation of Step 2 will take place in four phases:

7.7.1.1. Phase 1. Mandatory Enrollment populations indicated in Section 8.1 – Program Start Date February 1, 2016;

7.7.1.2. Phase 2. Choices For Independence Waiver ("CFI") – Program Start Date upon approval by DHHS of Implementation and Transition Plans developed by DHHS and the MCOs with consideration of stakeholder input and in compliance with legislative requirements;

7.7.1.3. Phase 3. Nursing Facility services ("NF") and DCYF services – Program Start Date upon approval by DHHS of Implementation and Transition Plans developed by DHHS and the MCOs with consideration of stakeholder input and in compliance with legislative requirements;

7.7.1.4. Phase 4. Developmental Disabilities, Acquired Brain Disorder and In Home Supports for Children with Developmental Disabilities waivers ("Waiver Services") will commence on a date to be determined by DHHS in consultation with the MCOs.

7.7.1.5. The MCO shall submit a Program Implementation Plan for each phase described above for DHHS approval no later than sixty (60) calendar days prior to the start date of initial member enrollment for each phase of Step 2, or as otherwise specified by DHHS.

7.7.2. The MCO shall participate in all DHHS trainings in preparation of implementing new phases of the program.

7.7.3. Each Step 2 Program Implementation Plan shall address the following elements and include timelines and identify staff responsible for implementation of the applicable Step 2 phase:

7.7.3.1. Provider credentialing/contracting processes for specific provider types

7.7.3.2. Capacity to pay providers according to the methodologies prescribed by DHHS,

7.7.3.3. Provider capacity sufficient to serve the population of each Step 2 phase without compromising access for Step 1 and NH Health Protection Plan (NHHPP) members

7.7.3.4. Plans to conduct communication, training, and outreach to specific provider groups.

7.7.3.5. Plans to conduct communication, training and outreach to members and member families

7.7.3.6. Production of new Member handbooks or updates to reflect the differences in Step 2 covered services

7.7.3.7. Call center training for Step 2 covered service-related inquiries

7.7.3.8. Performance standards for call center staff

7.7.3.9. Continuity of Care Policy;

7.7.3.10. Continuity of Care Transition Plan;

7.7.4. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for Step 2 implementation work.

7.7.5. The MCO shall follow its Step 2 Program Implementation Plan as approved by DHHS. The MCO must obtain prior written approval from DHHS for any change to the approved Step 2 Plans.

7.7.6. Throughout the implementation phase, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall including representatives of key MCO implementation staff and relevant DHHS personnel.

7.7.7. Throughout the implementation phase, the MCO shall submit a weekly status report to DHHS. The status reports at a minimum, shall include:

7.7.7.1. Risks/Issues and mitigation strategy;

7.7.7.2. Progress on Step 2 Implementation Plan;

7.7.7.3. Modifications to the Step 2 Implementation Plan;

7.7.7.4. Status report(s) on Corrective Action Plan(s);

7.7.7.5. Program delays; and

7.7.7.6. Upcoming activities.

7.7.8. DHHS shall conduct readiness reviews as follows:

7.7.8.1. Two readiness reviews for each phase of Step 2: one ninety (90) days prior to the Program Start Date of the Step 2 phase, and one thirty (30) days prior to the Program Start Date of the Step 2 phase

7.7.9. The MCO shall fully cooperate with DHHS during these readiness review(s).

7.7.10. DHHS may modify the timing and focus of the readiness reviews as appropriate, in consultation with the MCOs.

7.7.11. Should the MCO fail to successfully pass the readiness review(s), the MCO shall submit a Corrective Action Plan to pass the readiness review(s) and complete implementation on schedule. Corrective Action Plans will be incorporated into the Step 2 Implementation Plan and reported on in the weekly status report.

7.7.12. Should an MCO fail to correct deficiencies within twenty (20) calendar days, DHHS reserves the right to terminate the MCO's Agreement.

7.8. NHHPP Program Implementation Plan

7.8.1. Submission and Contents of the NHHPP Implementation Plan

7.8.1.1. The MCO shall submit a NHHPP Implementation Plan to DHHS for review and approval no later than fourteen days (14) calendar days after signing the related contract amendment. The Implementation Plan shall address, at a minimum, the following elements and include timelines and identify staff responsible for the implementation of the Plans:

7.8.1.1.1. Provider credentialing/contracting for SUD and chiropractic providers;

7.8.1.1.2. Provider agreements and or amendments for services provided to NHHPP members;

7.8.1.1.3. Paying NHHPP providers according to the methodology prescribed by DHHS Section 21.2.10.4;

7.8.1.1.4. Sufficient provider capacity to serve NHHPP population without compromising access for Step 1 members;

7.8.1.1.5. Production of new Member handbooks or updates to reflect the differences for the NHHPP plan members;

7.8.1.1.6. Implementation of a process by which to reduce inappropriate emergency room utilization;

7.8.1.1.7. Implementation of new member co-payments and cost sharing as required in Medicaid Care Management; and

7.8.1.1.8. Call center training for NHHPP related inquiries.

7.8.2. NHHPP Implementation

7.8.2.1. The MCO shall successfully complete all implementation activities at its own cost and will not be reimbursed by DHHS for this phase of work.

7.8.2.2. Throughout the implementation period, the MCO shall submit weekly status reports to DHHS that address:

7.8.2.2.1. Progress on NHHPP Implementation Plan;

7.8.2.2.2. Risks/Issues and mitigation strategy;

7.8.2.2.3. Modifications to the NHHPP Implementation Plan;

7.8.2.2.4. Progress on any Corrective Action Plans;

7.8.2.2.5. Program delays; and

7.8.2.2.6. Upcoming activities.

7.8.2.3. Throughout the implementation period, the MCO shall conduct weekly implementation status meetings with DHHS at a time and location to be decided by DHHS. These meetings shall include representatives of key MCO implementation staff and relevant DHHS personnel.

7.8.3. NHHPP Readiness Review

7.8.3.1. DHHS intends to conduct one (1) readiness review no sooner than thirty (30) days prior to the enrollment of NHHPP members. The MCO shall fully cooperate with DHHS during this review.

8. Covered Populations and Services

8.1. Covered Populations Matrix

The MCO shall provide managed care services to population groups deemed by DHHS to be eligible for managed care. The planned phase-in of population groups is depicted in the matrix below.

OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[1]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Beckett) - With Member Opt Out	X			
HC-CSD (Katie Beckett) - Mandatory Enrollment		X		
Children with special health care needs (enrolled in Special Medical Services / Partners in Health) - Mandatory Enrollment		X		
Children with Supplemental Security Income (SSI) - Mandatory Enrollment		X		
M-CHIP	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			

[1] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

Pregnant Women	X			
Native Americans and Native Alaskans w/ member opt out[2]	X			
Native Americans and Native Alaskans - Mandatory Enrollment (w/CMS waiver)		X		
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
Members with VA Benefits				X
NHHPP Enrollees			X	
Medically Frail			X	
Family Planning Only Benefit				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X
Health Insurance Premium Payment Program (HIPP)				X

8.2. Covered Services Matrix Overview

The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with CMS-approved Medicaid State Plan, to its members, reflecting the planned phase-in.

[2] Per 42 USC §1396u-2(a)(2)(c); however, NH has no recognized tribes.

Maternity & Newborn Kick Payments	x	x	x				
Inpatient Hospital	x	x	x				
Outpatient Hospital[3]	x	x	x				
Inpatient Psychiatric Facility Services Under Age 21[4]	x	x	x				
Physicians Services	x	x	x				
Advanced Practice Registered Nurse	x	x	x				
Rural Health Clinic & FQHC	x	x	x				
Prescribed Drugs[5]	x	x	x				
Community Mental Health Services	x	x	x				
Psychology	x	x	x				
Ambulatory Surgical Center	x	x	x				
Laboratory (Pathology)	x	x	x				
X-Ray Services	x	x	x				
Family Planning Services	x	x	x				
Medical Services Clinic (mostly methadone clinic)	x	x	x				
Physical Therapy[6]	x	x	x				
Occupational Therapy[7]	x	x	x				

[3] Including facility and ancillary services for dental procedures

[4] Under age 22 if individual admitted prior to age 21

[5] Except as indicated in Section 14.1.15

[6] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

Speech Therapy[8]	x	x	x				
Audiology Services	x	x	x				
Podiatrist Services	x	x	x				
Home Health Services	x	x	x				
EPSDT Services	x	x	x				
Private Duty Nursing	x	EPSDT only	x				
Adult Medical Day Care	x	EPSDT only	x				
Personal Care Services	x	EPSDT only	x				
Hospice	x	x	x				
Optometric Services Eyeglasses	x	x	x				
Furnished Medical Supplies & Durable Medical Equipment	x	x	x				
Non-Emergent Medical Transportation [9]	x	x	x				
Ambulance Service	x	x	x				
Wheelchair Van	x	x	x				
Independent Care Management	x	EPSDT only	x				
Home Visiting Services	x	x[10]					

[7] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[8] Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

[9] Also includes mileage reimbursement for medically necessary travel

[10] Provided within the SUD benefit

Acquired Brain Disorder Waiver Services						x	
Developmentally Disabled Waiver Services						x	
Choices for Independence Waiver Services				x			
In Home Supports Waiver Services						x	
Skilled Nursing Facility					x		
Skilled Nursing Facility Atypical Care					x		
Inpatient Hospital Swing Beds, SNF					x		
Intermediate Care Facility Nursing Home					x		
Intermediate Care Facility Atypical Care					x		
Inpatient Hospital Swing Beds, ICF					x		
Glencliff Home					x		
Developmental Services Early Supports and Services						x	
Home Based Therapy – DCYF					x		
Child Health Support Service – DCYF					x		
Intensive Home and Community Services – DCYF					x		
Placement Services – DCYF					x		
Private Non-Medical Institutional For Children – DCYF					x		
Crisis Intervention – DCYF					x		
Substance use disorder services as per He-W 513	x	x	x				
Chiropractic services (NHHPP population only)		x					

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)[11]					x		
Medicaid to Schools Services							x
Dental Benefit Services[12]							x

8.3. Covered Services Additional Provisions

8.3.1. While the MCO may provide a higher level of service and cover additional services than required by DHHS, the MCO shall, at a minimum, cover the services identified at least up to the limits described in N.H. Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by informing the MCO [42 CFR 438.210(a)(1) and (2)]. Changes to the Medicaid State Plan, state statutes and rules shall be done in accordance with Federal and state requirements.

8.3.2. Effective November 1, 2014, with the exception of HCBC waiver participants and nursing facility residents, the MCO shall require co-payment for services for members deemed by DHHS to have annual incomes at or above 100% of the FPL as follows:

8.3.2.1. Co-payments for drug prescriptions of up to $1 for generic drugs and $2 for brands and compound drugs for Step 1 members with annual incomes higher than 100% of the FPL, and for Step 2 members with annual incomes higher than 100% of the FPL consistent with the beneficiary and service exemptions as found in federal regulations and the approved Medicaid State Plan; and

8.3.2.2. Co-payments for drugs prescriptions of up to $1 for generic drugs and $4 for brands and compound drugs for NHHPP members with annual incomes higher than 100% of the FPL.

[11] e.g. Cedarcrest

[12] except facility and ancillary services for dental procedures

8.3.3. Effective 3/1/2016, the MCO Shall require point-of-service copayment for services for members deemed by DHHS to not be exempt from cost-sharing and have incomes above 100 percent of the federal poverty level as follows:

8.3.4. For Medicaid recipients subject to copayments:

8.3.4.1. A copay of $1.00 will be required for each preferred prescription drug and each refill of a preferred prescription drug.

8.3.4.2. A copay of $2.00 will be required for each non-preferred prescription drug and each refill of a nonpreferred prescription drug, unless the prescribing provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the copay for the non-preferred drug will be $1.00.

8.3.4.3. A copay of $1.00 will be required for a prescription drug that is not identified as either a preferred or nonpreferred prescription drug.

8.3.4.4. Copays are not required for family planning products or for Clozaril (Clozapine) prescriptions. All Cost sharing shall be applied consistent with beneficiary and service exemptions as found at 42 USC §§ 1396-o and 1396o-1, 42 C.F.R. §447.50 - 447.90, and New Hampshire's Medicaid State Plan.

8.3.5. The MCO may, with DHHS approval, require co-payment for services that do not exceed current Medicaid co-payment amounts established by DHHS.

8.3.6. The MCO shall with no disruption in service delivery to members or providers transition these services into managed care from fee-for-service (FFS).

8.3.7. All services shall be provided in accordance with 42 CFR 438.210.

8.3.8. The MCO shall adopt written policies and procedures to verify that services are actually provided [42 CFR 455.1(a)(2)].

8.3.9. The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Medicaid members for specialty care only.

8.3.10. The MCO shall cover services consistent with 45 CFR 92.207(b) including gender reassignment surgery.

8.4. Emergency Services

8.4.1. The MCO shall cover and pay for emergency services at rates that are no less than the equivalent DHHS fee-for-service rates if the provider that furnishes the services has an agreement with the MCO [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98].

8.4.2. If the provider that furnishes the emergency services has no agreement with the MCO, the MCO shall cover and pay for the emergency services in compliance with 1932(b)(2)(D) of the SSA; 42 CFR 438.114(c)(1)(i); SMD letter 2/20/98.

8.4.3. In accordance with the Deficit Recovery Act of 2005, the MCOs will cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall pay non-contracted providers of Emergency and Post-Stabilization services an amount no more than the amount that would have been paid under the DHHS Fee-For-Service system in place at the time the service was provided.

8.4.4. The MCO shall not deny treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition [§1932(b)(2) of the SSA; 42 CFR 438.114(c)(1)(ii)(A); SMD letter 2/20/98].

8.4.5. The MCO shall not deny payment for treatment obtained when a representative, such as a network provider, of the MCO instructs the member to seek emergency services [42 CFR 438.114(c)(1)(ii)(B); SMD letter 2/20/98].

8.4.6. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

8.4.7. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or DHHS of the member's screening and treatment within ten (10) calendar days of presentation for emergency services [42 CFR 438.114(d)(1)(ii)].

8.4.8. The MCO may not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient [42 CFR 438.114(d)(2)].

8.4.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment [42 CFR 438.114(d)(3)].

8.5. Post-Stabilization Services

8.5.1. Post-stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for post-stabilization services obtained within or outside the MCO that are pre-approved by a MCO provider or other MCO representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i); SMD letter 8/5/98]

8.5.2. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii); SMD letter 8/5/98.]

8.5.3. The MCO shall be financially responsible for post-stabilization care services obtained within or outside the MCO that are not pre-approved by a MCO provider or other MCO representative, but administered to maintain, improve or resolve the member's stabilized condition if:

8.5.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

8.5.3.2. The MCO cannot be contacted; or

8.5.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with a MCO physician and the treating physician may continue with care of the patient until a MCO physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)].

8.5.4. The MCO shall limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the MCO. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv); SMD letter 8/5/98]

8.5.5. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

8.5.5.1. A MCO physician with privileges at the treating hospital assumes responsibility for the member's care;

8.5.5.2. A MCO physician assumes responsibility for the member's care through transfer;

8.5.5.3. A MCO representative and the treating physician reach an agreement concerning the member's care; or

8.5.5.4. The member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3); SMD letter 8/5/98]

9. Payment Reform Plan

9.1. Payment Reform Plan Timeline

9.1.1. The MCO shall submit within sixty (60) calendar days from a Program Start Date and sixty (60) calendar days prior to the start of each Agreement year, its Payment Reform Plan to engage its provider network in health care delivery and payment reform activities, subject to review and approval by DHHS. These activities may include, but are not limited to, pay for performance programs, innovative provider reimbursement methodologies, risk sharing arrangements and sub-capitation agreements.

9.1.1.1. DHHS shall respond to the MCO regarding the Payment Reform Plan within thirty (30) calendar days of receipt.

9.1.2. Beginning July 1, 2018, DHHS will withhold one percent (1%) of MCO capitation payments in each year of the Agreement under the Payment Reform Plan. The MCO will earn a pay-out of that withheld amount if it meets the implementation milestones described in the Payment Reform Plan. The pay-out will be pro-rated to the number of milestones achieved by the MCO at the end of the year.

9.1.3. The MCO shall submit a report to DHHS describing its performance against the MCO's healthcare delivery and Payment Reform Plan within ninety (90) calendar days of the end of each year of the Agreement.

9.1.3.1. The report shall indicate, by provider type, the number and percentage participating in each type of payment reform activities.

9.1.3.2. DHHS will evaluate the MCO's performance and make payments to the MCO, if warranted, within ninety (90) calendar days of receipt of the report. DHHS shall provide the MCO with a written explanation of DHHS's evaluation of the MCO's performance within thirty (30) days of the MCO's request.

9.1.3.3. In the event that MCO disputes DHHS's evaluation of MCO's performance, MCO will have thirty (30) calendar days from receipt of DHHS's written explanation to submit a written request for reconsideration along with a description of MCO's reasons for the dispute, after which DHHS shall meet with the MCO within a reasonable time frame to achieve a good faith resolution of the disputed matter.

9.2. **Payment Reform Plan Content**

9.2.1. The Payment Reform Plan shall contain:

9.2.1.1. Information on the anticipated impact on member health outcomes of each specific activity, providers affected by the specific activity, outcomes anticipated as a result of the implementation of a process by which to reduce inappropriate emergency room use, an implementation plan for each activity and an implementation milestone to be met by the end of each year of the Agreement for each activity;

9.2.1.2. A process to ensure Equal Access to services; and

9.2.1.3. A process for engaging LTSS providers in health care delivery and payment reform activities.

9.3. **Payment Reform Plan Compliance Requirements**

9.3.1. The MCO's Payment Reform Plan(s) shall be in compliance with the following requirements:

9.3.1.1. FQHCs and RHCs will be paid at minimum the encounter rate paid by DHHS at the time of service.

9.3.1.2. The Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

9.3.1.3. The MCO's provider incentive plan shall comply with requirements set forth in 42 CFR 422.208 and 42 CFR 422.210 [42 CFR 438.6(h)].

9.3.1.4. The MCO's payment reform plan must comply with state and federal laws requiring nonpayment to a Contracted Provider for hospital-acquired conditions and for provider preventable conditions. The MCO shall report to NH DHHS all provider-preventable conditions in a form and frequency as specified by the State [42 CFR 438.3(g)].

9.3.1.5. The MCO may not make payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.6. The MCO shall provide information on its provider incentive program to any New Hampshire recipient upon request (this includes the right to adequate and

timely information on the plan) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.6(h)].

9.3.1.7. The MCO shall report whether services not furnished by physician/group are covered by an incentive plan. No further disclosure is required if the incentive plan does not cover services not furnished by the physician/group [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.7.1. The MCO shall report the type of incentive arrangement (e.g., withhold, bonus, capitation) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.3(i)].

9.3.1.8. The MCO shall report the percent of withhold or bonus (if applicable) [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.9. The MCO shall report panel size, and if patients are pooled, the approved method used [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.10. If the physician/group is at substantial financial risk, the MCO shall report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss [§1903(m)(2)(A)(x)of the SSA; 42 CFR 422.208 and 422.210; 42 CFR 438.6(h)].

9.3.1.11. Primary Care reimbursement to follow DHHS policy and to comply with 42 CFR 438, 42 CFR 441 and 42 CFR 447 II.A.5

9.3.1.11.1. MCO shall pass on the full benefit of the payment increase to eligible providers; and

9.3.1.11.2. MCO shall adhere to the definitions and requirements for eligible providers and services as specified in Section 1902(a)(13)(C), as amended by the Affordable Care Act of 2010 (ACA) and federal regulations; and

9.3.1.11.3. MCO shall submit sufficient documentation, as per DHHS policy, to DHHS to validate that enhanced rates were made to eligible providers.

10. Care Coordination Program

10.1. Minimum Care Coordination Program Components

10.1.1. The MCO shall implement a comprehensive care array of care coordination services that have at a minimum the following components:

10.1.1.1. Care Coordination

10.1.1.2. Support of Patient-Centered Medical Homes and Health Homes

10.1.1.3. Non-Emergent Medical Transportation

10.1.1.4. Wellness and Prevention programs

10.1.1.5. Chronic Care Coordination programs

10.1.1.6. High Risk/ High Cost Member Management programs

10.1.1.7. A Special Needs program

10.1.1.8. Coordination and Integration with Social Services and Community Care

10.1.1.9. A Long Term Services and Supports Program

10.2. Care Coordination: Role of the MCO

10.2.1. The MCO shall develop a strategy for coordinating all care for all members. Care coordination for its members includes coordination of primary care, specialty care, and all other MCO covered services as well as services provided through the fee-for-service program and non-Medicaid community based services. Care coordination shall promote and assure service accessibility, focus attention to individual needs, actively assist members or their caregiver to take personal responsibility for their health care, provide education regarding the use of inappropriate emergency room care, emphasize the importance of participating in health promotion activities, provide for continuity of care, and assure comprehensive coordinated and integrated culturally appropriate delivery of care.

10.2.2. The MCO shall ensure that services provided to children are family driven and based on the needs of the child and the family. The MCO shall support the family in having a primary decision making role in the care of their children utilizing the Substance Abuse and Mental Health Services Administration (SAMHSA) core elements of a children's services system of care. The MCO shall employ the SAMHSA principles in all children's behavioral health services assuring they:

10.2.2.1. Are person centered;

10.2.2.2. Include active family involvement;

10.2.2.3. Deliver behavioral health services that are anchored in the community;

10.2.2.4. Build upon the strengths of the member and the family;

10.2.2.5. Integrate services among multiple providers and organizations working with the child; and

10.2.2.6. Utilize a wraparound model of care within the context of a family driven model of care.

10.2.2.6.1. MCO shall submit a written policy to DHHS describing the integrated model of care including but not limited to the involvement of each member and family in the development of the plan.

10.2.3. The MCO will ensure that its providers are providing services to children, youth members, and their families in accordance with RSA 135-F.

10.2.4. The MCO shall provide a written policy to DHHS for approval that ensures that services to individuals who are homeless are to be prioritized and made available to those individuals.

10.3. Care Coordination: Role of the Primary Care Provider

10.3.1. MCO Cooperation with Primary Care Provider

10.3.1.1. The MCO shall implement procedures that ensure that each member has access to an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with 42 CFR 438.208(b)(1) through (6).

10.3.1.2. The MCO shall submit a written plan that describes the development, implementation and evaluation of programs to assess and support, wherever possible, primary care providers to act as a patient centered medical home. A patient centered medical home shall include all of the five key domains outlined by the Agency for Healthcare Research and Quality (AHRQ):

10.3.1.2.1. Comprehensive care;

10.3.1.2.2. Patient-centered care;

10.3.1.2.3. Coordinated care;

10.3.1.2.4. Accessible services; and

10.3.1.2.5. Quality and safety.

10.5. Non-Emergent Transportation (NEMT)

10.5.1. The MCO shall be required to arrange for the non-emergent medical transportation of its members to ensure members receive medically necessary services covered by the New Hampshire Medicaid program regardless of whether those medically necessary services are covered by the MCO. The MCO shall ensure that a member's lack of personal transportation is not a barrier to accessing care.

10.5.2. The MCO and/or any subcontractors shall be required to perform background checks on all non-emergent medical transportation providers.

10.5.3. The MCO shall provide quarterly reports to DHHS on its non-emergent medical transportation activities to include but not be limited to:

10.5.3.1. NEMT requests delivered by mode of transportation;

10.5.3.2. NEMT request authorization approval rates by mode of transportation;

10.5.3.3. NEMT scheduled trip results by outcome;

10.5.3.4. NEMT services delivered by type of medical service;

10.5.3.5. NEMT service use by population; and

10.5.3.6. Number of transportation requests that were delivered late and not on time.

10.5.3.6.1. On-time shall be defined as less than or equal to fifteen (15) minutes after the appointed time; and

10.5.3.6.2. Transportation requests for methadone services will be excluded from the calculation of late and not-on-time services.

10.5.3.7. Member cancellations of scheduled trips by reason for member cancellations.

10.6. Wellness and Prevention

10.6.1. The MCO shall develop and implement wellness and prevention programs for its members.

10.6.2. The MCO shall, at a minimum, develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs in consultation with DHHS.

10.6.3. The MCO shall, at minimum, provide primary and secondary preventive care services, rated A or B, in accordance with the recommendations of the U.S.

10.3.1.3. DHHS recognizes that there is a variety of ways in which these domains can be addressed in clinical practices. External accreditation is not required by DHHS to qualify as a medical home. The MCO's support to primary care providers acting as patient centered medical homes shall include, but is not limited to, the development of systems, processes and information that promote coordination of the services to the member outside of that provider's primary care practice.

10.4. Care Coordination: Role of Obstetric Providers

10.4.1. If, at the time of entering the MCO as a new member, the member is transferring from another MCO within the state system, is in her first trimester of pregnancy and is receiving, medically necessary covered prenatal care services, as defined within this Agreement as covered services, before enrollment the MCO shall be responsible for the costs of continuation of medically necessary prenatal care services, including prenatal care, delivery, and postpartum care.

10.4.2. If the member is receiving services from an out-of-network provider prior to enrollment in the MCO, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services until such time as the MCO can reasonably transfer the member to a network provider without impeding service delivery that might be harmful to the member's health.

10.4.3. If the member, at the time of enrollment, is receiving services from a network provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider through the postpartum period.

10.4.4. In the event a member entering the MCO, either as a new member or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services at the time of enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider, whether an out of network or in network provider, through the postpartum period.

10.4.5. Postpartum care includes the first postpartum visit, any additional visits necessary to manage any complications related to delivery, and completion of the medical record.

10.4.6. The MCO shall develop and maintain policies and procedures, subject to DHHS approval, regarding the transition of any pregnant members.

Preventive Services Task Force, and for children, those preventive services recommended by the American Academy of Pediatrics Bright Futures Program.

10.6.4. The MCO may substitute generally recognized accepted guidelines for the requirements set forth in 10.6.3, provided that such substitution is approved in advance by DHHS. The MCO shall provide members with a description of preventive care benefits to be used by the MCO in the member handbook and on the MCO's website.

10.6.5. The MCO shall provide members with general health information and provide services to help members make informed decisions about their health care needs. The MCO shall encourage patients to take an active role in shared decision making.

10.6.6. The MCO shall also participate in other public health initiatives at the direction of DHHS.

10.7. Member Health Education

10.7.1. The MCO shall develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of empowering patients to actively participate in their healthcare.

10.7.2. The MCO shall conduct a Health Needs Assessment for all new members within the following timeframes from the date of enrollment in the MCO:

10.7.2.1. thirty (30) calendar days for pregnant women, children with special health care needs, adults with special health care needs; and

10.7.2.2. ninety (90) calendar days for all other members, including members residing in a nursing facility longer than 100 days.

10.7.2.3. The MCO shall document at least three attempts to conduct the screen. If unsuccessful the MCO shall document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.

10.7.3. The MCO will submit their Health Needs Assessment forms to DHHS for review and approval.

10.7.4. The MCO shall report quarterly, with reports due the last day of the month following the reporting quarter, with the first report due January 31, 2015. Reports shall include:

10.7.4.1. the number of members and the percentage of eligible members who completed a Health Needs Assessment in the quarter;

10.7.4.2. the percentage of eligible members who completed the Health Needs Assessment in the prior year; and

10.7.4.3. the percentage of members eligible for chronic care coordination, high cost/high risk care coordination, complex care coordination and/or the MCO's special needs program who completed a Health Needs Assessment in the prior year.

10.7.5. The MCO shall actively engage members in both wellness program development and in program participation and shall provide additional or alternative outreach to members who are difficult to engage or who utilize the emergency room inappropriately.

10.8. Chronic Care Coordination, High Risk/High Cost Member and Other Complex Member Management

10.8.1. The MCO shall develop effective care coordination programs that assist members in the management of chronic and complex health conditions, as well as those clients that demonstrate high utilization of services indicating a need for more intensive management services. The MCO may delegate the chronic and complex care member management to a patient centered medical home or health home provided that all the criteria for qualifying as a patient centered medical home or a health home and the additional conditions of this section have been met. These programs shall incorporate a "whole person" approach to ensure that the member's physical, behavioral, developmental, and psychosocial needs are comprehensively addressed. The MCO or its delegated entity shall ensure that the member, and/or the member's care giver, is actively engaged in the development of the care plan.

10.8.2. The MCO shall submit status reports to DHHS on MCO care coordination activities and any delegated medical home or health home activities as requested or required by DHHS.

10.8.3. The MCO shall at, a minimum, provide chronic care coordination services for members with the following or other chronic disease states who are appropriate for such care coordination services based on MCO's methodologies, which have been approved by DHHS, for identifying such members:

10.8.3.1. Diabetes, in coordination with the forthcoming federal diabetes initiative;

10.8.3.2. Congestive Heart Failure (CHF);

10.8.3.3. Chronic Obstructive Pulmonary Disease (COPD);

10.8.3.4. Asthma;

10.8.3.5. Coronary Artery Disease (CAD), in coordination with the Million Hearts Campaign;

10.8.3.6. Obesity;

10.8.3.7. Mental Illness;

10.8.3.8. Requiring wound care.

10.8.4. The MCO shall report on the number and types of members receiving chronic care coordination services.

10.9. Special Needs Program

10.9.1. The MCO shall create an organizational structure to function as patient navigators to:

10.9.1.1. Reduce any barriers to care encountered by members with special needs

10.9.1.2. Ensure that each member with special needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists as appropriate

10.9.1.3. Support in accessing all covered services appropriate to the condition or circumstance.

10.9.2. The MCO shall identify special needs members based on the member's physical, developmental, behavioral condition, or adverse social circumstances, including but not limited to:

10.9.2.1. A member with at least two chronic conditions;

10.9.2.2. A member with one chronic condition and is at risk for another chronic condition;

10.9.2.3. A member with one serious and persistent mental health condition;

10.9.2.4. A member living with HIV/AIDS;

10.9.2.5. A member who is a child in foster care;

10.9.2.6. A member who is a child and a client of DCYF receiving services through a court order; and

10.9.2.7. A member who is homeless.

10.9.3. The MCO shall assess, pursuant to 42 CFR 438.208(c)(2), and reach out to members identified with special needs and their PCP to inform them of additional services and supports available to them through the MCO's special needs program.

10.9.4. The MCO shall share the results of its identification and assessment of any enrollee with special health care needs as described in this section with the State so that those activities will not be duplicated.

10.9.5. The MCO shall ensure enrollees determined to have special health care needs as described in this section and who need a course of treatment or regular care monitoring, will have direct access to a specialist as appropriate for the enrollee's condition and identified needs.

10.9.6. For enrollees with special health needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.9.7. The MCO shall report on the number and types of members in the special needs program.

10.10.Coordination and Integration with Social Services and Community Care

10.10.1.The MCO shall develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including not limited to:

10.10.1.1. Juvenile Justice and Adult Community Corrections;

10.10.1.2. Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

10.10.1.3. Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

10.10.1.4. Public Health Agencies;

10.10.1.5. Schools;

10.10.1.6. Step 2 Programs and Services;

10.10.1.7. The court system;

10.10.1.8. ServiceLink Resource Network; and

10.10.1.9. Housing

10.10.1.9.1.Veterans Administration Hospital and other programs and agencies serving service members, veterans and their families.

10.10.2.The MCO shall report on the number of referrals for social services and community care provided to members by member type.

10.11.Long Term Services and Supports (LTSS)

10.11.1.Navigators. The MCO shall create an organizational structure to function as navigators for members in need of LTSS to:

10.11.1.1. Reduce any barriers to care encountered by members with long term care needs;

10.11.1.2. Ensure that each member with long term care needs receives the medical services of PCPs and specialists trained and skilled in the unique needs of the member, including information about and access to specialists, as appropriate; and

10.11.1.3. Ensure that each member with long term care needs receives conflict free care coordination that facilitates the integration of physical health, behavioral health, psychosocial needs, and LTSS through person-centered care planning to identify a member's needs and the appropriate services to meet those needs; arranging, coordinating, and providing services; facilitating and advocating to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

10.11.2.Integrated Care. The MCO shall ensure that LTSS are delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation, based on the member's preferences and pursuant with 28 C.F.R. Pt. 35, App. A (2010), the Americans with Disabilities Act (ADA) [42 USC 126.12101] and Olmstead v. L.C., 527 U.S. 581 (1999).

10.11.2.1. The MCO shall support accessing all covered services appropriate to the medical, behavioral, psychosocial, and/or LTSS condition or circumstance.

10.11.2.2. The MCO shall identify members with long term care needs based on the member's physical, developmental, psychosocial, or behavioral conditions including but not limited to:

10.11.2.2.1.Children with DCYF involvement;

10.11.2.2.2.Children with special needs other than DCYF;

10.11.2.2.3.Children with Waiver, NF or CMHC services;

10.11.2.2.4.Adults with Special Needs with Waiver, NF or CMHC services;

10.11.2.2.5.Adults with Waiver, NF or CMHC services;

10.11.2.2.6.Older Adults with Waiver or CMHC services; or

10.11.2.2.7.Older adults with NF services.

10.11.2.3. The MCO shall reach out to members identified with long term care needs and their PCP to inform them of additional services and supports available to them through the MCO.

10.11.2.4. For enrollees with long term care needs determined through an assessment or through regular care monitoring to need services, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

10.11.2.5. For enrollees with long term care needs determined through an assessment or regular care monitoring, the MCO must have a mechanism in place to assist enrollees to access medically necessary and necessary services.

11. EPSDT

11.1. Compliance

11.1.1. The MCO shall provide Early Periodic Screening Diagnostic Treatment (EPSDT) services to members less than twenty-one (21) years of age in compliance with all requirements found below:

11.1.1.1. The MCO shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the SSA and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The MCO shall comply with all EPSDT requirements pursuant to the New Hampshire Medicaid Rules.

11.1.1.2. The MCO shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through Health Check screens and exams and follow-up on any abnormal screening exams. The EPSDT Plan shall also include procedures for referral, tracking, and follow up for annual dental examinations and visits, upon receipt of dental claims information from DHHS. The EPSDT Plan shall consider and be consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists to the extent that such policy statements relate to the role of the primary care provider in coordinating care for infants, children and adolescents. The MCO shall submit its EPSDT Plan to DHHS for review and approval ninety (90) days prior to program start and annually sixty (60) calendar days prior to the first day of each Agreement year.

11.1.1.3. The MCO shall ensure providers perform a full EPSDT visit according to the periodic schedule approved by DHHS and the American Academy of Pediatrics periodicity schedule. The visit shall include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements §1902(a)(43) of the SSA, §1905(a)(4)(B) of the SSA and 42 CFR 441.50-.62, and health education/anticipatory guidance. All five (5) components shall be performed for the visit to be considered an EPSDT visit.

12. Behavioral Health

12.1. Behavioral Health - General Provisions

12.1.1. This section applies to individuals who have been determined to be eligible for community mental health services based on diagnosis, level of impairment and the requirements outlined in N.H. Code of Administrative Rules, chapter He-M 401.

12.1.2. Community mental health services, as set forth in Section 8.2, shall be provided in accordance with the NH Medicaid State Plan, He-M 426, He-M 408 and all other applicable state and federal regulations.

12.1.3. All clinicians providing community mental health services are subject to the requirements of He-M 426 and any other applicable state and federal regulations.

12.1.4. All individuals approved to provide community mental health services through a waiver granted by NH DHHS shall be recognized as qualified providers under the MCO plan subject to NCQA credentialing requirements.

12.1.5. All other behavioral health services shall be provided to all NH Medicaid-eligible recipients in accordance with the NH Medicaid State Plan.

12.1.6. The MCO shall pay for all NH Medicaid State Plan Services for its members as ordered to be provided by the Mental Health Court.

12.1.7. The MCO shall continue to support and ensure that culturally and linguistically competent community mental health services currently provided for people who are deaf continue to be made available. These services shall be similar to services currently provided through the Deaf Services Team at Greater Nashua Mental Health Center.

12.2. Community Mental Health Services

12.2.1. The MCO shall ensure, through review of individual service plans and quarterly reviews, that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall inform DHHS of their findings on a monthly basis.

12.2.2. The MCO shall employ a trauma informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan, pursuant to He-M 401, that will effectively address the individual's trauma history.

12.2.3. The MCO shall make Community Mental Health Services available to all members who have a severe mental disability. DHHS encourages agreement between the MCO and CMHCs to develop a capitated payment program with the intent to establish payment mechanisms to meet the goals of DHHS to strengthen the State's outpatient community health service system and the requirements of the Community Mental Health Agreement, and to further payment reform. In the event that any CMHC fails to sign a contract with the MCO within thirty (30) days before the current contract end date, the MCO shall notify DHHS of the failure to reach agreement with a CMHC and DHHS shall implement action steps to designate a community mental health program to provide services in the designated community mental health services region.

12.2.3.1. The MCO shall submit to DHHS a plan to assure continuity of care for all members accessing a community mental health agency.

12.2.4. In the event that an alternative community mental health program is approved and designated by DHHS, a transition plan shall be submitted for approval by DHHS including implementation strategy and timeframes. State Administrative Rule He-M 426, Community Mental Health Services, details the services available to adults with a severe mental illness and children with serious emotional disturbance. The MCO shall, at a minimum, make these services available to all members determined eligible for community mental health services under State Administrative Rule He-M 401.

12.2.4.1. The MCO shall be required to continue the implementation of evidence based practices across the entire service delivery system.

12.2.4.2. Behavioral Health Services shall be recovery and resiliency oriented, based on SAMHSA's definition of recovery and resiliency.

12.2.4.3. The MCO shall ensure that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans.

12.2.4.4. The MCO shall ensure that community mental health services to individuals who are homeless continue to be prioritized and made available to those individuals.

12.2.4.5. The MCO shall maintain or increase the ratio of community based to office based services for each region in the State, as specified in He-M 425, to be greater than or equal to the regional current percentage or 50%, whichever is greater.

12.2.4.6. The MCO shall monitor the ratio of community based to office based services for each region in the State, as specified in He-M 425.

12.2.4.7. The Department of Health and Human Services (DHHS) will issue a list of covered office and community based services annually, by procedure code, that are used to determine the ratio outlined in 12.2.4.5.

12.2.4.8. The MCO shall submit a written report to the Department of Health and Human Services DHHS every six (6) months, by region, of the ratio of community based services to office based services.

12.2.5. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

12.2.5.1. Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web-based training and certification system.

12.2.5.1.1. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member eligibility renewal following clinician certification to utilize the CANS and the ANSA and upon eligibility determination for newly evaluated consumers effective July 1, 2015.

12.2.5.1.2. The community mental health long term care eligibility tool, specified in He-M 401, and in effect on January 1, 2012 shall continue to be utilized by a clinician until such time as the Department of Health and Human Services implements web-based access to the CANS and the ANSA, the clinician is certified in the use of the CANS and the ANSA, and the member annual review date has passed.

12.2.6. The MCO shall ensure that community mental health service providers operate in a manner that enables the State to meet its obligations under Title II of the Americans with Disabilities Act, with particular attention to the "integration mandate" contained in 28 CFR 35.130(d).

12.2.7. The MCO shall continue the implementation of New Hampshire's 10-year Olmstead Plan, as updated from time to time, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration."

12.2.7.1. The MCO shall include in its written Program Management Plan:

12.2.7.1.1. Screening criteria for Assertive Community Treatment Teams for all persons with serious mental disabilities.

12.2.7.1.2. A needs assessment, capacity analysis and access plan for Community Residential and Supported Housing.

12.2.7.1.3. New and innovative interventions that will reduce admissions and readmissions to New Hampshire Hospital and increase community tenure for adults with a severe mental illness and children with a serious emotional disturbance.

12.2.8. The MCO shall work collaboratively to support the implementation of the Medicaid-funded services described in the Class Action Settlement Agreement in the case of Amanda D. et al. v. Hassan, et al., US v. State of New Hampshire, Civ. No. 1:12-cv-53-SM in conjunction with DHHS and the Community Mental Health Centers.

12.2.8.1. Adult Assertive Community Treatment Teams (ACT). The MCO shall ensure that ACT teams are available twenty-four (24) hours per day, seven (7) days per week, with on-call availability from midnight to 8:00 am. At a minimum, ACT teams shall deliver comprehensive, individualized, and flexible services, supports, treatment, and rehabilitation in a timely manner as needed, onsite in the individuals homes and in other natural environments and community settings, or alternatively, via telephone where appropriate to meet the needs of the individual. Each ACT team shall be composed of a multi-disciplinary group of between seven (7) and ten (10) professionals, including, at a minimum, a psychiatrist, a nurse, a Masters-level clinician (or functional equivalent therapist), functional support worker and a peer specialist. The team also will have members who have been trained and are competent to provide substance abuse support services, housing assistance and supported employment. Caseloads for ACT teams serve no more than ten (10) to twelve (12) individuals per ACT team member (excluding the psychiatrist who will have no more than seventy (70) people served per 0.5 FTE psychiatrist).

12.2.8.2. Evidence-based Supported Employment (EBSE). The MCO shall ensure that EBSE is provided to eligible consumers in accordance with the Dartmouth model. The MCO shall ensure that the penetration rate of individuals receiving EBSE increases to 18.6 percent by June 30, 2017. The penetration rate is determined by dividing the number of adults with severe mental illness (SMI) receiving EBSE by the number of adults who have SMI being served.

12.2.9. The Department of Health and Human Services will lead regional planning activities in each community mental health region to develop and refine community mental health services in New Hampshire. The MCO shall support and actively participate in these activities.

12.2.9.1. The focus of the regional planning process will be on reducing the need for inpatient care and emergency department utilization, and on increasing community tenure.

12.2.10. The MCO shall develop a Training Plan each year of the Agreement for how it will support the New Hampshire community mental health service system's effort to hire and train qualified staff. The MCO shall submit this Training Plan to DHHS sixty (60) calendar days prior to program start and annually ninety (90) calendar days prior to beginning of each Agreement year.

12.2.10.1. The MCO shall submit a report summarizing what training was provided, a copy of the agenda for each training, a participant registration list for each contracted CMHC and a summary, for each training provided, of the evaluations done by program participants, within ninety (90) calendar days of the conclusion of each Agreement year.

12.2.10.2. As part of that Training Plan, the MCO shall promote provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

12.2.10.3. The MCO Training Plan outlined in 12.2.10.1 shall be designed to sustain and expand the use of the Evidence Based Practices of Illness Management and Recovery (IMR), Evidence Based Supported Employment (EBSE), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Treatment (DBT) and Assertive Community Treatment (ACT), and to improve NH's penetration rates for Illness Management and Recovery (IMR) and Supported Employment, by 2% each year of the Agreement. The baseline measure for penetration rates shall be the NH submission to the SAMHSA Uniform Reporting System for 2011.

12.2.10.4. The MCO shall offer a minimum of 2 hours of training each contract year to all contracted community mental health center staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the State's objective of reducing the number of suicides in New Hampshire.

12.2.10.5. The MCO shall submit an annual report no later than ninety (90) calendar days following the close of each Agreement year with a summary of the trainings provided, a list of attendees from each contracted community mental health program, and the proposed training for the next fiscal year.

12.3. Emergency Services

12.3.1. The MCO shall ensure, through its contracts with local providers, that regionally based crisis lines and Emergency Services as defined in He-M 403 and He-M 426 are in place 24 hours a day/ 7 days a week for individuals in crisis. These crisis lines and Emergency Services Teams shall employ clinicians who are trained in managing crisis intervention calls and who have access to a clinician available to evaluate the member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

12.3.2. The MCO shall submit for review to the DHHS MCM Account Manager and the Director of the Bureau of Mental Health an annual report identifying innovative and cost effective models of providing crisis and emergency response services that will provide the maximum clinical benefit to the consumer while also meeting the State's objectives in reducing admissions and increasing community tenure.

12.4. Care Coordination

12.4.1. The MCO shall develop policies governing the coordination of care with primary care providers and community mental health programs. These policies shall be submitted to DHHS for review and approval ninety (90) calendar days prior to the beginning of each Agreement year, including Year 1.

12.4.2. The MCO shall ensure that there is coordination between the primary care provider and the community mental health program.

12.4.3. The MCO shall ensure that both the primary care provider and community mental health program request written consent from the member to release information to coordinate care regarding mental health services or substance abuse services or both, and primary care.

12.4.4. The MCO shall monitor instances in which consent was not given, and if possible the reason why, and submit this report to DHHS no later than sixty (60) calendar days following the end of the fiscal year.

12.4.5. The MCO shall review with DHHS the approved policy, progress toward goals, barriers and plans to address identified barriers.

12.4.6. The MCO shall ensure integrated care coordination by requiring that providers accept all referrals for its members from the MCO that result from a court order or a request from DHHS.

12.5. New Hampshire Hospital

12.5.1. The MCO shall maintain a collaborative agreement with New Hampshire Hospital, the State of New Hampshire's state operated inpatient psychiatric facility. This collaborative agreement subject to the approval of DHHS shall at a minimum address the Americans with Disabilities Act requirement that individuals be served in the most integrated setting appropriate to their needs, include the responsibilities of the community mental health program in order to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.

12.5.2. It is the policy of the State to decrease discharges from inpatient care at New Hampshire Hospital to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning from New Hampshire Hospital. The MCO shall utilize the collaborative agreement to track any discharges that the MCO, through its provider network, was unable to place into the community and who instead were discharged to a shelter or into homelessness. The MCO shall submit a report to the Department of Health and Human Services DHHS, quarterly, detailing the reasons why members were placed into homelessness and include efforts made by the MCO to arrange appropriate placements.

12.5.3. The MCO shall designate a liaison with privileges, as required by New Hampshire Hospital, to continue members' care coordination activities, and assist in facilitating a coordinated discharge planning process for adults and children admitted to New Hampshire Hospital. Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital treatment team meetings and discharge planning meetings to ensure that individuals receive treatment in the least restrictive environment complying with the Americans with Disabilities Act and other applicable federal and State regulations.

12.5.3.1. The liaison shall actively participate, and assist New Hampshire Hospital staff in the development of a written discharge plan within twenty-four (24) hours of admission.

12.5.3.2. The MCO shall ensure that the final NHH Discharge Instruction Sheet shall be provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of members discharged. The MCO shall ensure that the discharge progress note shall be provided to the aftercare provider within 7 calendar days of member discharge for at least ninety percent (90%) of members discharged.

12.5.3.3. The MCO shall make at least three (3) attempts to contact members for whom the MCO has record of a telephone number within three (3) business days of discharge from New Hampshire Hospital in order to review the discharge plan, support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the member may have. The performance metric shall be that at least ninety-five percent (95%) of members discharged shall have been attempted to be contacted within three (3) business days.

12.5.3.4. The MCO shall ensure an appointment with a community mental health program or other appropriate mental health clinician for the member is scheduled prior to discharge. Such appointment shall occur within seven (7) calendar days after discharge.

12.5.3.4.1. Persons discharged from psychiatric hospitalization and new to a CMHC must have an intake appointment within seven (7) days.

12.5.3.5. The MCO shall work with DHHS to review cases of members that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

12.5.3.6. The MCO shall establish a reduction in readmissions plan, subject to approval by DHHS, to monitor the 30-day and 180-day readmission rates to New Hampshire Hospital, review member specific data with each of the community mental health programs, and implement measurable strategies within 90 days of the execution of this Agreement to reduce 30-day and 180-day readmission. The MCO shall include benchmarks and reduction goals in the Program Management Plan.

12.5.4. The MCO shall perform in-reach activities to New Hampshire Hospital designed to accomplish transitions to the community.

12.6. In Shape Program

12.6.1. The MCOs shall promote community mental health service recipients' whole health goals. Functional support services may be utilized to enable recipients to pursue and achieve whole health goals within an In Shape program or other program designed to improve health.

12.7. Parity

12.7.1. The MCO and its subcontractors must comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which requires the MCOs

to not discriminate based upon an enrollee's health status of having a mental health or substance use disorder.

12.7.1.1. The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.

12.7.1.2. The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

12.7.1.3. The MCO shall not impose Non- Quantitative Treatment Limits for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

12.7.1.4. Annual Certification with Federal Mental Health Parity Law: The MCOs must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the Federal Mental Health Parity Law, regulations and guidance issued by state and federal entities.

12.7.1.4.1. The MCO must submit a certification signed by the chief executive officer and chief medical officer stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.2. If the MCO determines that all administrative, clinical, and utilization practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will affirmatively state, that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law and any guidance issued by state and federal entities.

12.7.1.4.3. If the MCO determines that any administrative, clinical, and utilization practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law or guidance issued by state and federal entities during the calendar year, the certification will state that not all practices were in compliance with Federal Mental Health Parity Law or any guidance issued by state or federal entities and will include a list of the practices not in compliance and the steps the managed care entity has taken to bring these practices into compliance.

12.7.1.5. The MCO shall complete the DHHS Parity Compliance Report annually and shall include:

12.7.1.5.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCOs pursuant to DHHS criteria;

12.7.1.5.2. All member grievances and appeals regarding a parity violation and resolutions;

12.7.1.5.3. The processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification; and

12.7.1.5.4. Any other requirements identified by DHHS.

12.7.1.6. A member enrolled in any MCO may file a complaint with the New Hampshire Insurance Department at **https://www.nh.gov/insurance/consumers/complaints.htm** if services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance.

13. Substance Use Disorder

13.1. Substance Use Disorder - General Provisions

13.1.1. The MCO will offer contracts to Medicaid enrolled SUD providers who meet the MCO's credentialing standards. The MCO will reimburse those SUD providers in accordance with Section 21.2.10.

13.1.2. The MCO will submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of SUD service providers so that services are accessible without reasonable delays.

13.1.2.1. If the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours this provider is required to provide interim substance use disorder counselors services until such a time that the clients starts receiving the identified level of care. If the type of service is not provided by this agency they are then responsible for making an active referral to a provider of that type of service (for the identified level of care) within fourteen (14) days from initial contact and to provider interim substance use disorder counselors services until such a time that the member is accepted and starts receiving services by the receiving agency.

13.1.3. The MCO shall provide data, reports and plans in accordance with Exhibit O.

13.2. Compliance Metrics for Access to SUD Services

13.2.1. Agencies under contract with MCOs to provide SUD services to provide SUD services shall respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The SUD provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face to face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but not later than two (2) business days following the date of first contact.

13.2.2. Members who have screened positive for SUD services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation (as identified in the He-W 513 administrative rules) as soon as possible following the ASAM Level of Care Assessment and no later than (3) days after admission.

13.2.3. Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed. Members identified for Partial

Hospitalization (PH) or Rehabilitative Residential (RR) Services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

13.2.3.1. Pregnant women shall be admitted to the identified level of care within 24 hours of the ASAM Level of Care Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor shall:

13.2.3.1.1. Assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance must include actively reaching out to identify providers on the behalf of the client; and

13.2.3.1.2. Provide interim services until the appropriate level of care becomes available at either the contractor agency or an alternative provider. Interim services shall include:

a. At least one 60 minute individual or group outpatient session per week;

b. Recovery support services as needed by the client; and

c. Daily calls to the client to assess and respond to any emergent needs.

13.2.4. If the type of service identified in the ASAM Level of Care Assessment will not be available from the provider that conducted the initial assessment within the fourteen (14) business day period, or if the type of service is not provided by the agency that conducts the ASAM Level of Care Assessment, this agency is responsible for making an active referral to a provider of that type of services (for the identified level of care) within fourteen (14) business days from the date the ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.

14. Pharmacy Management

14.1. Pharmacy Management – General Provisions

14.1.1. The MCO's, including any pharmacy subcontractors, shall create: formulary and pharmacy prior authorization criteria and other point of service edits (i.e. prospective drug utilization review edits and dosage limits), pharmacy policies and pharmacy programs subject to DHHS approval, and in compliance with §1927 of the SSA [42 CFR 438.3(s)]. The MCO shall not include drugs by manufacturers not enrolled in the OBRA 90 Medicaid rebate program on its formulary without DHHS consent.

14.1.2. The MCO shall adhere to New Hampshire law with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, law 2004, SB 383-FN, Sect. IVa. Specifically, a MCO member shall continue to be treated, or, if newly diagnosed, may be treated with a non-preferred drug based on any one of the following criteria:

14.1.2.1. Allergy to all medications within the same class on the preferred drug list;

14.1.2.2. Contraindication to or drug-to-drug interaction with all medications within the same class on the preferred drug list;

14.1.2.3. History of unacceptable or toxic side effects to all medications within the same class on the preferred drug list;

14.1.2.4. Therapeutic failure of all medications within the same class on the preferred drug list;

14.1.2.5. An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal Food and Drug Administration-approved indication;

14.1.2.6. Age specific indication;

14.1.2.7. Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or

14.1.2.8. Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

14.1.3. The MCO shall submit all of its policies, prior authorizations, point-of-sale and drug utilization review edits and pharmacy services procedures related to its maintenance drug policy, specialty pharmacy programs, and any new pharmacy service program proposed by the MCO to DHHS for its approval at least 60 calendar days prior to implementation.

14.1.4. The MCO shall submit the items described in 14.1.1 and 14.1.3 to DHHS for approval sixty (60) calendar days prior to the program start date of Step 1.

14.1.5. Any modifications to items listed in 14.1.1 and 14.1.3 shall be submitted for approval at least sixty (60) calendar days prior to the proposed effective date of the modification.

14.1.6. The MCO shall notify members and providers of any modifications to items listed in 14.1.1 and 14.1.3 thirty (30) calendar days prior to the modification effective date.

14.1.7. Implementation of a modification shall not commence prior to DHHS approval.

14.1.8. At the time a member with currently prescribed medications transitions to an MCO: upon MCO's receipt of (written or verbal) notification validating such prescribed medications from a treating provider, or a request or verification from a pharmacy that has previously dispensed the medication, or via direct data from DHHS, the MCO shall continue to cover such medications through the earlier of sixty (60) calendar days from the member's enrollment date, or until completion of a medical necessity review. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

14.1.9. The MCO shall adjudicate pharmacy claims for its members utilizing a point of service (POS) system where appropriate. System modifications, including but not limited to systems maintenance, software upgrades, implementation of International Classification of Diseases- 10 (ICD-10) code sets, and NDC code sets or migrations to new versions of National Council for Prescription Drug Programs (NCPDP) transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

14.1.10. In accordance with Section 1927 (d)(5)(A and B) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization and reimburse for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation when prior authorization cannot be obtained.

14.1.11.The MCO shall develop or participate in other State of New Hampshire pharmacy related quality improvement initiatives. At minimum, the MCO shall routinely monitor and address:

14.1.11.1. Polypharmacy (physical health and behavioral health medications);

14.1.11.2. Adherence to the appropriate use of maintenance medications, such as the elimination of gaps in refills;

14.1.11.3. The appropriate use of behavioral health medications in children by encouraging the use of and reimbursing for consultations with child psychiatrists;

14.1.11.4. For those beneficiaries with a diagnosis for substance use disorder (SUD) and all infants with a diagnosis of neonatal abstinence syndrome (NAS), or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall evaluate these patients needs for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment;

14.1.11.5. For those beneficiaries who enter the MCO lock-in program, the MCO shall evaluate the need for SUD treatment.

14.1.11.6. The MCO shall require prior authorization documenting the rationale for the prescription of more than 200 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective April 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescription of more than 120 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries. Effective October 1, 2016, the MCO shall require prior authorization documenting the rationale for the prescriptions of more than 100 mg daily Morphine Equivalent Doses (MED) of opioids for beneficiaries effective upon NH Board Administrative Rule MED 502 Opioid Prescribing;

14.1.12.In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 (CMS) rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process, in accordance with section 1927(b) of the SSA, and the MCO shall submit the encounter data file within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment.

14.1.13.The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for members for medications covered by other payers.

14.1.14.Specialty Drugs. The MCO shall pay for all specialty drugs consistent with the MCO's formulary and pharmacy edits and criteria.

14.1.15. DHHS will be directly responsible for the pharmacy benefit for Carbaglu and Ravicti, and those Hepatitis C and Hemophilia drugs specifically excluded from the actuarial rate calculations.

14.1.16.Other specialty and orphan drugs.

14.1.16.1. Other currently FDA approved specialty and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

14.1.16.2. When medically necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

14.1.17.Polypharmacy medication review. The MCO shall provide an offer for medication review and counseling to address polypharmacy.

14.1.17.1. MCO shall offer a medication review and counseling no less than annually by a pharmacist or other health care professional as follows:

14.1.17.1.1. To the primary care provider and care taker for children less than 19 years dispensed four (4) or more drugs per month (or prescriptions for 90 day supply covering each month); and

14.1.17.1.2.To adult beneficiaries dispensed more than 10 drugs each month (or prescriptions for 90 day supply covering each month).

14.1.18.The MCO shall adhere to federal regulation with respect to providing pharmacy data required to complete the Annual Drug Utilization Review Report to CMS:

14.1.18.1. The MCO must provide a detailed description of its drug utilization review program to DHHS on an annual basis in accordance with the Medicaid Drug Utilization Review Annual Report format and requirements; and

14.1.18.2. The MCO must operate a drug utilization review program in accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, which includes:

14.1.18.2.1. Prospective drug utilization review;

14.1.18.2.2.Retrospective drug utilization review; and

14.1.18.2.3. An educational program for providers including prescribers and dispensers.

14.2. Continuity of Care

14.2.1. The MCO shall provide continuity of care for current beneficiaries after the transition of the PDL to the MCO. For existing beneficiaries, the MCO shall provide coverage for all drugs for each current beneficiary for six months beginning September 1, 2015 for those drugs dispensed to the beneficiary within the six months prior to September 1, 2015.

14.3. Use of Psychotropic Medicines for Children in Foster Care – DCYF's SafeRx Program:

14.3.1. The MCO shall assist in the oversight and management of the use of psychotropic medicines for children and youth in DCYF placement in accordance with PL (Public Law 112-34) and in accordance with DCYF policy 1653. Assistance includes:

14.3.1.1. Psychiatry review of Medications when requested by DCYF staff, with Peer To Peer discussion if warranted to include:

14.3.1.1.1. Pharmacy claims;

14.3.1.1.2. Provider progress notes;

14.3.1.1.3. Telephone contact with the providers, if necessary;

14.3.1.1.4. Current Diagnoses, DSM I-III;

14.3.1.1.5. Current Behavioral Functioning; and

14.3.1.1.6. Information from the placement provider, either foster care or residential re: behaviors and medication response.

14.3.1.2. Edits in pharmacy systems for outlying red flag criteria that would require further explanation and authorization including:

14.3.1.2.1. Children 5 and under being prescribed antipsychotics;

14.3.1.2.2. Children 3 and under on any psychotropic medicine; and

14.3.1.2.3. A child or youth being prescribed 4 or more psychotropic medicines, allowing for tapering schedules for ending one medicine and starting a new medicine.

15. Reserved for Future

16. Member Enrollment and Disenrollment

16.1. Eligibility

16.1.1. The State has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether he/she will be enrolled in the Care Management program. The State shall maintain its current responsibility for determining member eligibility. The MCO shall comply with eligibility decisions made by DHHS.

16.1.2. The MCO shall ensure that ninety-five percent (95%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. Data received Monday-Friday is to be uploaded Tuesday-Saturday between 12 AM EST and 8AM EST. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded by 10AM EST. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond 10AM EST.

16.1.3. The ASCX12 834 enrollment file will limit enrollment history to eligibility spans reflective of any assignment of the member with the MCO.

16.1.4. To ensure appropriate continuity of care, DHHS will provide up to two (2) years (as available) of all fee-for-service paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all fee-for-service Medicaid beneficiaries assigned to MCO. For members transitioning from another MCO, DHHS will also provide such claims data as well as available encounter information regarding the member supplied by other MCOs.

16.2. Relationship with Enrollment Services

16.2.1. DHHS or its designee shall be responsible for member enrollment and passing that information along to the MCO for plan enrollment [42 CFR 438.3(d)(2)].

16.2.2. The MCO shall accept individuals into its plan from DHHS or its designee in the order in which they apply without restriction, (unless authorized by the regional administrator), up to the limits set in this Agreement [42 CFR 438.3(d)(1)].

16.2.3. The MCO will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll [42 CFR 438.3(d)(3)].

16.2.4. The MCO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has a discriminatory effect [42 CFR 438.3(d)(4].

16.2.5. The MCO shall furnish information to DHHS or its designee so that it may comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the recipient receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; State Medicaid Manual (SMM) 2090.1; SMM 2101].

16.2.6. The MCO shall provide information, within five (5) business days, to DHHS or its designee that allows for a determination of a possible change in eligibility of members (for example, those who have died, been incarcerated, or moved out-of-state).

16.3. Enrollment

16.3.1. The MCO shall accept members who choose to enroll in the MCO:

16.3.1.1. During the initial enrollment period;

16.3.1.2. During an annual enrollment period;

16.3.1.3. During a renegotiation or reprocurement enrollment period;

16.3.1.4. If the member requests to be assigned to the same plan in which another family member is currently enrolled; or

16.3.1.5. Who have disenrolled with another MCO at the time described in 16.5.3.1.

16.3.2. The MCO shall accept that enrollee enrollment is voluntary, except as described in 42 CFR 438.50.

16.3.3. The MCO shall accept for automatic re-enrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less.

16.3.4. The MCO shall accept members who have been auto-assigned by DHHS to the MCO.

16.3.5. The MCO shall accept members who are auto-assigned to another MCO but have an established relationship with a primary care provider that is not in the network of the auto-assigned MCO. The member can request enrollment any time during the first twelve (12) months of auto-assignment.

16.4. Auto-Assignment

16.4.1. DHHS will use the following auto-assignment methodology:

16.4.1.1. Preference to an MCO with which there is already a family affiliation;

16.4.1.2. Equal assignment among the MCOs.

16.4.2. DHHS reserves the right to change the auto assignment process at its discretion.

16.4.3. DHHS may also revise its auto-assignment methodology during the Contract Period for new Medicaid members who do not select an MCO (Default Members). The new assignment methodology would reward those MCOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. DHHS will also consider other appropriate factors.

16.4.4. DHHS may revise its auto-assignment methodology when exercising renegotiation and reprocurement rights under section 3.9.1 of this Agreement.

16.5. Disenrollment

16.5.1. Disenrollment provisions of 42 CFR 438.56(d)(2) apply to all members, regardless of whether the member is mandatory or voluntary [42 CFR 438.56(a); SMD letter 01/21/98].

16.5.2. A member may request disenrollment with cause at any time when:

16.5.2.1. The member moves out of state;

16.5.2.2. The member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the member to unnecessary risk; or

16.5.2.3. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to providers experienced in dealing with the member's health care needs [42 CFR 438.56(d)(2)]

16.5.3. A member may request disenrollment without cause, at the following times:

16.5.3.1. During the ninety (90) calendar days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later;

16.5.3.2. For members who are auto-assigned to a MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO, the member can request disenrollment during the first twelve (12) months of enrollment at any time;

16.5.3.3. Any time for members who enroll on a voluntary basis;

16.5.3.4. During open enrollment every twelve (12) months;

16.5.3.5. During open enrollment related to renegotiation and reprocurement under Section 3.9.

16.5.3.6. For sixty (60) calendar days following an automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual enrollment/disenrollment opportunity (This provision applies to re-determinations only and does not apply when a member is completing a new application for Medicaid eligibility); and

16.5.3.7. When DHHS imposes the intermediate sanction on the MCO specified in 42 CFR 438.702(a)(3) [§1932(a)(4)(A) of the SSA; §1932(e)(2)(C) of the SSA; 42 CFR 438.56(c)(1); 438.56(c)(2)(i), (ii), (iii), and (iv); 42 CFR 438.702(a)(3); SMD letter 02/20/98; SMD letter 01/21/98]

16.5.4. The MCO shall provide members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period.

16.5.5. If a member is requesting disenrollment, the member (or his or her representative) shall submit an oral or written request to DHHS or its agent.

16.5.6. The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS' request for information.

16.5.7. The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons [42 CFR 438.56(b)(1); SMM 2090.12]:

16.5.7.1. Member has established out of state residence;

16.5.7.2. Member death;

16.5.7.3. Determination that the member is ineligible for enrollment based on the criteria specified in this Agreement regarding excluded populations; or

16.5.7.4. Fraudulent use of the member ID card.

16.5.8. The MCO shall not request disenrollment of a member for any reason not permitted in this Agreement [42 CFR 438.56(b)(3)].

16.5.9. The MCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular

member or other members) or abuse of substances, prescribed or illicit, and any legal consequences resulting from substance abuse. [42 CFR 438.56(b)(2)].

16.5.10. The MCO may request disenrollment in the event of threatening or abusive behavior that jeopardizes the health or safety of members, staff, or providers.

16.5.11. If an MCO is requesting disenrollment of a member, the MCO shall:

16.5.11.1. Specify the reasons for the requested disenrollment of the member; and

16.5.11.2. Submit a request for involuntary disenrollment to DHHS (or its agent) along with documentation and justification, for review and approval

16.5.12. Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member or the MCO files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); SMM 2090.6; SMM 2090.11].

16.5.13. DHHS (or its agent) shall provide for automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less [42 CFR 438.56(g)].

17. Member Services

17.1. Member Information

17.1.1. The MCO shall maintain a Member Services Department to assist members and their family members, guardians or other authorized individuals in obtaining covered services under the Care Management program.

17.1.2. The MCO shall have a 'No Wrong Door' approach, consistent with the DHHS Balancing Incentive Program, to member calls and inquiries, and shall have one toll-free number for members to contact.

17.1.3. The MCO shall have in place a mechanism to help members and potential members understand the requirement and benefits of the plan [42 CFR 438.10(c)(7)].

17.1.4. The MCO shall make a welcome call to each new member within thirty (30) days of the member's enrollment in the MCO. A minimum of three (3) attempts should be made at various times of the day, on different days, for at least ninety-five percent (95%) of new members. The welcome call shall at a minimum:

17.1.4.1. Assist the member to select a Primary Care Provider (PCP) or confirm selection of a PCP;

17.1.4.2. Include a brief Health Needs Assessment;

17.1.4.3. Screen for special needs and /or services of the member; and

17.1.4.4. Answer any other member questions about the MCO and ensure that members can access information in their preferred language.

17.1.5. Welcome calls shall not be required for members residing in a nursing facility longer than 120 days. The MCO shall:

17.1.5.1. Meet with each nursing facility no less than annually to provide an orientation to the MCM program and instructions regarding completion of the Health Needs Assessment for each member residing in a nursing facility longer than 120 days; and

17.1.5.2. Send letters to members residing in nursing facilities longer than 120 days or their authorized representatives describing welcome calls and how a member or their authorized representative can request a welcome call.

17.1.6. The MCO shall send a letter to a member upon initial enrollment, and anytime the member requests a new Primary Care Provider (PCP), confirming the member's PCP and providing the PCP's name address and telephone number.

17.1.7. The MCO shall issue an Identification Card (ID Card) to all new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. The ID Card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the ID card:

17.1.7.1. The member's name;

17.1.7.2. The member's date of birth;

17.1.7.3. The member's Medicaid ID number assigned by DHHS at the time of eligibility determination;

17.1.7.4. The name of the MCO; and

17.1.7.5. The name of MCO's NHHPP product;

17.1.7.6. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

17.1.7.7. How to file an appeal or grievance.

17.1.8. The MCO shall reissue a Member ID card if:

17.1.8.1. A member reports a lost card;

17.1.8.2. A member has a name change; or

17.1.8.3. Any other reason that results in a change to the information disclosed on the ID card.

17.1.9. The MCO shall publish member information in the form of a member handbook available at the time of member enrollment in the plan for benefits effective January 1, 2018. The member handbook shall be based upon the model enrollee handbook developed by DHHS.

17.1.9.1. Two weeks in advance of open enrollment, the MCOs shall inform all members by mail of their right to receive at no cost to any member a written copy of the member handbook effective for the new benefit year.

17.1.10. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives.

17.1.11.The MCO shall submit the member handbook to DHHS for approval at the time it is developed and after any substantive revisions, prior to publication and distribution

17.1.12.Pursuant to the requirements set forth in 42 CFR 438.10, the Member Handbook shall include, in easily understood language, but not be limited to:

17.1.12.1. A table of contents;

17.1.12.2. DHHS developed definitions so that enrollees can understand the following terminology: appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, grievance, habilitation services and devices, home health care, hospice services, hospitalization, hospital, outpatient care, physician services, prescription drug coverage, prescription drugs, primary care physician, PCP, rehabilitation services and devices, skilled nursing care, and specialist.

17.1.12.3. Information about the role of the primary care provider (PCP);

17.1.12.4. Information about choosing and changing a PCP;

17.1.12.5. Appointment procedures;

17.1.12.6.

17.1.12.7. Description of all available benefits and services, including information on out-of-network providers;Information on how to access services, including EPSDT services, non-emergency transportation services, and maternity and family planning services. The handbook should also explain that the MCO cannot require a member to receive prior approval prior to choosing a family planning provider;

17.1.12.8. An explanation of any service limitations or exclusions from coverage;

17.1.12.9. A notice stating that the MCO shall be liable only for those services authorized by or required of the health plan;

17.1.12.10.Information on where and how members may access benefits not available from or not covered by the MCO;

17.1.12.11.The Necessity definitions used in determining whether services will be covered;

17.1.12.12.Detailed information regarding the amount, duration, and scope of benefits so that enrollees understand the benefits to which they are entitled.

17.1.12.13.A description of all pre-certification, prior authorization, or other requirements for treatments and services;

17.1.12.14.Information regarding prior authorization in the event the member chooses to transfer to another MCO and the member's right to continue to utilize a provider specified in a prior authorization regardless of whether the provider is participating in the MCO network;

17.1.12.15.The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;

17.1.12.16.Information on how to obtain services when the member is out of the State and for after-hours coverage;

17.1.12.17.Cost-sharing requirements;

17.1.12.18.Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including an inclusion of the MCO's toll-free telephone line and website;

17.1.12.19.A description of Utilization Review policies and procedures used by the MCO;

17.1.12.20.A description of those member rights and responsibilities, described in 17.3 of this Agreement, but also including but not limited to notification that:

17.1.12.20.1.Oral interpretation is available for any language, and information as to how to access those services;

17.1.12.20.2.Written translation is available in prevalent languages, and information as to how to access those services;

17.1.12.20.3.Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and information as to how to access those services;

17.1.12.21.The policies and procedures for disenrollment;

17.1.12.22.Information on Advance Directives;

17.1.12.23.A statement that additional information, including information on the structure and operation of the MCO plan and provider incentive plans, shall be made available upon request;

17.1.12.24.Member rights and protections;

17.1.12.25.Information on the Grievance, Appeal, and Fair Hearing procedures and timeframes in a DHHS-approved description, including:

17.1.12.25.1.The right to file grievances and appeals;

17.1.12.25.2.The requirements and timeframes for filing a grievance or appeal;

17.1.12.25.3.The availability of assistance in the filing process;

17.1.12.25.4.The right to request a State fair hearing after the MCO has made a determination on an enrollee's appeal which is adverse to the enrollee; and

17.1.12.25.5.An enrollee's right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however if the enrollee receives an adverse decision then the enrollee may be required to pay for the cost of service furnished while the appeal or State fair hearing is pending as specified in 42 CFR 438.10(g)(2); zzz

17.1.12.26.Member's right to a second opinion from a qualified health care professional within the network, or one outside the network arranged by the MCO at no cost to the member. [42 CFR 438.206(b)(3)].

17.1.12.27.The extent to which, and how, after hours and emergency coverage are provided including:

17.1.12.27.1.What constitutes an emergency and emergency medical care; and

17.1.12.27.2.The fact that prior authorization is not required for emergency services; and

17.1.12.27.3.The enrollee's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)];

17.1.12.28.Information on how to access the New Hampshire Office of the Long Term Care Ombudsman;

17.1.12.29. Information on how to access auxiliary aids and services, including additional information in alternative formats or languages;

17.1.12.30. Information and guidance as to how the enrollee can effectively use the managed care program as described in 42 CFR 438.10(g)(2);

17.1.12.31. Information on how to report suspected fraud or abuse;

17.1.12.32. Information on how to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center who can provide all enrollees and potential enrollees choice counseling and information on managed care; and

17.1.12.33. Disenrollment information.

17.1.13. The MCO shall produce a revised member handbook, or an insert informing members of changes to covered services, upon DHHS notification of any change in covered services, and at least thirty (30) calendar days prior to the effective date of such change. In addition to changes to documentation, the MCO shall notify all existing members of the covered services changes at least thirty (30) calendar days prior to the effective date of such changes.

17.1.14. The MCO shall mail the handbook to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment [42 CFR 438.10(g)(1)].

17.1.15. The MCO shall notify all enrollees of their disenrollment rights, at a minimum, annually [42 CFR 438.10 (f)].

17.1.16.

17.1.17. The MCO shall notify all enrollees, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the plan's website. The member information appearing on the website shall include the following, at a minimum:

17.1.17.1. Information contained in the Member Handbook

17.1.17.2. The following information on the MCO's provider network:

17.1.17.2.1. Names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English languages (including American Sign Language) spoken by current contracted providers, including identification of providers that are not accepting new patients. This shall include, at a minimum: information on PCPs, specialists, Family Planning Providers, pharmacies, Federally

Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals;

17.1.17.2.2. Any restrictions on the member's freedom of choice among network providers; and

17.1.17.2.3. How to file an appeal and/or a grievance.

17.1.18. For any change that affects member rights, filing requirements, time frames for grievances, appeals, and State fair hearing, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each member written notice of the change at least thirty (30) days before the intended effective date of the change.

17.1.19. The MCO shall notify members of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the enrollee can access those services. [42 CFR 438.102(b)(1)(ii)(B) and 42 CFR 438.10].

17.1.20. The MCO shall submit a copy of all information intended for members to DHHS for approval ten (10) business days prior to distribution.

17.2. Language and Format of Member Information

17.2.1. The MCO shall develop all member materials at or below a sixth (6th) grade reading level, as measured by the appropriate score on the Flesch reading ease test.

17.2.2. The MCO shall use the DHHS developed definitions consistently throughout its user manual, notices, and in any other form of client communication.

17.2.3. The MCO shall develop enrollee notices in accordance with the DHHS model notices.

17.2.4. The MCO shall provide all enrollment notices, information materials, and instructional materials relating to members and potential members in a manner and format that may be easily understood in a font size no smaller than 12 point [42 CFR 438.10(d) / SMD Letter 2/20/98].

17.2.5. The MCO's written materials shall be developed to meet all applicable Cultural Considerations requirements in Section 18 so that they are communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The MCO shall inform members that information is available in alternative formats and how to access those formats [42 CFR 438.10(d)(6)].

17.2.6. The MCO shall make all written member information available in English, Spanish, and the commonly encountered languages of New Hampshire. All written member information shall include at the bottom a tagline explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the MCO's Customer Service Center. The MCO shall also provide all written member information in large print with a font size no smaller than 18 point upon request [42 CFR 438.10(d)(3)].

17.2.6.1. Written member information shall include at a minimum provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.

17.2.7.

17.2.8. The MCO shall also make oral interpretation services available free of charge to each member or potential member for MCO covered services. This applies to all non-English languages, not just those that DHHS identifies as languages of other Major Population Groups. The beneficiary shall not to be charged for interpretation services. The MCO shall notify members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services [42 CFR 438.10(d)].The MCO shall provide auxiliary aids such as TTY/TDY and American Sign Language interpreters available free of charge to each member or potential member who requires these services [42 CFR 438.10(d)].

17.3. Member Rights

17.3.1. The MCO shall have written policies which shall be included in the member handbook and posted on the MCO website regarding member rights [42 CFR 438.100] including:

17.3.1.1. Each managed care member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;

17.3.1.2. Each managed care member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

17.3.1.3. Each managed care member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment;

17.3.1.4. Each managed care member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

17.3.1.5. Each managed care member is guaranteed the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 42 CFR 438.100; and

17.3.1.6. Each managed care member has a right to a second opinion. [42 CFR 438.206].

17.3.2. Each member is free to exercise his/her rights, and that the MCO shall assure that the exercise of those rights shall not adversely affect the way the MCO and its providers or DHHS treat the member [42 CFR 438.100(c)].

17.3.3. Each managed care member has the right to request and receive any MCO's written physician incentive plans.

17.4. **Member Call Center**

17.4.1. The MCO shall operate a NH specific call center Monday through Friday, except for state approved holidays. The call center shall be staffed with personnel who are knowledgeable about the MCOs plan in NH to answer member inquiries.

17.4.2. At a minimum, the call center shall be operational:

17.4.2.1. Two days per week: 8:00 am EST to 5:00 pm EST;

17.4.2.2. Three days per week: 8:00 am EST to 8:00 pm EST; and

17.4.2.3. During major program transitions; additional hours and capacity shall be accommodated by the MCO.

17.4.3. The member call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

17.4.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

17.4.3.2. Average Speed of Answer: Ninety percent (90%) of calls will be answered with live voice within thirty (30) seconds; and

17.4.3.3. Voicemail messages shall be responded to no later than the next business day.

17.4.4. The MCO shall develop a means of coordinating its call center with the DHHS Customer Service Center.

17.4.5. The MCO shall develop a warm transfer protocol for members who may call the incorrect call center to speak to the correct representative and provide monthly reports

to DHHS on the number of warm transfers made and the program to which the member was transferred.

17.5. Member Information Line

17.5.1. The MCO shall establish a member hotline that shall be an automated system that operates outside of the call center standard hours, Monday through Friday, and at all hours on weekends and holidays.

17.5.2. The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for callers to leave messages.

17.5.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages.

17.5.4. A representative of the MCO shall return messages no later than the next business day.

17.6. Marketing

17.6.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing to potential members [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.2. The MCO shall submit all MCO marketing material to DHHS for approval before distribution [§1932(d)(2)(A)(1) of the SSA; 42 CFR 438.104(b)(1)(i); SMD letter 12/30/97]. DHHS will identify any required changes to the marketing materials within fifteen (15) business days. If DHHS has not responded to a request for review by the fifteenth (15th) business day, the MCO may proceed to use the submitted materials.

17.6.3. The MCO shall comply with federal requirements for provision of information that ensures the potential member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

17.6.4. The MCO marketing materials shall not contain false or materially misleading information.

17.6.5. The MCO shall not offer other insurance products as inducement to enroll.

17.6.6. The MCO shall ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients of DHHS [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii),

(iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.6.7. The MCO's marketing materials shall not contain any written or oral assertions or statements that:

17.6.7.1. The recipient must enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

17.6.7.2. That the MCO is endorsed by CMS, the Federal or State government, or similar entity [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101]

17.6.8. The MCO shall distribute marketing materials to the entire state in accordance with §1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1 and SMM 2101. The MCO's marketing materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance [§1932(d)(2)(A)(i)(II) of the SSA; §1932(d)(2)(B), (C), (D) and (E) of the SSA; 42 CFR 438.104(b)(1)(ii), (iii), (iv) and (v); 42 CFR 438.104(b)(2); 42 CFR 438.104(b)(2)(i) and (ii); SMD letter 12/30/97; SMD letter 2/20/98; SMM 2090.1; SMM 2101].

17.7. Member Engagement Strategy

17.7.1. The MCO shall develop and facilitate an active member advisory board that is composed of members who represent its member population. At least twenty-five percent (25%) of the members of the advisory board should be receiving an LTSS service or be a support person, who is not a paid service provider or employed as an advocate, to a member receiving an LTSS service. Representation on the consumer advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. The advisory board shall meet at least quarterly. The advisory board shall meet in-person or through interactive technology including but not limited to a conference call or webinar and provide a member perspective to influence the MCO's quality improvement program, program changes and decisions. All costs related to the member advisory board shall be the responsibility of the MCO.

17.7.2. The MCO shall hold in-person regional member meetings for two-way communication where members can provide input and ask questions and the MCO can ask questions and obtain feedback from members. Regional meetings shall be held at least twice each Agreement year. The MCO shall make efforts to provide video conferencing opportunities for members to attend the regional meetings. If video conferencing is not available then, the MCO shall use alternate technologies as available for all meetings.

17.7.3. The MCO shall report on the activities of the meetings required in Sections 17.7.1 and 17.7.2 including meeting dates, board members, topics discussed and actions taken in response to Board contributions to DHHS in the Medicaid Care Management Program Comprehensive Annual Report.

17.7.4. The MCO shall conduct a member satisfaction survey at least annually in accordance with National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) requirements to gain a broader perspective of member opinions. The MCO survey instrument is subject to DHHS approval. The results of these surveys shall be made available to DHHS to be measured against criteria established by DHHS, and to the MCO's membership [§1903(m)(2)(A)(x) of the SSA; 42 CFR 422.208; 42 CFR 422.210; 42 CFR 438.10(f)(6); 42 CFR 438.10(g); 42 CFR 438.6(h)].

17.7.5. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

17.8. Provider Directory

17.8.1. The MCO shall publish a Provider Directory that shall be approved by DHHS prior to publication and distribution. The MCO shall submit the draft directory and all substantive changes to DHHS for approval.

17.8.2. The Provider Directory shall include names, gender, locations, office hours, telephone numbers of, website (if applicable), specialty (if any), description of accommodations offered for people with disabilities, whether the provider has completed cultural competence training, and non-English language (including American Sign Language) spoken by, current contracted providers. This shall include, at a minimum; information on PCPs, specialists, Family Planning Providers, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), Mental Health and Substance Abuse Providers, LTSS Providers, Nursing Facilities and hospitals.

17.8.3. The Provider Directory shall provide all information according to the requirements of 42 CFR 438.10(h).

17.8.4. The MCO shall send a letter to new members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the member to the Provider Directory on the MCO's website and informing the member of the right to a printed version of provider directory information upon request [42 CFR 438.10(h)].

17.8.5. The MCO shall notify all members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the plan's website in a machine readable file and format as specified by the Secretary. The MCO shall update the paper copy of the Provider Directory at least monthly and shall update no later than thirty (30) calendar days after the MCO receives updated information. [42 CFR 438.10(h)(4)].

17.8.6. The MCO shall post on its website a searchable list of all contracted providers. At a minimum, this list shall be searchable by provider name, specialty, and location.

17.8.7. Thirty (30) calendar days after contract effective date or ninety (90) calendar days prior to the Program start date, whichever is later, the MCO shall develop and submit the draft Provider Directory template to DHHS for approval and thirty (30) calendar days prior to each Program Start Date the MCO shall submit the final provider directory.

17.8.8. Upon the termination of a contracted provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify enrollees who received their primary care from, or was seen on a regular basis by, the terminated provider.

17.9. Program Website

17.9.1. The MCO shall develop and maintain, consistent with DHHS standards and other applicable Federal and State laws, a website to provide general information about the MCO's program, its provider network, the member handbook, its member services, and its grievance and appeals process.

17.9.2. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes.

17.9.3. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory. The Provider Directory shall identify all providers, including primary care, specialty care, behavioral health, substance abuse, home health, home care, rehabilitation, hospital, LTSS, and other providers, and include the following information for each provider:

17.9.3.1. Address of all practice/facility locations;

17.9.3.2. Gender;

17.9.3.3. Office hours;

17.9.3.4. Telephone numbers;

17.9.3.5. Website (if applicable);

17.9.3.6. Accommodations provided for people with disabilities;

17.9.3.7. Whether the provider has completed cultural competence training;

17.9.3.8. Hospital affiliations, if applicable;

17.9.3.9. Open/close status for MCO members;

17.9.3.10. Languages spoken (including American Sign Language) in each provider location;

17.9.3.11. Medical Specialty; and

17.9.3.12. Board certification, when applicable.

17.9.3.13. The MCO program content included on the website shall be:

17.9.3.14. Written in English, Spanish, and any other of the commonly encountered languages in the State;

17.9.3.15. Culturally appropriate;

17.9.3.16. Written for understanding at the 6th grade reading level; and

17.9.3.17. Geared to the health needs of the enrolled MCO program population.

17.9.4. The MCO shall maintain an updated list of formulary drug lists on its website. Such information shall include:

17.9.4.1. Which medications are covered (both generic and name brand); and

17.9.4.2. Which tier each medication is on.

17.9.5. The MCO's NH Medicaid Care Management website shall be compliant with the Federal Department of Justice "Accessibility of State and Local Government Websites to people with disabilities".

18. Culturally and Linguistically Competent Services

18.1. Cultural Competency Plan

18.1.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how the MCO shall ensure that services are provided in a culturally and linguistically competent manner to all Medicaid members, including those with Limited English Proficiency (LEP). The Cultural Competency Plan shall describe how the providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. The MCO shall work with DHHS Office of Minority Heath & Refugee Affairs and the New Hampshire Medical Society to address cultural and linguistic considerations as defined in the section.

18.2. General Provisions

18.2.1. The MCO shall participate in efforts to promote the delivery of services in a culturally and linguistically competent manner to all members and their families, including those with LEP and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)].

18.2.2. The MCO shall develop appropriate methods of communicating and working with its members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

18.2.3. The MCO shall develop appropriate methods for identifying and tracking members' needs for communication assistance for health encounters including preferred spoken language for health encounters, need for interpreter, and preferred language for written health information.

18.2.4. The MCO shall collect data regarding member's race, ethnicity, and spoken language in accordance with the current best practice standards from the Office of Management and Budget and/or the 2011 final standards for data collection as required by Section 4302 of the Affordable Care Act from the federal Department of Health and Human Services.

18.2.5. The MCO shall not use children or minors to provide interpretation services.

18.2.6. If the member declines offered free interpretation services, there must be a process in place for informing the member of the potential consequences of declination with the assistance of a competent interpreter to assure the member's understanding, as well as a process to document the member's declination. Interpreter services must be re-offered at every new contact. Every declination requires new documentation of the offer and decline.

18.2.7. The MCO shall respect members whose lifestyle or customs may differ from those of the majority of members.

18.2.8. The MCO shall ensure interpreter services are available to any member who requests them, regardless of the prevalence of the member's language within the overall program for all health plan and MCO services exclusive of inpatient services. The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e., will provide meaningful access) for all members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and will be based upon the unique needs and circumstances of each individual. Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the provider of the encounter service.

18.2.9. The MCO shall bear the cost of interpretive services, including American Sign Language (ASL) interpreters and translation into Braille materials available to hearing- and vision-impaired members.

18.2.10. The Member Handbook shall include information on the availability of oral and interpretive services.

18.2.11. The MCO shall communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care.

18.2.12. As a condition of receipt of Federal financial assistance, the MCO acknowledges and agrees that it must comply with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin (42 U.S.C. 2000d et seq.).

18.2.13. As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of Limited English Proficiency (LEP). To ensure compliance with Title VI, the MCO must take reasonable steps to ensure that LEP persons have meaningful access to the MCO's programs. The MCO shall provide the following assistance, including, but not limited to:

18.2.13.1. Offer language assistance to individuals who have LEP and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

18.2.13.2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

18.2.13.3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

18.2.13.4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

18.2.14. Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. MCOs are encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. For assistance and information regarding MCO LEP obligations, go to **http://www.lep.gov**.

19. Grievances and Appeals

19.1. General Requirements

19.1.1. The MCO shall develop, implement and maintain a Grievance System under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance and which includes a grievance process, an appeal process, and access to the State's fair hearing system. The MCO shall ensure that the Grievance System is in compliance with 42 CFR 438 Subpart F, and N.H. Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

19.1.2. The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS' review and approval prior to the first readiness review. Any proposed changes to the Grievance System must be approved by DHHS prior to implementation.

19.1.3. The Grievance System shall be responsive to any grievance or appeal of dual- eligible members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accord with this Agreement. In the event the MCO, after review, determines that the dual-eligible member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the member to the State's SHIP program, which is currently administered by Service Link Aging and Disability Resource Center.

19.1.4. The MCO shall be responsible for ensuring that the Grievance System (grievance process, appeal process, and access to the State's fair hearing system) complies with the following general requirements. The MCO must:

19.1.4.1. Give members any reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the member in providing written consent for appeals;

19.1.4.2. Acknowledge receipt of each grievance and appeal (including oral appeals), unless the enrollee or authorized provider requests expedited resolution;

19.1.4.3. Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making;

19.1.4.4. Ensure that decision makers take into account all comments, documents, records, and other information submitted by the enrollee of their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination; and

19.1.4.4.1. If deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the member's condition or disease:

a. An appeal of a denial based on lack of medical necessity;

b. A grievance regarding denial of expedited resolutions of an appeal; or

c. A grievance or appeal that involves clinical issues.

19.1.5. The MCO shall send written notice to members and providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

19.1.6. The MCO shall provide information as specified in 42 CFR § 438.10(g) about the Grievance System to providers and subcontractors at the time they enter into a contact or subcontract. The information shall include, but is not limited to:

19.1.6.1. The member's right (or provider acting on their behalf) to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

19.1.6.2. The member's right to file grievances and appeals and their requirements and timeframes for filing;

19.1.6.3. The availability of assistance with filing;

19.1.6.4. The toll-free numbers to file oral grievances and appeals;

19.1.6.5. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

19.1.6.6. Any State-determined provider appeal rights to challenge the failure of the MCO to cover a service.

19.1.7. The MCO shall make available training to providers in supporting and assisting members in the Grievance System.

19.1.8. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the member, the dates received, the dates of each review, the dates of the grievance or appeal, and the date of resolution.

19.1.9. The MCO shall provide a report of all actions, grievances, and appeals, including all matters handled by delegated entities, to DHHS on a monthly basis..

19.1.10.The MCO shall review Grievance System information as part of the State quality strategy and in accord with this Agreement and 42 CFR 438.402. The MCO shall make such information accessible to the State and available upon request to CMS.

19.1.11. The MCO shall provide any and all provider complaint and appeal logs to DHHS.

19.2. Grievance Process

19.2.1. The MCO shall develop, implement, and maintain a grievance process that establishes the procedure for addressing member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.2.2. The grievance process shall address member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. An enrollee or the enrollee's authorized representative with written consent may file a grievance at any time.

19.2.3. Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated, may file a complaint with the MCO in accordance with He-M 204.

19.2.4. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR part 438, subpart K may file a grievance.

19.2.5. The MCO shall have policies and procedures addressing the grievance process, which comply with the requirements of this Agreement. The MCO shall submit in advance to DHHS for its review and approval, all grievance process policies and procedures and related notices to members regarding the grievance process. Any proposed changes to the grievance process must be approved by DHHS prior to implementation.

19.2.6. The MCO shall allow a member, or the member's authorized representative with the member's written consent to file a grievance with the MCO either orally or in writing [42 CFR 438.402(c)].

19.2.7. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance for at least one hundred percent (100%) of members filing a grievance. If the enrollee requests disenrollment, then the MCO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment.

19.2.8. The MCO shall notify members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues must be in writing.

19.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

19.3. Appeal Process

19.3.1. The MCO shall develop, implement, and maintain an appeal process that establishes the procedure for addressing member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

19.3.2. The MCO shall allow a member, or the member's authorized representative, or a provider acting on behalf of the member and with the member's written consent, to request an appeal orally or in writing of any MCO action [42 CFR 438.402(c)].

19.3.3. The MCO shall include as parties to the appeal, the member and the member's authorized representative, or the legal representative of the deceased member's estate.

19.3.4. For appeals of standard service authorization decisions, the MCO shall allow a member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. This shall also apply to a member's request for an expedited appeal. An oral appeal must be followed by a written, signed appeal.

19.3.5. The MCO shall ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the member or the authorized provider requests expedited resolution. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution.

19.3.6. If DHHS receives a request to appeal an action of the MCO, DHHS will forward relevant information to the MCO and the MCO will contact the member and acknowledge receipt of the appeal.

19.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

19.3.8. The MCO shall allow the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO shall inform the member of the limited time available for this in the case of expedited resolution.

19.3.9. The MCO shall provide the member and the member's representative opportunity, to receive the member's case file, including medical records, and any other documents and records considered during the appeal process free of charge prior to the hearing.

19.3.10.The MCO shall resolve at least one hundred percent (100%) of member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. The date of filing shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest. Or, in the case of a provider filing an appeal on behalf of the member, the date of filing shall be considered the date upon which the MCO receives authorization from the member for the provider to file an appeal on the member's behalf.

19.3.11.If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the enrollee is deemed to have exhausted the MCO's appeals process, and the enrollee may initiate a state fair hearing.

19.3.12. Members who believe the MCO is not providing mental health or substance use disorder benefits in violation of 42 CFR 42 CFR part 438, subpart K may file an appeal.

19.4. Actions

19.4.1. The MCO shall allow for the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

19.4.1.1. Denial or limited authorization of a requested service, including the type or level of service;

19.4.1.2. Reduction, suspension, or termination of a previously authorized service;

19.4.1.3. Denial, in whole or in part, of payment for a service;

19.4.1.4. Failure to provide services in a timely manner, as defined by the State;

19.4.1.5. Untimely service authorizations;

19.4.1.6. Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

19.4.1.7. At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one MCO, the denial of a member's request to obtain services outside the network, in accord with 42 CFR 438.52(b)(2)(ii).

19.5. Expedited Appeal

19.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the member, or a provider request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

19.5.1.1. The MCO must inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals.

19.5.1.2. The MCO shall make a decision on the member's request for expedited appeal and provide notice, as expeditiously as the member's health condition requires, within 72 hours after the MCO receives the appeal. The MCO may extend the 72 hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest. The MCO shall also make reasonable efforts to provide oral notice. The first date shall

be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest.

19.5.1.3. If the MCO extends the timeframes not at the request of the enrollee, it must:

19.5.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.5.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision;

19.5.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.5.1.4. The MCO shall meet the timeframes in 19.5.1.2 for at least one hundred percent (100%) of requests for expedited appeals.

19.5.1.5. The MCO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

19.5.1.6. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

19.5.1.7. The member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the member of his/her right and the procedures to file a grievance in the notice of denial.

19.6. Content of Notices

19.6.1. The MCO shall notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing.

19.6.2. Each notice of adverse action shall conform with 42 CFR 431.210, contain and explain:

19.6.2.1. The action the MCO or its subcontractor has taken or intends to take;

19.6.2.2. The reasons for the action;

19.6.2.3. The member's or the provider's right to file an appeal;

19.6.2.4. Procedures for exercising member's rights to appeal or grieve;

19.6.2.5. Circumstances under which expedited resolution is available and how to request it; and

19.6.2.6. The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits.

19.6.3. The MCO shall ensure that all notices of adverse action be in writing and must meet the following language and format requirements:

19.6.3.1. Written notice must be translated for the individuals who speak one of the commonly encountered languages spoken in New Hampshire (as defined by the State per 42 CFR 438.10(d));

19.6.3.2. Notice must include language clarifying that oral interpretation is available for all languages and how to access it; and

19.6.3.3. Notices must use easily understood language and format, and must be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All members and potential members must be informed that information is available in alternative formats and how to access those formats.

19.6.4. The MCO shall mail the notice of adverse benefit determination by the date of the action when any of the following occur:

19.6.4.1 The enrollee has died;

19.6.4.2 The enrollee submits a signed written statement requesting service termination;

19.6.4.3 The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction will result;

19.6.4.4 The enrollee has been admitted to an institution where he or she is ineligible under the state plan for further services;

19.6.4.5 The enrollee's address is determined unknown based on returned mail with no forwarding address;

19.6.4.6 The enrollee is accepted for Medicaid services by another state, territory, or commonwealth;

19.6.4.7 A change in the level of medical care is prescribed by the enrollee's physician;

19.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act;

19.6.4.9 The transfer or discharge from a facility will occur in an expedited fashion.

19.7. Timing of Notices

19.7.1. Termination, suspension or reduction of services - The MCO shall provide members written notice at least ten (10) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services, except the period of advance notice shall be five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the member.

19.7.2. Denial of payment - The MCO shall provide members written notice on the date of action when the action is a denial of payment or reimbursement.

19.7.3. Standard service authorization denial or partial denial- The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

19.7.3.1. The member or the provider requests the extension; or

19.7.3.2. The MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.3.3. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

19.7.4. Expedited process - For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or

health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

19.7.4.1. The MCO may extend the three (3) business days' time period by up to seven (7) calendar days if the member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the member's interest.

19.7.5. Untimely service authorizations - The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations.

19.8. Continuation of Benefits

19.8.1. The MCO shall continue the member's benefits if:

19.8.1.1. The appeal is filed timely, meaning on or before the later of the following:

19.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action; or

19.8.1.1.2. The intended effective date of the MCO's proposed action.

19.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

19.8.1.3. The services was ordered by an authorized provider;

19.8.1.4. The authorization period has not expired; and

19.8.1.5. The member requests extension of benefits, orally or in writing.

19.8.2. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

19.8.2.1. The member withdraws the appeal, in writing;

19.8.2.2. The member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision;

19.8.2.3. A State fair hearing decision adverse to the member is made; or

19.8.2.4. The authorization expires or authorization service limits are met.

19.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the member the amount paid for the services provided to the member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

19.9. Resolution of Appeals

19.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within the following timeframes:

19.9.1.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within thirty (30) calendar days after receipt of the appeal, unless the MCO notifies the member that an extension is necessary to complete the appeal.

19.9.1.2. The MCO may extend the timeframes up to fourteen (14) calendar days if:

19.9.1.2.1. The member requests an extension, orally or in writing; or

19.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the member's best interest.

19.9.1.3. If the MCO extends the timeframes not at the request of the enrollee then it must:

19.9.1.3.1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;

19.9.1.3.2. Within two (2) calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

19.9.1.3.3. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

19.9.1.4. Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request.

19.9.2. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

19.9.3. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting provider or member may obtain the Utilization Management clinical review or decision-making criteria.

19.9.4. For notice of an expedited resolution, the MCO shall make reasonable efforts to provide oral notice.

19.9.5. For appeals not resolved wholly in favor of the member, the notice shall:

19.9.5.1. Include information on the member's right to request a State fair hearing;

19.9.5.2. How to request a State fair hearing;

19.9.5.3. Include information on the member's right to receive services while the hearing is pending and how to make the request; and

19.9.5.4. Inform the member that the member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action.

19.10.State Fair Hearing

19.10.1.The MCO shall inform members and providers regarding the State fair hearing process, including but not limited to, members right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F. The Parties to the State fair hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

19.10.2.The MCO shall ensure that members are informed, at a minimum, of the following:

19.10.2.1. That members must exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

19.10.2.2. That if a member does not agree with the MCO's resolution of the appeal, the member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date on the MCO's notice of the resolution of the appeal.

19.10.3.If the member requests a fair hearing, the MCO shall provide to DHHS and the member, upon request, and within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

19.10.4.The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit. The MCO shall consult with DHHS regarding the State fair hearing process In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate and at no additional cost. In the event the State fair hearing

decision is appealed by the member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost. The Office of the Attorney General or designee shall represent the State on an appeal from a fair hearing decision by a member.

19.10.5. DHHS shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

19.11.Effect of Adverse Decisions of Appeals and Hearings

19.11.1.If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

19.11.2.If the MCO or DHHS reverses a decision to deny authorization of services, and the member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services.

19.12.Survival

19.12.1.The obligations of the MCO pursuant to Section 19 to fully resolve all grievances and appeals including, but not limited to, providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

20. Access

20.1. Network

20.1.1. The MCO shall provide documentation to DHHS showing that it is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 20 and 21.

20.1.2. The MCO's network shall have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the geographic standards in Section 20.2, the timely provision of services requirements in Section 20.4, Equal Access, and reasonable choice by members to meet their needs.

20.1.3. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the readiness review for the enrollment of NHHPP members.

20.1.4. The MCO shall submit documentation to DHHS to demonstrate that it maintains a substantial provider network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)] prior to the first readiness review for each phase of Step 2.

20.1.5. The MCO shall submit documentation to DHHS to demonstrate that it maintains an adequate network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)]:

20.1.5.1. At the second readiness review prior to the Program start date;

20.1.5.2. Forty-five (45) calendar days following the end of the semi-annual period; and

20.1.5.3. At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to:

20.1.5.3.1. Changes in services, benefits, geographic service area, or payments

20.1.5.3.2. Enrollment of a new population in the MCO [42 CFR 438.207(c)]

20.1.6. The MCO shall submit documentation quarterly to DHHS to demonstrate Equal Access to services for Step 1, 2 and NHHPP populations.

20.1.7. The MCO shall be subject to annual, external independent reviews of the timeliness of, and access to the services covered under this Agreement [42 CFR 438.204].

20.1.8. For Step 1 Implementation, the anticipated number of members in Sections 20.1.1 and 20.1.2 shall be based on the "NH Medicaid Care Management Fifty Percent Population Estimate by Zip code" report provided by DHHS.

20.2. Geographic Distance

20.2.1. The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and Equal Access to its members.

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
SUD Councilors (MLDAC)	One (1) within forty-five (45) minutes or fifteen (15) miles
SUD Programs (Comprehensive, Outpatient, Methadone Clinics)	One (1) within sixty (60) minutes or forty-five (45) miles.

20.3. NH Ins 2701.06 Standards for Geographic Accessibility

20.3.1. The MCO may request exceptions from these standards after demonstrating its efforts to create a sufficient network of providers to meet these standards. DHHS reserves the right at its discretion to approve or disapprove these requests, approval shall not be unreasonably withheld.

20.3.1.1. Should the MCO, after good faith negotiations, be unable to create a sufficient number of providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with the help of DHHS, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) days after start date Section 34.7.1 shall not apply.

20.3.1.2. Except for the provisions of 20.3.1.1, should the MCO, after good faith negotiations, be unable to create a sufficient number of providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with the help of DHHS, continue to be unable to meet geographic and timely access to service delivery standards DHHS may, at its discretion, provide temporary exemption to the MCO from Section 34.7.1.

20.3.2. At any time the provisions of this section may apply, the MCO will work with DHHS to ensure that members have access to needed services.

20.3.3. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the provider network to ensure that necessary admissions can be made.

20.4. Timely Access to Service Delivery

20.4.1. The MCO shall make services available for members twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR 438.206(c)(1)(iii)].

20.4.2. The MCO shall require that all network providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial, and FFS patients. [42 CFR 438.206(c)(1)(ii)].

20.4.3. The MCO shall encourage its PCPs to offer after-hours office care in the evenings and on weekends.

20.4.4. The MCO's network shall meet the following minimum timely access to service delivery standards [42 CFR 438.206(c)(1)(i)]

20.4.4.1. Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

20.4.4.2. The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

20.4.4.2.1. Transitional healthcare by a provider shall be available from a primary or specialty provider for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

20.4.4.2.2. Transitional home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the member's primary care or specialty care provider or as part of the discharge plan.

20.4.4.2.3. Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

20.4.4.2.4. Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

20.4.4.2.5. Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and don't meet the definition of Emergency Medical Condition.

20.4.4.2.6. Emergency medical, SUD and psychiatric care shall be available twenty-four (24) hours per day, seven (7) days per week.

20.4.4.2.7. Behavioral health care shall be available as follows:

a. care within six (6) hours for a non-life threatening emergency;

b. care within forty-eight (48) hours for urgent care; or

c. an appointment within ten (10) business days for a routine office visit.

20.4.4.2.8. For members receiving Step 2 covered services, transitional care shall be readily available and delivered, after discharge from a nursing facility, inpatient or institutional care, in accordance with the member's discharge plan or as ordered by the member's primary care or specialty care provider. Transfers and discharges shall be done in accordance with RSA 151:21 and RSA 151:26.

20.4.5. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide a semi-annual report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v).

20.4.6. The MCO shall develop a Corrective Action Plan if there is a failure to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

20.4.7. The MCO shall monitor waiting times for appointments at approved community mental health providers and report case details on a semi-annual basis.

20.5. Women's Health

20.5.1. The MCO shall provide female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

20.5.2. The MCO shall provide access to family planning services to members without the need for a referral or prior-authorization. Additionally, members shall be able to access these services by providers whether they are in or out of the MCO's network.

20.5.2.1. Family Planning Services shall include, but not be limited to, the following:

20.5.2.1.1. Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

20.5.2.1.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

20.5.2.1.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

20.5.2.1.4. Referral of members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

20.5.2.1.5. Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and HPV vaccine

20.5.2.2. Enrollment in the MCO shall not restrict the choice of the provider from whom the member may receive family planning services and supplies [42 CFR 431.51(b)(2)].

20.5.2.3. The MCO shall only provide for abortions in the following situations:

20.5.2.3.1. If the pregnancy is the result of an act of rape or incest; or

20.5.2.3.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed [42 CFR 441.202].

20.5.3. The MCO shall not provide abortions as a benefit, regardless or funding, for any reasons other than those identified in this Agreement [42 CFR 441.202].

20.6. Access to Special Services

20.6.1. The MCO shall ensure members have access to DHHS-designated Level I and Level II trauma centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.

20.6.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, hospice programs, and licensed long term care facilities with Medicare-certified skilled nursing beds. To the extent that the above specialty services are available within New Hampshire, the plan shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable.

20.6.3. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude New Hampshire providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

20.7. Out-of-Network Providers

20.7.1. If the MCO's network is unable to provide necessary medical, behavioral, SUD and LTSS services covered under the Agreement to a particular member, the MCO shall adequately and in a timely manner cover these services for the member through out-of-network sources [42 CFR 438.206(b)(4)]. The MCO shall inform the out-of-network provider that the member cannot be balance billed.

20.7.2. The MCO shall coordinate with out-of-network providers regarding payment. For payment to out-of-network, or non-participating providers, the following requirements apply:

20.7.2.1. If the MCO offers the service through an in-network provider(s), and the member chooses to access non-emergent services from an out-of-network provider, the MCO is not responsible for payment.

20.7.2.2. If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the MCO and the out-of-network provider.

20.7.3. The MCO shall ensure that cost to the member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

20.8. Second Opinion

20.8.1. The MCO shall provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no greater cost to the member than allowed by DHHS [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a second opinion in its Member Handbook.

20.9. Provider Choice

20.9.1. The MCO shall allow each member to choose his or her health professional to the extent possible and appropriate [42 CFR 438.3(l)].

21. Network Management

21.1. Provider Network

21.1.1. The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered medical, behavioral health, SUD, psychosocial and LTSS needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

21.1.1.1. Current and anticipated New Hampshire Medicaid enrollment;

21.1.1.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the covered New Hampshire population;

21.1.1.3. The number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services;

21.1.1.4. The number of network providers not accepting new or any New Hampshire Medicaid patients;

21.1.1.5. The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by New Hampshire members;

21.1.1.6. Accessibility of provider practices for members with disabilities [42 CFR 438.206(b)(1)];

21.1.1.7. Adequacy of the primary care network to offer each member a choice of at least two appropriate primary care providers that are accepting new Medicaid patients; and

21.1.1.8. Required access standards identified in this Agreement

21.1.2. In developing its network, the MCO's provider selection policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

21.1.3. The MCO shall not employ or contract with providers excluded from participation in federal health care programs.

21.1.4. The MCO shall not employ or contract with providers who fail to provide Equal Access to services.

21.1.5. The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of all members including those with LEP and those with unique cultural needs.

21.1.6. The MCO shall maintain an updated list of participating providers on its website in a Provider Directory, as specified in Section 17.9 of this Agreement.

21.2. Network Requirements

21.2.1. The MCO shall ensure its providers and subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement.

21.2.2. All providers shall be licensed and or certified in accordance with the laws of the state in which they provide the covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program. All provider types that may obtain a National Provider Identifier (NPI) shall have an NPI in accordance with 45 CFR Part 162, Subpart D.

21.2.3. All providers in the MCO's network are required to be enrolled as New Hampshire Medicaid providers. DHHS may waive this requirement for good cause on a case-by-case basis.

21.2.4. In all contracts with health care professionals, the MCO shall comply with requirements in 42 CFR 438.214, NCQA standards, and RSA 420-J:4, which includes selection and retention of providers, credentialing and re-credentialing requirements, and non-discrimination (42 CFR 438.12(a)(2); 42 CFR 438.214].

21.2.5. The MCO shall not require a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

21.2.6. The MCO's Agreement with health care providers shall be in writing, shall be in compliance with applicable federal and state laws and regulations, and shall include the requirements in this Agreement.

21.2.7. The MCO shall submit all model provider contracts to DHHS for review during the Readiness Review process. The MCO shall resubmit the model provider contracts any time it makes substantive modifications to such Agreements. DHHS retains the right to reject or require changes to any provider Agreement.

21.2.8. The MCO shall negotiate rates with providers in accordance with Section 9 of this Agreement, unless otherwise specified in this Agreement.

21.2.9. The MCO shall reimburse private duty nursing agencies for private duty nursing services provided on or after April 1, 2016 at the fee-for-for service rate established by DHHS. The MCO shall provide the following information to determine if access to private duty nursing services is increasing:

21.2.9.1. The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

21.2.9.2. The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

21.2.10. The MCO shall submit model provider contracts related to the implementation of NHHPP to DHHS prior to the beginning of enrollment in NHHPP. The contract will provide for:

21.2.10.1. An in-state provider of services included in Step 1 must provide services to both the MCO's Step 1 and NHHPP members, except for SUD providers and chiropractors; provided, however, that exceptions to this requirement may be made upon a request by the MCO and approved by DHHS for providers that only want to provide coverage for Step 1 Services.

21.2.10.2. The provider shall provide equal availability of services and access to both Step 1 and NHHPP members unless an exception to the requirement in section 21.2.10.1 was approved for the provider and the provider is not required to provide coverage for NHHPP Services.

21.2.10.3. The MCO shall pay the provider for services at a rate not more than nor less than the amounts established according to Section 21.2.10.4.

21.2.10.4. The MCO shall reimburse providers for NHHPP services according to the NHHPP Provider Fee Schedule posted at **https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms** as of August 15, 2017and incorporated herein. DHHS shall provide the MCO sixty (60) days notice prior to any change to the Schedule. Services falling outside the published NHHPP Provider Fee Schedule shall be paid at a rate determined by the Department and enforced in the sixty (60) calendar day notification period.

21.2.10.5. The MCO shall allow a participating provider thirty (30) days to review contract modifications to an existing contract relating to the implementation of the NHHPP.

21.2.11.The MCO provider Agreement shall require providers in the MCO network to accept the member's Medicaid ID Card as proof of enrollment in the MCO until the member receives his/her MCO ID Card.

21.2.12.The MCO shall maintain a provider relations presence in New Hampshire as approved by DHHS.

21.2.13.The MCO shall prepare and issue Provider Manual(s) upon request to all Network Providers, including any necessary specialty manuals (e.g., behavioral health). For newly contracted and credentialed providers, the MCO shall issue copies of the Provider Manual(s) no later than seven (7) calendar days after inclusion in the network. The provider manual shall be available on the web and updated no less than annually.

21.2.14.The MCO shall provide training to all providers and their staff regarding the requirements of this Agreement including the grievance and appeal system. The MCO's provider training shall be completed within thirty (30) calendar days of entering into a contract with a provider. The MCO shall provide ongoing training to new and existing providers as required by the MCO, or as required by DHHS.

21.2.15.Provider materials shall comply with state and federal laws and DHHS and NHID requirements. The MCO shall submit any Provider Manual(s) and provider training materials to DHHS for review and approval sixty (60) calendar days prior to any substantive revisions. Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

21.2.16.The MCO shall operate a toll-free telephone line for provider inquiries from 8 a.m. to 5 p.m. EST, Monday through Friday, except for State-approved holidays. The provider toll free line shall be staffed with personnel who are knowledgeable about the MCO's plan in New Hampshire. The provider call center shall meet the following minimum standards, but DHHS reserves the right to modify standards:

21.2.16.1. Call Abandonment Rate: Fewer than five percent (5%) of calls will be abandoned;

21.2.16.2. Average Speed of Answer: Eighty percent (80%) of calls will be answered with live voice within thirty (30) seconds; and

21.2.16.3. Ninety percent (90%) of voicemail messages shall be responded to no later than the next business day.

21.2.17.The MCO shall maintain a Transition Plan providing for continuity of care in the event of Agreement termination, or modification limiting service to members, between the MCO and any of its contracted providers, or in the event of site closing(s) involving a primary care provider with more than one location of service.

The Transition Plan shall describe how members will be identified by the MCO and how continuity of care will be provided.

21.2.18. The MCO shall ensure that after regular business hours the provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a member. The MCO shall have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent medical, behavioral health or LTSS related condition or an emergency medical or behavioral health condition.

21.2.19. The MCO shall notify DHHS and affected current members in writing of a provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. Within three (3) calendar days following the effective date of the termination the MCO shall have a Transition Plan in place for all affected members.

21.2.20. If a member is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services, the MCO shall notify the member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a Transition Plan for the affected members.

21.2.21. The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the provider network. As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued member access to needed service and how the MCO will maintain compliance with its contractual obligations for member access to needed services. A significant change is defined as:

21.2.21.1. A decrease in the total number of PCPs by more than five percent (5%);

21.2.21.2. A loss of all providers in a specific specialty where another provider in that specialty is not available within sixty (60) minutes or forty-five (45) miles;

21.2.21.3. A loss of a hospital in an area where another contracted hospital of equal service ability is not available within forty-five (45) miles or sixty (60) minutes; or

21.2.21.4. Other adverse changes to the composition of the network, which impair or deny the members' adequate access to in-network providers.

21.2.22.The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its network, the MCO shall give the affected providers written notice of the reason for its decision. [42 CFR 438.12(a)(1) ; 42 CFR 438.214(c); SMD letter 02/20/98)].

21.2.23.The requirements in 42 CFR 438.12 (a) may not be construed to:

21.2.23.1. Require the MCO to contract with providers beyond the number necessary to meet the needs of its member;

21.2.23.2. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

21.2.23.3. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)].

21.3. Screening and Enrollment

21.3.1. No later than January 1, 2018, the MCO shall ensure that all of its network providers are enrolled with DHHS Medicaid.

21.3.2. No later than November 1, 2017, the MCO shall provide to DHHS all identifying information for its enrolled network providers including:

21.3.2.1.Name;

21.3.2.2.Specialty;

21.3.2.3.Date of Birth;

21.3.2.4.Social Security number;

21.3.2.5.National Provider identifier;

21.3.2.6.Federal taxpayer identification number; and

21.3.2.7.State license or certification number of the provider.

21.4. Provider Credentialing and Re-Credentialing

21.4.1. The MCO shall demonstrate to DHHS that its providers are credentialed according to the requirements of 42 CFR 438.206(b)(6), current NCQA standards, Code of Administrative Rules He-M 403, and RSA 420-J:4.

21.4.2. The MCO shall submit to DHHS its credentialing standards relating to the implementation of Choices for Independence waiver services.

21.4.3. The MCO shall have written policies and procedures to review, approve and at least every three (3) years recertify the credentials of all participating physician and all other licensed providers who participate in the MCO's network [42 CFR 438.214(a); 42 CFR 438.214(b) (1&2); RSA 420-J:4]. At a minimum, the scope and structure of a MCO's credentialing and re-credentialing processes shall be consistent NCQA standards and NHID, and relevant state and federal regulations relating to provider credentialing and notice. The MCO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with NCQA delegated credentialing requirements and any comparable requirements defined by DHHS.

21.4.4. The MCO shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: within thirty (30) calendar days for primary care providers; within forty-five (45) calendar days for specialists, SUD providers, chiropractors, Nursing Facilities and CFI service providers. [RSA 420-J:4). The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying the provider of the MCO's decision.

21.4.5. The re-credentialing process shall occur in accordance with NCQA guidelines The re-credentialing process shall take into consideration provider performance data including, but not be limited to: member complaints and appeals, quality of care, and appropriate utilization of services.

21.4.6. The MCO shall maintain a policy that mandates board certification levels that, at a minimum, meets the ninety (90) percentile rates indicated in NCQA standards (HEDIS Medicaid All Lines of Business National Board Certification Measures as published by NCQA in Quality Compass) for PCPs and specialty physicians in the provider network. The MCO shall make information on the percentage of board-certified PCPs in the provider network and the percentage of board-certified specialty physicians, by specialty, available to DHHS upon request.

21.4.7. The MCO shall provide that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number [42 CFR 493.1 and 42 CFR 493.3].

21.4.8. The MCO shall not employ or contract with providers, business managers, owners or others excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or 42 CFR 1000.

21.4.9. The MCO shall ensure that providers whose Medicare certification is a precondition of participation in the Medicaid program obtain certification within one year of enrollment in MCO's provider network.

21.4.10. The MCO shall notify DHHS when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

21.5. Provider Engagement

21.5.1. The MCO shall, at a minimum, develop and facilitate an active provider advisory board that is composed of a broad spectrum of provider types. Representation on the provider advisory board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the care management program. This advisory board shall include representation from CFI service providers. This advisory board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the meetings shall be provided to DHHS within thirty (30) calendar days of the meeting.

21.5.2. The MCO shall conduct a provider satisfaction survey, approved by DHHS and administered by a third party, on a statistically valid sample of each major provider type; PCP, specialists, hospitals, pharmacies, DME and Home Health providers, Nursing Facilities and CFI service providers. DHHS shall have input to the development of the survey. The survey shall be conducted semi-annually the first year after the program start date and at least once an Agreement year thereafter to gain a broader perspective of provider opinions. The results of these surveys shall be made available to DHHS and published on the DHHS website.

21.5.3. The MCO shall support DHHS' interaction and reporting to the Governor's Commission on Medicaid Care Management.

21.6. Anti-Gag Clause for Providers

21.6.1. The MCO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

21.6.1.1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

21.6.1.2. For any information the member needs in order to decide among all relevant treatment options;

21.6.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

21.6.1.4. For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [§1923(b)(3)(D) of the SSA; 42 CFR 438.102(a)(1)(i), (ii), (iii), and (iv); SMD letter 2/20/98]

21.7. Reporting

21.7.1. Provider Participation Report: Provide provider participation reports on an annual basis by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of member access to health care.

21.7.2. Provider Quality Report Card: Ability to provide dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc.

22. Quality Management

22.1. General Provisions

22.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO shall work in collaboration with members and providers to actively improve the quality of care provided to members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate into the MCO's quality improvement activities.

22.1.2. The MCO shall support and comply with the most current version of the Quality Strategy for the New Hampshire Medicaid Care Management Program.

22.1.3. The MCO shall have an ongoing quality assessment and performance improvement program for the operations and the services it furnishes for members [42 CFR 438.330(b); and SMM 2091.7].

22.1.4. The MCO shall approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and shall:

22.1.4.1. Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

22.1.4.2. Foster data-driven decision-making;

22.1.4.3. Solicit member and provider input on the prioritization and strategies for QAPI activities;

22.1.4.4. Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and member and provider satisfaction;

22.1.4.5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements;

22.1.4.6. Support re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions as appropriate; and

22.1.4.7. The MCO shall undertake a member experience of care survey;

22.1.4.7.1. The MCO shall deploy the CMS Home and Community Based Care Service Experience of Care Survey, Testing Experience and Functional Tools (TEFT) as early as 6 months but not later than 9 months from Step 2 Phase 2 start date, if ready for deployment.

22.1.4.7.2. The MCO shall deploy an in-person patient experience survey (PES) if the CMS Home and Community Based Care Service Experience of Care Survey is not ready for deployment with this same timeframe.

22.1.4.7.3. The MCO shall use a DHHS approved, external vendor and statistically sound methodology to conduct the member experience of care survey.

22.1.5. The MCO shall have mechanisms that detect both underutilization and overutilization of services.

22.1.6. The MCO shall develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the requirements of this Agreement. The MCOs shall also meet the requirements of for the QAPI Program [42 CFR 438.330; SMM 2091.7].

22.1.7. The MCO shall submit a QAPI Program Annual Summary in a format and timeframe specified by DHHS or its designee for its approval. The MCO shall keep participating physicians and other Network Providers informed and engaged in the QAPI Program and related activities. The MCO shall include in provider contracts a requirement securing cooperation with the QAPI.

22.1.8. The MCO shall maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO shall designate a senior executive responsible for the QAPI Program and the Medical Director shall have substantial involvement in QAPI Program activities. At a minimum, the MCO shall ensure that the QAPI Program structure:

22.1.8.1. Is organization-wide, with clear lines of accountability within the organization;

22.1.8.2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;

22.1.8.3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

22.1.8.4. Evaluates the effectiveness of clinical and non-clinical initiatives.

22.1.9. If the MCO sub-contracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO shall maintain detailed files documenting work performed by the sub-contractor. The file shall be available for review by DHHS or its designee upon request.

22.1.10. The MCO shall integrate behavioral health and LTSS into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services and LTSS provided to members. The MCO shall collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from the integration and coordination of physical and behavioral health services and LTSS.

22.1.11. The MCO shall conduct any performance improvement projects required by CMS and a minimum of four (4) performance improvement projects, subject to DHHS approval, per year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one (1) of these projects shall have a behavioral health focus. At least one (1) of these projects shall have an LTSS focus. The MCO shall report the status and results of each project to DHHS as requested and shall report on the status results of the CMS performance improvement projects described in 42 CFR 438.330.

22.1.12. The performance improvement projects shall involve the following:

22.1.12.1. Measurement of performance using statistically valid, national recognized objective quality indicators;

22.1.12.2. Implementation of system interventions to achieve improvement in the access to and quality of care;

22.1.12.3. Evaluation of the effectiveness of the interventions based on any performance measures required by CMS as outlined in 42 CFR 438.330(c); and

22.1.12.4. Planning and initiation of activities for increasing or sustaining improvement; and

22.1.12.5. Reporting on the status and results to DHHS on an annual basis.

22.1.13. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

22.1.14.The MCO shall have a plan to assess and report the quality and appropriateness of care furnished to members with special needs in order to identify any ongoing special conditions of a member that require a course of treatment or regular care monitoring The plan must be submitted to DHHS for review and approval. The assessment mechanisms must use appropriate health care professionals.[42 CFR 438.208(c)(2); 42 CFR 438.330].

22.1.15.The MCO's Medical Director and Quality Improvement Director will participate in quarterly Quality Improvement meetings with DHHS and the other MCOs contracted with DHHS to discuss quality related initiatives and how those initiatives could be coordinated across the MCOs.

22.1.16.The MCOs shall be required to be accredited by NCQA, including all applicable Medicaid Standards and Guidelines and the MCOs must authorize NCQA to provide DHHS a copy of its most recent accreditation review, including:

22.1.16.1. Accreditation status, survey type, and level (as applicable);

22.1.16.2.Accreditation results, including recommended actions or improvements, corrective actions plans, and summaries of findings; and

22.1.16.3.Expiration date of the accreditation.

22.2. Practice Guidelines and Standards

22.2.1. The MCO shall adopt evidence-based clinical practice guidelines built upon high quality data and strong evidence. Such practice guidelines shall consider the needs of the MCO's members, be adopted in consultation with Network Providers, and be reviewed and updated periodically, as appropriate.

22.2.2. The MCO shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

22.2.3. The MCO shall make practice guidelines available, including, but not limited to, the web, to all affected providers and, upon request, to members and potential members.

22.2.4. The MCO's decisions regarding utilization management, member education, and coverage of services shall be consistent with the MCO's clinical practice guidelines [42 CFR 438.236(d)].

22.3. External Quality Review Organization

22.3.1. The MCO shall collaborate with DHHS's External Quality Review Organization (EQRO) as outlined in 42 CFR 438.358 to assess the quality of care and services provided to members and to identify opportunities for MCO improvement. To

facilitate this process, the MCO shall supply data, including but not limited to claims data and medical records, to the EQRO.

22.4. Evaluation

22.4.1. The MCO shall prepare a written report within ninety (90) calendar days at the end of each Agreement year on the QAPI that describes:

22.4.1.1. Completed and ongoing Quality management activities, including all delegated functions;

22.4.1.2. Performance trends on QAPI measures to assess performance in quality of care and quality of service;

22.4.1.3. An analysis of whether there have been any demonstrated improvements in the quality of care or service; and

22.4.1.4. An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement

22.4.2. The annual evaluation report shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

22.4.3. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, members, and appropriate MCO staff, as well as posted on the web. The MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

22.5. Quality Measures

22.5.1. MCO shall report annually, according to the then current industry/regulatory standard definitions, the following quality measure sets:

22.5.1.1. CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP;

22.5.1.2. CMS Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid;

22.5.1.3. NCQA Medicaid Accreditation HEDIS/CAHPS Measures, which shall be validated by submission to NCQA; and

22.5.1.4. All available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment; and

22.5.1.5. Any CMS mandated measures outlined in 42 CFR 438.330(c)(1)(i).

22.5.2. If additional measures are added to the NCQA or CMS measure sets, MCO shall include those new measures. For measures that are no longer part of the measures sets, DHHS may at its option continue to require those measures.

22.5.3. In addition MCO shall submit other quality measures as specified by DHHS in Exhibit O in a format to be specified by DHHS.

22.5.4. DHHS shall provide the MCO with ninety (90) calendar days notice of any additions or modifications to the quality measures as specified by DHHS in Exhibit O.

22.5.5. Each Data Year as defined by NCQA HEDIS specifications, or other twelve (12) month period determined by DHHS, at DHHS discretion, DHHS may select four (4) measures to be included in the Quality Incentive Program (QIP). DHHS shall notify the MCO of the four (4) measures to be included in the QIP no later than three (3) months prior to the start of the period for which data will be collected to evaluate the program.

22.5.6. For each measure selected by DHHS for the QIP, DHHS will monitor MCO performance to determine baseline measures and levels of improvement.

22.5.7. Should DHHS choose QIPs and implement withholds for QIP performance, in the event of changes to the Medicaid Care Management program or material circumstances beyond DHHS or the MCOs' control, which DHHS determines would unduly limit all MCOs' ability to reasonably perform and achieve the withhold return threshold, DHHS will evaluate the impact of the circumstances and make such changes as required, at the discretion of DHHS.

22.5.8. At such time DHHS provides access to Medicare data sets to the MCOs, the MCO shall integrate expanded Medicare data sets into its Care Coordination and Quality Programs and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual members. The MCO shall:

22.5.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes, psycho-social outcomes, and LTSS outcomes resulting from care coordination of the dual members;

22.5.8.2. Include Medicare data in DHHS quality reporting; and

22.5.8.3. Sign data use agreements and submit data management plans as required by CMS.

23. Utilization Management

23.1. Policies & Procedures

23.1.1. The MCO's policies and procedures related to the authorization of services shall be in compliance with 42 CFR 438.210 and NH RSA Chapter 420-E:2.

23.1.2. The MCO shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services [42 CFR 438.210(b)(1)].

23.1.3. The MCO shall submit its written utilization management policies, procedures, and criteria to DHHS for approval as part of the first readiness review. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.4. The MCO shall submit its written utilization management policies, procedures, and criteria specific to each phase of Step 2 to DHHS for approval as part of the first readiness review. Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs (not just those for LTSS) and a subsequent person-centered planning process. Thereafter the MCO shall submit its written utilization management policies, procedures, and criteria that have changed and an attestation listing those that have not changed since the prior year's submission to DHHS for approval ninety (90) calendar days prior to the end of the Agreement Year.

23.1.5. The MCO's written utilization management policies, procedures, and criteria shall, at a minimum, conform to the standards of NCQA.

23.1.6. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)].

23.1.7. The MCO's written utilization management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Further such policies, procedures and criteria shall address, at a minimum, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information.

23.1.8. The MCO's written utilization management policies, procedures, and criteria shall be:

23.1.8.1. Developed with input from appropriate actively practicing practitioners in the MCO's service area;

23.1.8.2. Updated at least biennially and as new treatments, applications, and technologies emerge;

23.1.8.3. Developed in accordance with the standards of national accreditation entities;

23.1.8.4. Based on current, nationally accepted standards of medical practice;

23.1.8.5. If practicable, evidence-based; and

23.1.8.6. Be made available upon request to DHHS, providers and members.

23.1.9. The MCOs shall work in good faith with DHHS develop prior authorization forms with consistent information and documentation requirements from providers wherever feasible. Providers shall be able to submit the prior authorizations forms electronically, by mail, or fax. The MCOs shall submit a proposed plan for the development of common prior authorization processes within ninety (90) calendar days of the NHHPP Program Start Date.

23.1.10. The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including, but not limited to, interrater reliability monitoring, and consult with the requesting provider when appropriate and at the request of the provider submitting the authorization [42 CFR 438.210(b)(2)].

23.1.11. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)(3)].

23.1.12. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member [42 CFR 438.210(e)].

23.1.13. Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

23.1.14. When a member receiving State Plan Home Health Services and Step 1 services chooses to change to another MCO, the new MCO shall be responsible for the member's claims as of the effective date of the member's enrollment in the new MCO except as specified in Section 31.2.17. Upon receipt of prior authorization information from DHHS, the new MCO shall honor prior authorizations in place by the former MCO for fifteen (15) calendar days or until the expiration of previously issued prior authorizations, whichever comes first. The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 23.4.2.1.

23.1.15. Prior authorizations in place for long term services and supports at the time a member transitions to an MCO will be honored until the earliest of (a) the authorization's expiration date, (b) the member's needs changes, (c) the provider loses its Medicaid status or (d) otherwise approved by DHHS. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO. In the event that the prior authorization specifies a specific provider, that MCO will continue to utilize that provider regardless of whether the provider is participating in the MCO network until such time as services are available in the MCO's network. The MCO will ensure that the member's needs are met continuously and will continue to cover services under the previously issued prior authorization until the MCO issues new authorizations that address the member's needs.

23.1.16. Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire.

23.2. Medical Necessity Determination

23.2.1. The MCO shall specify what constitutes "medically necessary services" in a manner that:

23.2.1.1. Is no more restrictive than the State Medicaid program; and

23.2.1.2. Addresses the extent to which the MCO is responsible for covering services related to the following [42 CFR 438.210(a)]:

23.2.1.2.1. The prevention, diagnosis, and treatment of health impairments;

23.2.1.2.2. The ability to achieve age-appropriate growth and development; and

23.2.1.2.3. The ability to attain, maintain, or regain functional capacity.

23.2.2. For members twenty-one (21) years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are [He-W 530.01(f)]:

23.2.2.1. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

23.2.2.2. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

23.2.2.3. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

23.2.2.4. Not experimental, investigative, cosmetic, or duplicative in nature.

23.2.3. For EPSDT services the following definition of medical necessity shall be used: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service He-W546.01(f).

23.2.4. The MCO must provide the criteria for medical necessity determinations for mental health or substance use disorder benefits to any enrollee, potential enrollee, or contracting provider upon request.

23.3. Necessity Determination

23.3.1. For long term services and supports (including CFI Waiver services) the following definition of necessity shall be used: "Necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction, or is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence, and no other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term services and supports within the limits of current waivers, statutes, administrative rules, and/or Medicaid State Plan amendments.

23.4. Notices of Coverage Determinations

23.4.1. The MCO shall provide the requesting provider and the member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

23.4.2. The MCO shall make utilization management decisions in a timely manner. The following minimum standards shall apply:

23.4.2.1. Urgent determinations: The determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for ninety-eight percent (98%) of requests, unless the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the MCO shall notify the member or member's representative within twenty-four (24) hours of receipt of the request and shall advise the member or member's representative of the specific information necessary to make a determination. The member or member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information.

23.4.2.2. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

23.4.2.3. Routine determinations: The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but in no event exceed the following timeframes for ninety-five percent (95%) of requests:

23.4.2.3.1. Fourteen (14) calendar days after the receipt of a request:

a. An extension of up to fourteen (14) calendar days is permissible if:

i. the member or the provider requests the extension; or

ii. the MCO justifies a need for additional information and that the extension is in the member's interest;

23.4.2.3.2. Two (2) calendar days for diagnostic radiology.

23.4.2.4. The MCO shall provide members written notice as expeditiously as the member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services, except an extension of up to an additional fourteen (14) calendar days is permissible, if:

23.4.2.5. The member or the provider requests the extension; or

23.4.2.6. The MCO justifies a need for additional information and how the extension is in the member's interest.

23.4.2.7. If such an extension is necessary due to a failure of the member or member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the member or member's representative shall be given at least forty- five (45) calendar days from receipt of the notice within which to provide the specified information. Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of (1) the MCO's receipt of the specified additional information, or (2) the end of the period afforded the member or member's representative to provide the specified additional information. When the MCO extends the timeframe, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

23.4.2.8. Determination for Services that have been delivered: The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the member fails to provide sufficient information to determine the request, the MCO shall notify the member within fifteen (15) calendar days of the date of filing; as to what additional information is required to process the request and the member shall be given at least forty-five (45) calendar days to provide the required information. The thirty (30) calendar day period for determination shall be tolled until such time as the member submits the required information.

23.4.3. Whenever there is an adverse determination, the MCO shall notify the ordering provider and the member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

23.5. Advance Directives

23.5.1. The MCO shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489.

23.5.2. The MCO shall adhere to the definition of advance directives as defined in 42 CFR 489.100.

23.5.3. The MCO shall maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCO [42 CFR 422.128].

23.5.4. The MCO shall not condition the provision of care or otherwise discriminate against an enrollee or potential enrollee based on whether or not the individual has executed an advance directive.

23.5.5. The MCO shall provide information in the member handbook with respect to the following:

23.5.5.1. The member's rights under the state law. The information provided by the MCO shall reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change [42 CFR 438.3(j)(3) and (4)].

23.5.5.2. The MCO's policies respecting the implementation of those rights including a statement of any limitation regarding the implementation of advance directives as a matter of conscience

23.5.5.3. That complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State Agency [42 CFR 438.3(;)(1); 42 CFR 438.10(g)(2); 42 CFR 422.128; 42 CFR 489 (subpart I); 42 CFR 489.100].

24. MCIS

24.1. System Functionality

24.1.1. The MCO Managed Care Information System (MCIS) shall include, but not be limited to:

24.1.1.1. Management of Recipient Demographic Eligibility and Enrollment and History

24.1.1.2. Management of Provider Enrollment and Credentialing

24.1.1.3. Benefit Plan Coverage Management, History and Reporting

24.1.1.4. Eligibility Verification

24.1.1.5. Encounter Data

24.1.1.6. Weekly Reference File Updates

24.1.1.7. Service Authorization Tracking, Support and Management

24.1.1.8. Third Party Coverage and Cost Avoidance Management

24.1.1.9. Financial Transactions Management and Reporting

24.1.1.10. Payment Management (Checks, EFT, Remittance Advices, Banking)

24.1.1.11. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)

24.1.1.12. Call Center Management

24.1.1.13. Claims Adjudication

24.1.1.14. Claims Payments

24.1.1.15. Quality of Services (QOS) metrics

24.2. Information System Data Transfer

24.2.1. Effective communication between the MCO and DHHS will require secure, accurate, complete and auditable transfer of data to/from the MCO and DHHS management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

24.2.1.1. DHHS read access to all NH Medicaid Care Management data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

24.2.1.2. Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

24.2.1.3. Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state.

24.2.1.4. Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

24.2.1.5. MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

24.2.1.6. Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and provide for source to target or source to specification mappings;

24.2.1.7. Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

24.2.1.8. A given day's data transmissions, as specified in 24.5.9, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions will be included in the next batch transmission.

24.2.2. The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

24.2.3. The State shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.

24.3. Ownership and Access to Systems and Data

24.3.1. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data will be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

24.4. Records Retention

24.4.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than seven (7) years from the date of termination of this Agreement. Records involving matters that are the subject of litigation shall be retained for a period of not less than seven (7) years following the termination of litigation. Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

24.4.2. Upon expiration of the seven (7) year retention period and upon request, the subject records must be transferred to DHHS' possession. No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

24.5. MCIS Requirements

24.5.1. The MCO shall have a comprehensive, automated, and integrated Managed Care Information System (MCIS) that is capable of meeting the requirements listed below and throughout this Agreement and for providing all of the data and information necessary for DHHS to meet federal Medicaid reporting and information regulations.

24.5.2. All subcontractors shall meet the same standards, as described in this Section 24, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a subcontractor with respect to its provided functions.

24.5.3. Specific functionality related to the above shall include, but is not limited to, the following :

24.5.3.1. The MCIS membership management system must have the capability to receive, update, and maintain New Hampshire's membership files consistent with information provided by DHHS.

24.5.3.2. The MCIS shall have the capability to provide daily updates of membership information to sub-contractors or providers with responsibility for processing claims or authorizing services based on membership information.

24.5.3.3. The MCIS' provider file must be maintained with detailed information on each provider sufficient to support provider enrollment and payment and also meet DHHS' reporting and encounter data requirements.

24.5.3.4. The MCIS' claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system.

24.5.3.5. The MCIS' Services Authorization system shall be integrated with the claims processing system.

24.5.3.6. The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements.

24.5.3.7. The MCIS' credentialing system shall have the capability to store and report on provider specific data sufficient to meet the provider credentialing requirements, Quality Management, and Utilization Management Program Requirements.

24.5.3.8. The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in member, provider, claims and authorization files, and in order to enable encounter data to be utilized for member profiling, provider profiling, claims validation, fraud, waste and abuse monitoring activities, and any other research and reporting purposes defined by DHHS.

24.5.3.9. The encounter data system shall have a mechanism in place to receive, process, and store the required data.

24.5.3.10. The MCO system shall be compliant with the requirements of HIPAA, including privacy, security, National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format. This also includes IRS Pub 1075 where applicable.

24.5.4. MCIS capability shall include, but not be limited to the following:

24.5.4.1. Provider network connectivity to Electronic Data Interchange (EDI) and provider portal systems;

24.5.4.2. Documented scheduled down time and maintenance windows as agreed upon with DHHS for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

24.5.4.3. DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes, and procedures (approved by the State) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

24.5.4.4. DHHS access to user acceptance test environment for externally accessible systems including websites and secure portals;

24.5.4.5. Documented instructions and user manuals for each component; and

24.5.4.6. Secure access.

24.5.5. MCIS Up-time

24.5.5.1. Externally accessible systems, including telephony, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours per day, seven (7) days per week, three-hundred-sixty-five (365) days per year, except for scheduled maintenance upon notification of and pre-approval by DHHS. Maintenance period cannot exceed four (4) consecutive hours without prior DHHS approval.

24.5.5.2. MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions will result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

24.5.6. Systems operations and support shall include, but not be limited to the following:

24.5.6.1. On-call procedures and contacts

24.5.6.2. Job scheduling and failure notification documentation

24.5.6.3. Secure (encrypted) data transmission and storage methodology

24.5.6.4. Interface acknowledgements and error reporting

24.5.6.5. Technical issue escalation procedures

24.5.6.6. Business and member notification

24.5.6.7. Change control management

24.5.6.8. Assistance with User Acceptance Testing (UAT) and implementation coordination

24.5.6.9. Documented data interface specifications – data imported and extracts exported including database mapping specifications.

24.5.6.10. Disaster Recovery and Business Continuity Plan

24.5.6.11. Journaling and internal backup procedures. Facility for storage MUST be class 3 compliant.

24.5.6.12. Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

24.5.7. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

24.5.7.1. Network diagram that fully defines the topology of the MCO's network.

24.5.7.2. State/MCO connectivity

24.5.7.3. Any MCO/subcontractor locations requiring MCIS access/support

24.5.7.4. Web access for DHHS staff, providers and recipients

24.5.8. Data transmissions from DHHS to the MCO will include, but not be limited to the following:

24.5.8.1. Provider Extract (Daily)

24.5.8.2. Recipient Eligibility Extract (Daily)

24.5.8.3. Recipient Eligibility Audit/Roster (Monthly)

24.5.8.4. Medical and Pharmacy Service Authorizations (Daily)

24.5.8.5. Commercial and Medical Third Party Coverage (Daily)

24.5.8.6. Claims History (Bi-Weekly)

24.5.8.7. Capitation payment data

24.5.9. Data transmissions from the MCO to DHHS shall include but not be limited to:

24.5.9.1. Member Demographic changes (Daily)

24.5.9.2. MCO Provider Network Data (Daily)

24.5.9.3. Medical and Pharmacy Service Authorizations (Daily)

24.5.9.4. Beneficiary Encounter Data including paid, denied, adjustment transactions by pay period (Weekly)

24.5.9.5. Financial Transaction Data

24.5.9.6. Updates to Third Party Coverage Data (Weekly)

24.5.9.7. Behavioral Health Certification Data (Monthly)

24.5.10.The MCO shall provide DHHS staff with access to timely and complete data:

24.5.10.1. All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS.

24.5.10.2. The MCO shall work collaboratively with DHHS, DHHS' MMIS fiscal agent, the New Hampshire Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement.

24.5.10.3. The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/subcontractor locations supporting the New Hampshire program.

24.5.10.4. The MCO shall utilize data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

24.5.10.5. The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including encounter data

24.5.10.6. The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this document (24.2.1.8).

24.5.10.7. Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable state and federal law.

24.5.10.8. Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

24.5.11.The MCIS shall include web access for use by and support to enrolled providers and members. The services shall be provided at no cost to the provider or members. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

24.5.11.1. The MCO shall create secure web access for Medicaid providers and members and authorized DHHS staff to access case-specific information.

24.5.11.2. The MCO shall manage provider and member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist providers and members with gaining access and utilizing the web portal.

24.5.11.3. Providers will have the ability to electronically submit service authorization requests and access and utilize other utilization management tools.

24.5.11.4. Providers and members shall have the ability to download and print any needed Medicaid MCO program forms and other information.

24.5.11.5. Providers shall have an option to e-prescribe as an option without electronic medical records or hand held devices.

24.5.11.6. MCO shall support provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es).

24.5.11.7. Providers shall have access to drug information.

24.5.11.8. The website shall provide an e-mail link to the MCO to allow providers and members or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website.

24.5.11.9. The website shall be secure and HIPAA compliant in order to ensure the protection of Protected Health Information and Medicaid recipient confidentiality. Access shall be limited to verified users via passwords and any other available industry standards. Audit logs must be maintained reflecting access to the system and random audits will be conducted.

24.5.11.10.The MCO shall have this system available no later than the Program Start Date.

24.5.11.11.Support Performance Standards shall include:

24.5.11.11.1.Email inquiries – one (1) business day response

24.5.11.11.2.New information posted within one (1) business day of receipt

24.5.11.11.3.Routine maintenance

24.5.11.11.4. Standard reports regarding portal usage such as hits per month by providers/members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports.

24.5.11.11.5. Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO must redirect user to site to install appropriate browser.

24.5.12. Critical systems within the MCIS support the delivery of critical medical services to members and reimbursement to providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

24.5.12.1. The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to New Hampshire within twenty-four (24) hours of incident onset.

24.5.12.2. The MCO shall ensure that the New Hampshire PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements as defined in Section 24.5.13.

24.5.12.3. The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction. Archiving processes shall not modify the data composition of DHHS' records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

24.5.12.4. The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between providers, provider billing agents/clearing houses, or DHHS and the MCO. Audit logs of activities will be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

24.5.12.5. Thirty (30) calendar days prior to the beginning of each State Fiscal Year, the MCO shall submit the following documents and corresponding checklists for DHHS' review and approval:

24.5.12.5.1. Disaster Recovery Plan

24.5.12.5.2. Business Continuity Plan

24.5.12.5.3. Security Plan

24.5.12.5.4. The MCO shall provide the following documents. If after the original documents are submitted the MCO modifies any of them, the revised documents and corresponding checklists shall be submitted to DHHS for review and approval:

a. Risk Management Plan

b. Systems Quality Assurance Plan

c. Confirmation of 5010 compliance and Companion Guides

d. Confirmation of compliance with IRS Publication 1075

e. Approach to implementation of ICD-10 and ultimate compliance

24.5.13. Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements shall be part of the change management process:

24.5.13.1. The complete system shall have proper configuration management/change management in place (to be reviewed and approved by DHHS). The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

24.5.13.2. The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent. DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

24.5.13.3. The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day. The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

24.5.13.4. A New Hampshire program centralized electronic repository shall be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

24.5.13.5. The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any member.

24.5.13.6. The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

24.5.14.DHHS, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

24.5.14.1. The System Readiness Review may include a desk review and/or an onsite review.

24.5.14.2. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

24.5.14.3. If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency.

24.5.15.Systems enhancements developed specifically, and data accumulated, as part of the New Hampshire Care Management program remain the property of the State of New Hampshire.

24.5.15.1. Source code developed for this program shall remain the property of the vendor but will be held in escrow.

24.5.15.2. All data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

24.5.15.3. The MCO shall not destroy or purge DHHS' data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be

retrievable for review and or reporting by DHHS in the timeframe set forth by DHHS.

24.5.16. The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute ad-hoc queries to support DHHS data and information needs. DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

24.5.17. Quality of Service (QOS) Metrics:

24.5.17.1. System Integrity: The system shall ensure that both user and provider portal design, and implementation is in accordance with Federal, standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

24.5.17.2. The security of the care management processing system must minimally provide the following three types of controls to maintain data integrity that directly impacts QOS . These controls shall be in place at all appropriate points of processing:

24.5.17.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

24.5.17.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

24.5.17.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

24.5.17.2.4. System Administration: Ability to comply with HIPAA, ADA, and other federal and state regulations, and perform in accordance with Agreement terms and conditions. Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions at no additional cost.

25. Data Reporting

25.1. General Provisions

25.1.1. The MCO shall make all collected data available to DHHS upon request and upon the request of CMS [42 CFR 438.242(b)(4)].

25.1.2. The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility [42 CFR 438.242(a)].

25.1.3. The MCO shall collect data on member and provider characteristics as specified by DHHS and on services furnished to members through a MCIS system or other methods as may be specified by DHHS [42 CFR 438.242(b)(2)].

25.1.4. The MCO shall ensure that data received from providers are accurate and complete by:

25.1.4.1. Verifying the accuracy and timeliness of reported data;

25.1.4.2. Screening the data for completeness, logic, and consistency; and

25.1.4.3. Collecting service information in standardized formats to the extent feasible and appropriate [42 CFR 438.242(b)(3)].

25.2. Encounter Data

25.2.1. The MCO shall submit encounter data in the format and content, timeliness, completeness, and accuracy as specified by the DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS.

25.2.2. All encounter data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

25.2.2.1. The MCO shall provide support to DHHS to substantiate the validity, integrity and reconciliation of DHHS reports that utilize the MCO encounter data.

25.2.3. Submission of encounter data to DHHS does not eliminate the MCO's responsibility under state statute to submit member and claims data to the Comprehensive Healthcare Information System [NH RSA 420-G:1,1 II. (a)]

25.2.4. The MCO shall ensure that encounter records are consistent with the DHHS requirements and all applicable state and federal laws.

25.2.5. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

25.2.6. The MCO shall use appropriate member identifiers as defined by DHHS.

25.2.7. The MCO shall maintain a record of both servicing and billing information in its encounter records.

25.2.8. The MCO shall also use appropriate provider identifiers for encounter records as directed by DHHS.

25.2.9. The MCO shall have a computer and data processing system sufficient to accurately produce the data, reports, and encounter record set in formats and timelines prescribed by DHHS as defined in this Agreement.

25.2.10. The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

25.2.11. The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS. The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

25.2.12. The MCO's systems that are required to use or otherwise contain the applicable data type shall conform with current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards:

25.2.12.1. Health Care Common Procedure Coding System (HCPCS)

25.2.12.2. CPT codes

25.2.12.3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the U.S. Department of Health and Human Services (HHS).

25.2.12.4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

25.2.12.5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.

25.2.12.6. National Drug Codes (NDC): The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

25.2.12.7. Code on Dental Procedures and Nomenclature (CDT): The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

25.2.12.8. Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains point of service (POS) codes used throughout the health care industry.

25.2.12.9. Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

25.2.12.10. Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the Medicaid Management Information System (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

25.2.13. All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format.

25.2.14. All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and as applicable the Medicare paid amount, other insurance paid amount and expected member co-payment amount.

25.2.15. The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

25.2.16.The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

25.2.17.The MCO shall collect, and submit to the State's fiscal agent, member service level encounter data for all covered services. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

25.2.18.The MCO shall conform to all current and future HIPAA-compliant standards for information exchange. Batch and Online Transaction Types are as follows:

25.2.18.1. Batch transaction types

25.2.18.1.1.ASC X12N 820 Premium Payment Transaction

25.2.18.1.2.ASC X12N 834 Enrollment and Audit Transaction

25.2.18.1.3.ASC X12N 835 Claims Payment Remittance Advice Transaction

25.2.18.1.4.ASC X12N 837I Institutional Claim/Encounter Transaction

25.2.18.1.5.ASC X12N 837P Professional Claim/Encounter Transaction

25.2.18.1.6.ASC X12N 837D Dental Claim/Encounter Transaction

25.2.18.1.7.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.18.2. Online transaction types

25.2.18.2.1.ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

25.2.18.2.2.ASC X12N 276 Claims Status Inquiry

25.2.18.2.3.ASC X12N 277 Claims Status Response

25.2.18.2.4.ASC X12N 278/279 Utilization Review Inquiry/Response

25.2.18.2.5.NCPDP D.0 Pharmacy Claim/Encounter Transaction

25.2.19.Submitted encounter data shall include all elements specified by DHHS including, but not limited to, those specified in Exhibit N and detailed in the Medicaid Encounter Submission Guidelines.

25.2.20.The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims. Any exceptions will be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception. The MCO shall also use the provider identifiers as directed by DHHS for both Encounter and fee-for-service claims submissions, as applicable.

25.2.21. The MCO shall provide as a supplement to the encounter data submission a member file, which shall contain appropriate member identification numbers, the primary care provider assignment of each member, and the group affiliation of the primary care provider.

25.2.22. The MCO shall submit complete encounter data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

25.2.23. The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

25.2.24. The MCO shall provide complete and accurate encounters to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards:

25.2.24.1. Completeness

25.2.24.1.1. The MCO shall submit encounters that represent at least ninety-nine percent (99%) of the covered services provided by the MCO's network and non-network providers. All data submitted by the providers to the MCO shall be included in the encounter submissions.

25.2.24.2. Accuracy

25.2.24.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits.

25.2.24.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

25.2.24.2.3. One-hundred percent (100%) of member identification numbers shall be accurate and valid.

25.2.24.2.4. Ninety-eight percent (98%) of servicing provider information will be accurate and valid.

25.2.24.2.5. Ninety-eight percent (98%) of member address information shall be accurate and valid.

25.2.24.3. Timeliness

25.2.24.3.1. Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment. All encounters shall be submitted, both paid and denied claims. The paid claims shall include the MCO paid amount.

25.2.24.3.2. The MCO shall be subject to remedies as specified in Section 34 for failure to timely submit encounter data, in accordance with the accuracy standards established in this Agreement.

25.2.24.4. Error Resolution

25.2.24.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice. For all ongoing claim encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fifteen (15) calendar days after such notice. If the MCO fails to do so, DHHS will require a Corrective Action Plan and assess liquidated damages as described in Section 34. MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

25.2.24.4.2. All sub-contracts with providers or other vendors of service shall have provisions requiring that encounter records are reported or submitted in an accurate and timely fashion.

25.2.24.5. Survival

25.2.24.5.1. All encounter data accumulated as part of this program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS.

25.3. Data Certification

25.3.1. All data submitted to DHHS by the MCO shall be certified by one of the following:

25.3.1.1. The MCO's Chief Executive Officer;

25.3.1.2. The MCO's Chief Financial Officer; or

25.3.1.3. An individual who has delegated authority to sign for, and who reports directly to, the MCO's Chief Executive Officer or Chief Financial Officer.

25.3.2. The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, encounter data, and other information contained in contracts, proposals. The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data. The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

25.4. Data System Support for QAPI

25.4.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI requirements described in Section 21. The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of MCO providers, member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

25.5. Data Requirements for CFI Waiver Program

25.5.1. The MCO shall have a data collection, processing, and reporting system sufficient to support the reporting requirements described in New Hampshire's home and community-based care 1915(c) waivers and applicable federal and state statutes and rules. The reporting system shall be able to support and provide data needed for the Annual Report on Home and Community-Based Services Waivers (CMS Form HCFA-372(S)) each reporting period or lag reporting period, which includes but not limited to:

25.5.1.1. The unduplicated number of persons who participated in the waiver during the waiver year;

25.5.1.2. The total expenditures for waiver services;

25.5.1.3. The number of participants who utilized each waiver service;

25.5.1.4. The amount expended for each waiver service and for all waiver services in total;

25.5.1.5. The average annual per participant expenditures for waiver service;

25.5.1.6. The total number of days of waiver coverage for all waiver participants and the average length of stay (ALOS) on the waiver;

25.5.1.7. Expenditures under the Medicaid State Plan for non-waiver services (including expanded EPSDT services when the waiver serves children) that

were made on behalf of waiver participants and average per participant expenditures for such services (based on the number of participants who utilized such services);

25.5.1.8. Information about the impact of the waiver on the health and welfare of waiver participants;

25.5.1.9. Total number of members who utilized nursing facility services;

25.5.1.10. Total expenditures for the members identified in 25.5.1.9, broken out by waiver, institutional and acute care expenditures;

25.5.1.11. The average expenditure per member, broken out by waiver, non-waiver and total expenditures;

25.5.1.12. The total number of days of nursing long term care coverage for the members identified in 25.5.1.9; and

25.5.1.13. Measures in Exhibit O.

26. Fraud Waste and Abuse

26.1. Program Integrity Plan

26.1.1. The MCO shall have a Program Integrity Plan in place that has been approved by DHHS and that shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse. The MCO is expected to be familiar with, comply with, and require compliance with, all state and federal regulations related to Medicaid Program Integrity, whether or not those regulations are listed herein, and as required in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008, and Section 1902(a)(68) of the Social Security Act.

26.1.1.1. The MCO shall retain all data, information, and documentation described in 42 CFR 438.604, 438.606, 438.608, and 438.610 for period no less than ten (10) years.

26.1.1.2. Fraud, waste and abuse investigations are targeted reviews of a provider or member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services. Cases which would be considered investigations are as follows, but not limited to:

26.1.1.2.1. review of instances which may range from outliers identified through data mining;

26.1.1.2.2. pervasive or persistent findings of routine audits to specific allegations that involve or appear to involve intentional misrepresentation in an effort to receive an improper payment;

26.1.1.2.3. notification of potential fraud, waste, and abuse through member verification of services, or complaint filed; and.

26.1.1.2.4. any reviews as defined by CMS as fraud, waste, and abuse investigation.

26.1.1.3. Routine claims audits are random reviews conducted for the purpose of verifying provider compliance with contractual requirements including, but not limited to, quality standards, reimbursement guidelines, and/or medical policies.

26.2. Fraud, Waste and Abuse Prevention Procedures

26.2.1. The MCO shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud, waste and abuse. The MCO procedures shall include, at a minimum, the following:

26.2.1.1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;

26.2.1.2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

26.2.1.3. Effective training and education for the compliance officer and the MCO's employees;

26.2.1.4. Effective lines of communication between the compliance officer and the MCO's employees;

26.2.1.5. Enforcement of standards through well-publicized disciplinary guidelines;

26.2.1.6. Provisions for internal monitoring and auditing;

26.2.1.7. Provisions for the MCO's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23; and

26.2.1.8. Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's Agreement [42 CFR 438.608(a) and (b)]

26.2.2. The MCO shall establish a Program Integrity Unit within the MCO comprised of:

26.2.2.1. Experienced Fraud, Waste and Abuse reviewers who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein; and

26.2.2.2. An experienced Fraud, Waste, and Abuse Coordinator who is qualified by having appropriate background, training,education, and experience in health care provider fraud, waste and abuse.

26.2.3. This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud, Waste and Abuse that may be committed by providers that are paid by the MCO and/or their subcontractors. The MCO Program Integrity Plan shall also include the prevention, detection, investigation and reporting of suspected fraud by the MCO, the MCO's employees, subcontractors, subcontractor's employees, or any other third parties with whom the MCO contracts. The MCO shall refer all suspected provider fraud to the DHHS Program Integrity Unit upon discovery. The MCO shall refer all suspected member fraud to DHHS Special Investigations Unit.

26.3. Reporting

26.3.1. The MCO shall promptly report provider fraud, waste and abuse information to DHHS' Program Integrity Unit, which is responsible for such reporting to federal oversight agencies pursuant to [42 CFR 455.1(a)(1) and 42 CFR438.608].

26.3.1.1. The MCO shall perform a preliminary investigation of all incidents of suspected fraud, wasteand abuse internally. The MCO shall not take any of the following actions as they specifically relate to claims involved with the investigation unless prior written approval is obtained from DHHS' Program Integrity Unit, utilizing the MCO Request to Open Investigation form:

26.3.1.1.1. Contact the subject of the investigation about any matters related to the investigation, either in person, verbally or in writing, hardcopy, or electronic;

26.3.1.1.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

26.3.1.1.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

26.3.2. The MCO shall promptly report to DHHS' Division of Client Services all information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including but not limited to:

26.3.2.1. Changes in the enrollee's residence; and

26.3.2.2. Death of an enrollee.

26.3.3. The MCO shall promptly report to DHHS' Office of Medicaid Services and the Program Integrity Unit all changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

26.3.4. The MCO shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (five (5) percent or greater) in the MCO, or any sub-contractor in which the MCO has a five percent (5%) or greater ownership interest [42 CFR 438.608(c)(2)].

26.3.5.

26.3.6. The MCO shall provide written disclosure of any prohibited affiliation under §438.610 and as described in subparagraph 4.3.2 of this Agreement [42 CFR 438.608(c)(1)].The MCO shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State.

26.3.7. As an integral part of the Program Integrity function, and in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438, the MCO shall provide DHHS or its designee real time access to all of the MCO electronic encounter and claims data from the MCO's current claims reporting system. The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in section 24.5.16.

26.3.7.1. MCOs shall provide any additional data access upon written request from DHHS for any potential fraud, waste, or abuse investigation or for MCO oversight review. The additional access shall be provider within 3 business days of the request.

26.3.8. The MCO shall make claims and encounter data available to DHHS (and other State staff) using a reporting system that is compatible with DHHS' system(s).

26.3.9. The MCO, their subcontractors, their contracted providers, their subcontractor's providers, and any subcontractor's subcontractor's providers shall cooperate fully with Federal and State agencies and contractors in any program integrity related investigations and subsequent legal actions. The MCO, their subcontractors and their contracted providers, subcontractor's providers, and any subcontractor's subcontractor's providers shall, upon written request and as required by this Agreement or state and/or federal law, make available any and all administrative, financial and medical records relating to the delivery of items or services for which MCO monies are expended. In addition, and as required by this Agreement or state and/or federal law, such agencies shall, also be allowed access to the place of business and to all MCO records of any contractor, their subcontractor or their contracted provider, subcontractor's providers, and any subcontractor's subcontractor's providers.

26.3.9.1. The MCO is responsible for program integrity oversight of its subcontractors. In accordance with federal regulations, CMS requires MCO contracts to contain provisions giving states' Program Integrity Units audit and access authority over MCOs and their subcontractors to include direct on site access to ordinal policies and procedures, claims processing, and provider credentialing for validation purposes at the expense of the MCO.

26.3.10. The MCO shall have a written process approved by DHHS for Recipient Explanation of Medicaid Benefits, which shall include tracking of actions taken on responses, as a means of determining and verifying that services billed by providers were actually provided to members. The MCO shall provide DHHS with a quarterly EOB activity report, including, but not limited to, tracking of all responses received, action taken by the MCO, and the outcome of the activity. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the MCO.

26.3.11.

The MCO shall maintain an effective fraud, waste and abuse-related provider overpayment identification, recovery and tracking process. This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with providers, and a system for managing and tracking of investigation findings, recoveries, and underpayments related to fraud, waste and abuse investigations. DHHS and the AG Medicaid Fraud Unit shall have unrestricted access to information and documentation related to the NH Medicaid program for use during annual MCO Program Integrity audits and on other occasions as needed as a means of verifying and validating MCO compliance with the established policies, procedures, methodologies, and investigational activity regarding provider fraud, waste and abuse.

26.3.12.The MCO shall provide DHHS with a monthly report of all Program Integrity, in process and completed during the month, including fraud, waste and abuse by the MCO, the MCO's employees, subcontractors, subcontractor's employees, and contracted providers. [42 CFR 455.17]. The MCO will supply at a minimum:

26.3.12.1. provider name/ID number,

26.3.12.2. source of complaint,

26.3.12.3. type of provider,

26.3.12.4. nature of complaint,

26.3.12.5. review activity, and

26.3.12.6. approximate dollars involved,

26.3.12.7. Provider Enrollment Safeguards related to Program Integrity;

26.3.12.8. Overpayments, Recoveries, and Claim Adjustments;

26.3.12.9. Audits/Investigations Activity;

26.3.12.10.MFCU Referrals;

26.3.12.11.Involuntary Provider Terminations; and

26.3.12.12.Provider Appeal/Hearings Activity resulting from, or related to, Program Integrity.

26.3.13.All fraud, waste and abuse reports submitted to DHHS shall be mutually developed and agreed upon between DHHS and the MCO. The reports will be submitted to DHHS in a format and mode of delivery, mutually agreed upon between DHHS and the MCO.

26.3.14.In the event DHHS is unable to produce a desired Ad Hoc report through its access to the MCO's data as provided herein, DHHS shall request in writing such Ad hoc report from the MCO and, within three (3) business days of receipt of such request, the MCO shall notify DHHS of the time required by the MCO to produce and deliver the Ad hoc report to DHHS, at no additional cost to DHHS.

26.3.15. The MCO shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the MCO discovers wasteful and or abusive incorrect billing trends with a particular provider/provider type, specific billing issue trends, or quality trends, it is the MCO's responsibility, as part of the provider audit/investigative process, to recover any inappropriately paid funds, and as part of the resolution and outcome, for the MCO to determine the appropriate remediation, such as reaching out to the provider to provide individualized or group training/education regarding the issues at hand. Within sixty (60) days of discovery, the MCO shall report overpayments identified during investigations to DHHS Program Integrity and shall include them on the monthly investigation activity report. The MCO shall still notify Program Integrity unit to request approval to proceed with a suspected fraud or abuse investigation.

26.3.16.

26.3.17. Annually, the MCO shall submit to DHHS a report of the overpayments it recovered and certify by its Chief Financial Officer that this information is accurate to the best of his or her information, knowledge, and belief [42 CFR 438.606]. DHHS reserves the right to conduct peer reviews of final program integrity investigations completed by the MCO.

26.3.18. DHHS will perform an annual program integrity audit, conducted on-site at the MCO (at the expense of the MCO) to verify and validate the MCO's compliance. The review will include, but not limited to, the plan's established policies and methodologies, credentialing, provider and staff education/training, provider contracts, and case record reviews to ensure that the MCO is making proper payments to providers for services under their agreements, and pursuant to 42 CFR 438 6(g). The review will include direct access to MCO system while on site and hard copy of documentation while on site as requested. Any documentation request at the end of the on site shall be delivered to Program Integrity witin 3 business days of request. The MCO shall provide DHHS staff with access to appropriate on-site private work space to conduct DHHS's program integrity contract management reviews.

26.3.19. The MCO shall meet with DHHS monthly, or as determined by DHHS, to discuss audit and investigation results and make recommendations for program improvements. DHHS shall meet with both MCOs together quarterly, or as determined by DHHS, to discuss areas of interest for past, current and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities, and to discuss and share provider audit information and results.

26.3.20. The MCO shall provide DHHS with an annual report of all investigations in process and completed during the Agreement year within thirty (30) calendar days of the end of the Agreement year. The report shall consist of, at a minimum, an aggregate of the

monthly reports, as well as any recommendations by the MCO for future reviews, changes in the review process and reporting process, and any other findings related to the review of claims for fraud, waste and abuse.

26.3.21. The MCO shall provide DHHS with a final report within thirty (30) calendar days following the termination of this Agreement. The final report format shall be developed jointly by DHHS and the MCO, and shall consist of an aggregate compilation of the data received in the monthly reports.

26.3.22. The MCO shall refer all suspected provider Medicaid fraud cases to DHHS upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.

26.3.23. The MCO shall institute a Pharmacy Lock-In Program for members which has been reviewed and approved by DHHS.

26.3.23.1. If the MCO determines that a member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to members regarding the Pharmacy Lock-In determination.

26.3.24. MCOs may, with prior approval from DHHS, implement Lock-In Programs for other medical services.

26.3.25. The MCO shall provide DHHS with a monthly report regarding the Pharmacy Lock-In Program. Report format, content, design, and mode of transmission shall be mutually agreed upon between DHHS and the MCO.

26.3.26. DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit or DHHS Special Investigations Unit.

26.3.27. Subject to applicable state and federal confidentiality/privacy laws, upon written request, the MCO will allow access to all NH Medicaid medical records and claims information to State and Federal agencies or contractors such as, but not limited to Medicaid Fraud Control Unit, Recovery Audit Contractors (RAC) the Medicaid Integrity Contractors (MIC), or DHHS Special Investigations Unit.

26.3.27.1. The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency (State and Federal) or their contractors, whether administrative, civil, or criminal. Such cooperation shall include providing, upon written request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

26.3.28.The MCO's MCIS system shall have specific processes and internal controls relating to fraud, waste and abuse in place, including, but not limited to the following areas:

26.3.28.1. Prospective claims editing;

26.3.28.2. NCCI edits;

26.3.28.3. Post-processing review of claims; and

26.3.28.4. Ability to pend any provider's claims for pre-payment review if the provider has shown evidence of credible fraud [42 CFR 455.21] in the Medicaid Program.

26.3.29.The MCO and their subcontractors shall post and maintain DHHS approved information related to Fraud, Waste and Abuse on its website, including but not limited to provider notices, updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

26.3.30.The MCO and their subcontractors shall be subject to on-site reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests as a result of an annual or targeted on-site review (at the expense of the MCO).

26.3.31.DHHS shall conduct investigations related to suspected provider fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for any and all types of claims older than six months for which the MCO does not have an active investigation.

26.3.32.DHHS shall validate the MCO and their subcontractors' performance on the program integrity scope of services to ensure the MCO and their subcontractors are taking appropriate actions to identify, prevent, and discourage improper payments made to providers, as set forth in 42 CFR 455 – Program Integrity.

26.3.33.DHHS shall establish performance measures to monitor the MCO compliance with the Program Integrity requirements set forth in this Agreement.

26.3.34.DHHS shall notify the MCO of any policy changes that impact the function and responsibilities required under this section of the Agreement.

26.3.35.DHHS shall notify the MCO of any changes within its agreement with its fiscal agent that may impact this section of this Agreement as soon as reasonably possible.

26.3.36.The MCO(s) shall report to DHHS all identified providers prior to being investigated, to avoid duplication of on-going reviews with the RAC, MIC, MFCU and, using the MCO Request to Open Investigation Form. DHHS will either approve

the MCO to proceed with the investigation, or deny the request due to potential interference with an existing investigation.

26.3.37. The MCO(s) shall maintain appropriate record systems for services to members pursuant to 42 CFR 434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff, or its designee, to MCO(s) NH Medicaid related data files. Such information shall include, but not be limited to:

26.3.37.1. Recipient – First Name, Last Name, DOB, gender, and identifying number;

26.3.37.2. Provider Name and number (rendering, billing and Referring);

26.3.37.3. Date of Service(s) Begin/End;

26.3.37.4. Place Of Service;

26.3.37.5. Billed amount/Paid amount;

26.3.37.6. Paid date;

26.3.37.7. Standard diagnosis codes (ICD-9-CM and ICD-10-CM), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim);

26.3.37.8. Paid, denied, and adjusted claims;

26.3.37.9. Recouped claims and reason for recoupment;

26.3.37.10. Discharge status;

26.3.37.11. Present on Admission (POA);

26.3.37.12. Length of Stay;

26.3.37.13. Claim Type;

26.3.37.14. Prior Authorization Information;

26.3.37.15. Detail claim information;

26.3.37.16. Provider type;

26.3.37.17. Category of Service;

26.3.37.18. Admit time and discharge date;

26.3.37.19.Admit code;

26.3.37.20.Admit source;

26.3.37.21.Covered days;

26.3.37.22.TPL information;

26.3.37.23.Units of service;

26.3.37.24.EOB;

26.3.37.25.MCO ID#;

26.3.37.26.Member MCO enrollment date;

26.3.37.27.If available, provider time in and time out for the specific service(s) provided;

26.3.37.28.Data shall be clean, not scrubbed; and

26.3.37.29.And any other data deemed necessary by DHHS

26.3.38.The MCO shall provide DHHS with the following monthly reports as required by CMS:

26.3.38.1.

26.3.38.2. Date of Death.

26.3.39.The MCO shall provide DHHS with any new reports as identified and required by state and federal regulation. The timing, format, content and mode of transmission will be mutually agreed upon between DHHS and the MCO.

27. Third Party Liability

DHHS and the MCO will cooperate in implementing cost avoidance and cost recovery activities. The rights and responsibilities of the parties relating to members and Third Party Payors are as follows:

27.1. MCO Cost Avoidance Activities

27.1.1. The MCO shall have primary responsibility for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans, and workers compensation. The MCO must attempt to avoid initial payment of claims, whenever possible, when federal or private health insurance resources are available. To support that responsibility, the MCO must implement a file transfer protocol between the DHHS MMIS and the MCO's MCIS to receive Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138. MCO shall require its subcontractors to promptly and consistently report COB daily information to the MCO.

27.1.2. The MCO shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

27.1.3. The number of claims cost avoided by the MCO's claims system, including the amount of funds, the amounts billed, the amounts not collected, and the amounts denied, must be reported weekly to DHHS in delimited text format.

27.1.4. The MCO shall maintain records of all COB collection efforts and results and report such information either through monthly electronic data transfers or access rights for DHHS to the MCO's data files. The data extract shall be in the delimited text format. Data elements may be subject to change during the course of the Agreement. The MCO shall accommodate changes required by DHHS and DHHS shall have access to all billing histories and other COB related data.

27.1.5. The MCO shall provide DHHS with a detailed claim history of all claims for a member, including adjusted claims, on a monthly basis based on a specific service date parameter requested for accident and trauma cases. This shall be a full replacement file each month for those members requested. These data shall be in the delimited text format. The claim history shall have, at a minimum, the following data elements:

27.1.5.1. Member name;

27.1.5.2. Member ID;

27.1.5.3. Dates of service;

27.1.5.4. Claim unique identifier (transaction code number);

27.1.5.5. Claim line number;

27.1.5.6. National Diagnosis Code;

27.1.5.7. Diagnosis code description;

27.1.5.8. National Drug Code;

27.1.5.9. Drug code description;

27.1.5.10. Amount billed by the provider;

27.1.5.11. Amount paid by the MCO;

27.1.5.12. Amount of other insurance recovery, name or Carrier ID;

27.1.5.13. Date claim paid;

27.1.5.14. Billing provider name; and

27.1.5.15. Billing provider NPI.

27.1.6. The MCO shall provide DHHS with a monthly file of COB collection effort and results. These data shall be in a delimited text format. The file should contain the following data elements:

27.1.6.1. Medicaid member name;

27.1.6.2. Medicaid member ID;

27.1.6.3. Insurance Carrier, other public payer, PBM, or benefit administrator ID;

27.1.6.4. Insurance Carrier, other public payer, PBM, or benefit administrator name;

27.1.6.5. Date of Service;

27.1.6.6. Claim unique identifier (transaction code number);

27.1.6.7. Date billed to the insurance carrier, other public payer, PBM, or benefit administrator;

27.1.6.8. Amount billed;

27.1.6.9. Amount recovered;

27.1.6.10. Denial reason code;

27.1.6.11. Denial reason description; and

27.1.6.12. Performing provider.

27.1.7. The MCO and its subcontractors shall not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations nor bill or pursue collection from a member for services. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third Party Liability is established at the time the claim is adjudicated.

27.2. DHHS Cost Avoidance and Recovery Activities

27.2.1. DHHS shall be responsible for:

27.2.1.1. Medicare and newly eligible members' initial insurance verification and submitting this information to the MCO;

27.2.1.2. Cost avoidance and pay and chase of those services that are excluded from the MCO;

27.2.1.3. Accident and trauma recoveries;

27.2.1.4. Lien, Adjustments and Recoveries and Transfer of Assets pursuant to § 1917 of the SSA;

27.2.1.5. Mail order co-pay deductible pharmacy program for Fee for Service and HIPP (Health Insurance Premium Payment) program;

27.2.1.6. Veterans Administration benefit determination;

27.2.1.7. Health Insurance Premium Payment Program; and

27.2.1.8. Audits of MCO collection efforts and recovery.

27.3. Post-Payment Recovery Activities

27.3.1. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources.

27.3.2. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts.

27.3.3. Other resources with regard to Third Party Liability include but are not limited to: recoveries from personal injury claims, liability insurance, first party automobile medical insurance, and accident indemnity insurance.

27.4. *MCO Post Payment Activities*

27.4.1. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources, including a claim involving Workers' Compensation or where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible or collection through either legal action or traditional subrogation and collection procedures.

27.4.2. The MCO shall be responsible for Reviewing claims for accident and trauma codes as required under 42 C.F.R. §433.138 (e). The MCO shall specify the guideline used in determining accident and trauma claims and establish a procedure to send the DHHS Accident Questionnaire to Medicaid members, postage pre-paid, when such potential claim is identified. The MCO shall instruct members to return the Accident Questionnaire to DHHS. The MCO shall provide the guidelines and procedures to DHHS for review and approval. Any changes to procedures must be submitted to DHHS at least thirty days for approval prior to implementation.

27.4.3. Due to potential time constraints involving accident and trauma cases and due to the large dollar value of many claims which are potentially recoverable by DHHS, the MCO must identify these cases before a settlement has been negotiated. Should DHHS fail to identify and establish a claim prior to settlement due to the MCO's untimely submission of notice of legal involvement where the MCO has received such notice, the amount of the actual loss of recovery shall be assessed against the MCO. The actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by DHHS.

27.4.4. The MCO has the latter of eighteen (18) months from the date of service or twelve (12) months from the date of payment of health-related insurance resources to initiate recovery and may keep any funds that it collects. The MCO must indicate its intent to recover on health-related insurance by providing to DHHS an electronic file of those cases that will be pursued. The cases must be identified and a file provided to DHHS by the MCO within thirty (30) days of the date of discovery of the resource.

27.4.5. The MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a Medically Necessary determination or lack of coverage. The MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

27.5. DHHS Post Payment Recovery Activity

27.5.1. DHHS retains the sole and exclusive right to investigate, pursue, collect and retain all Other Resources, including accident and trauma. DHHS is assigned the MCO's subrogation rights to collect the "Other Resources" covered by this provision. Any correspondence or Inquiry forwarded to the MCO (by an attorney, provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forward to DHHS.

27.5.2. The MCO may neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by DHHS under the scope of these "Other Resources" shall be retained by DHHS.

27.5.3. DHHS may pursue, collect and retain recoveries of all health-related insurance cases; provided, however, that if the MCO has not notified DHHS of its intent to pursue a case identified for recovery before the latter of eighteen (18) months after the date of service or twelve (12) months after the date of payment, such cases not identified for recovery by the MCO will become the sole and exclusive right of DHHS to pursue, collect and retain. The MCO must notify DHHS through the prescribed electronic file process of all outcomes for those cases identified for pursuit by the MCO.

27.5.4. Should DHHS lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in billing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable Claim shall be assessed against the MCO.

28. Compliance with State and Federal Laws

28.1. General

28.1.1. The MCO, its subcontractors, and the providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

28.1.2. The MCO 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].

28.1.3. The MCO shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

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

28.1.3.2. Related rules: Title 42 Chapter IV;

28.1.3.3. 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);

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

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

28.1.3.6. Regulations promulgated thereunder: 42 CFR 457;

28.1.3.7. Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

28.1.3.8. Patient Protection and Affordable Care Act of 2010;

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

28.1.3.10. State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26; and

28.1.3.11. American Recovery and Reinvestment Act.

28.1.4. The MCO will not release and make public statements or press releases concerning the program without the prior consent of DHHS.

28.1.5. The MCO shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and the MCO, 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.

28.2. Non-Discrimination

28.2.1. The MCO shall require its providers and 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 or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

28.2.2. ADA Compliance

28.2.2.1. The MCO shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA.

28.2.2.1.1. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

28.2.2.2. The MCO shall submit to DHHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the MCO's knowledge. The MCO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by the MCO and shall be available for inspection by the DHHS. The MCO warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA. Where applicable, the MCO shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

28.2.2.3. The MCO shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all members who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

28.2.2.4. The MCO shall forward to DHHS copies of all grievances alleging discrimination against members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability for review and appropriate action within three (3) business days of receipt by the MCO.

28.2.3. Non-Discrimination in employment:

28.2.3.1. The MCO shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. The MCO 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. The MCO 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.

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

28.2.3.3. The MCO 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 the MCO'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.

28.2.3.4. The MCO 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.

28.2.3.5. The MCO 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.

28.2.3.6. In the event of the MCO'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 the MCO 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.

28.2.3.7. The MCO 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. The MCO 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 the MCO

becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

28.2.4. Non-Discrimination in Enrollment

28.2.4.1. The MCO shall and shall require its providers and subcontractors to accept assignment of an member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

28.2.4.2. The MCO shall and shall require its providers and subcontractors to not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

28.2.5. Non-Discrimination with Respect to Providers

28.2.5.1. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's members, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the MCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

28.3. Changes in Law

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

29. Administrative Quality Assurance Standards

29.1. Claims Payment Standards

29.1.1. The MCO shall pay or deny ninety-five percent (95%) of clean claims within thirty (30) days of receipt, or receipt of additional information [42 CFR 447.46; 42 CFR 447.45(d)(2), (d)(3), (d)(5), and (d)(6)].

29.1.2. The MCO shall pay interest on any clean claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

29.1.3. The MCO shall pay or deny all claims within sixty (60) calendar days of receipt.

29.1.4. Additional information necessary to process incomplete claims shall be requested from the provider within thirty (30) days from the date of original claim receipt.

29.1.5. For purposes of this requirement, New Hampshire DHHS has adopted the claims definitions established by CMS under the Medicare program, which are as follows:

29.1.5.1. "clean" claim: a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and

29.1.5.2. "incomplete" claim: a claim that is denied for the purpose of obtaining additional information from the provider.

29.1.6. Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or electronic funds transfer is issued to the service provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

29.2. Quality Assurance Program

29.2.1. The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS on a monthly basis.

29.2.2. Monthly reporting shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

29.2.3. The MCO shall implement Corrective Action Plans to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

29.3. Claims Financial Accuracy

29.3.1. Claims financial accuracy measures the accuracy of dollars paid to providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

29.4. Claims Payment Accuracy

29.4.1. Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay ninety-seven percent (97%) of claims accurately.

29.5. Claims Processing Accuracy

29.5.1. Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process ninety-five percent (95%) of all claims correctly.

30. Privacy and Security of Members

30.1. General Provisions

30.1.1. The MCO shall be in compliance with privacy policies established by governmental agencies or by State or federal law.

30.1.2. The MCO shall provide sufficient security to protect the State and DHHS data in network, transit, storage, and cache.

30.1.3. In addition to adhering to privacy and security requirements contained in other applicable laws and statutes, the MCO shall execute as part of this Agreement a Business Associates Agreement governing the permitted uses and disclosure and security of Protected Health Information.

30.1.4. The MCO shall ensure that it uses and discloses individually identifiable health information in accordance with HIPAA privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable [42 CFR 438.224]; complies with federal statutes and regulations governing the privacy of drug and alcohol abuse patient records (42 CFR, Part 2), and all applicable state statutes and regulations, including but not limited to: R.S.A. 167:30: protects the confidentiality of all DHHS records with identifying medical information in them.

30.1.5. With the exception of submission to the Comprehensive Healthcare Information System or other requirements of State or federal law, claims and member data on New Hampshire Medicaid members may not be released to any party without the express written consent of DHHS.

30.1.6. The MCO shall ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information [42 CFR 438.208(b)].

31. Finance

31.1. Financial Standards

31.1.1. In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with New Hampshire Insurance Department regulations, and any other relevant laws and regulations.

31.1.2. Capitation Rates for State Fiscal Year 2018. Any increase in the capitation rates for each of the rating categories for the MCM program for the extension period between July 1, 2017 to June 30, 2018 shall not result in a total average increase for all rating categories combined in excess of 3.8% over the capitation rates in effect at the end of State Fiscal Year 2017, which average increase shall be calculated: a) based on the membership in the MCM program at the time the State Fiscal Year 2018 capitation rates are developed and b) net of the cost impact of any program changes that will take effect in State Fiscal Year 2018; provided, however, that the capitation rate proposed for each rating category for State Fiscal Year 2018 must be sufficient to be certified as actuarially sound per 42 CFR 438.4 and approvable by the Centers for Medicare and Medicaid Services.

31.1.3. The MCO shall maintain a risk-based capital (RBC) ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

31.1.4. With the exception of payment of a claim for a medical product or service that was provided to a member, and that is in accordance with a written Agreement with the provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

31.1.4.1. RBC ratio was less than 2.0 for the most recent year filing, per R.S.A. 404-F:14 (III); and

31.1.4.2. MCO was not in compliance with the NHID solvency requirement.

31.1.5. The MCO shall notify DHHS within ten (10) calendar days when its Agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

31.1.6. The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

31.1.7. The MCO shall not be responsible for DSH/GME (IME/DME) payments to hospitals. DSH and GME amounts are not included in capitation payments.

31.1.8. The MCO shall submit data on the basis of which DHHS determines that the MCO has made adequate provision against the risk of insolvency.

31.2. Capitation Payments

31.2.1. Preliminary capitation rates for non NHHPP members for the agreement period through June 30, 2018 are shown in Exhibit B. For each of the subsequent years of the Agreement actuarially sound per member, per month capitated rates will be calculated and certified by the DHHS's actuary.

31.2.2. Capitation rates for NHHPP members are shown in Exhibit B and were determined as part of Agreement negotiations, any best and final offer process, and the DHHS actuary's soundness certification.

31.2.3. Capitation rate cell is determined as of the first day of the capitation month and does not change during the entire month regardless of member changes (e.g., age).

31.2.4. DHHS will make a monthly payment to the MCO for each member enrolled in the MCO's plan. Capitation payments shall only be made for Medicaid-eligible enrollees and be retained by the MCOs for those enrollees. The capitation rates, as set forth in Exhibit B, will be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis as follows:

31.2.4.1. The Chronic Illness and Disability Payment System and/or Medicaid Rx risk adjuster (CDPS + Rx, Medicaid Rx) will be used to risk adjust MCO capitation payments;

31.2.4.2.

A risk score will be developed for members with six (6) months or more months of Medicaid eligibility (either FFS or managed care) inclusive of three (3) months of claims run out in the base experience period. For members with less than six (6) months of eligibility, a score equal to the average of those scored beneficiaries in each cohort will be used; and

31.2.4.3.The MCO risk score for a particular rate cell will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population enrolled in the Care Management program. For rate cells with an opt-out provision, the MCO risk score will equal the average risk factor across all beneficiaries that the MCO enrolls divided by the average risk factor for the entire population

that is eligible to enroll in the Care Management program (FFS eligibles + MCO members).

31.2.5. DHHS reserves the right to terminate or implement the use of a risk adjustment process for specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates. For example, the risk adjustment process may need to be modified when Long Term Services and Supports (LTSS) are added to the capitation rates.

31.2.6. The capitation payment for Medicaid Managed Care members will be made retrospectively with a two (2) month delay. For example, a payment will be made within five (5) business days of the first day in October 2012 for services provided in July 2012.

31.2.7. Section 31.2.6 notwithstanding, capitation payments for NHHPP members will be paid in the month of service.

31.2.8. Capitation payment settlements will be made at three (3) month intervals. DHHS will recover capitation payments made for deceased members, or members who were later determined to be ineligible for Medicaid and/or for Medicaid managed care or need rate cell or kick payment corrections. DHHS will pay MCO for retroactive member assignments, corrections to kick payments, behavioral health certification level correction or other rate assignment corrections.

31.2.9. Capitation payments for members who became ineligible for services in the middle of the month will be prorated based on the number of days eligible in the month.

31.2.10. The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement [42 CFR 438.608(c)(3)].

31.2.11. For each live birth, DHHS will make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all maternity expenses, including all delivery and postpartum care. In the event of a multiple birth DHHS will only make only one maternity kick payment. A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

31.2.12. For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2012 and August 2012 for a baby born any time in July 2012. Enrolled babies will be covered under the MCO capitated rates thereafter.

31.2.13. The MCO shall submit information on maternity and newborn events to DHHS. The MCO shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

31.2.14. Beginning July 1, 2018, one percent (1.0%) of each member's capitation payment to the MCO will be withheld annually to support DHHS's payment reform incentive program. Details of the Incentive Program are described in Section 9.

31.2.15. DHHS will inform the MCO of any required program revisions or additions in a timely manner. DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

31.2.16. When requested by DHHS, the MCO shall submit base data to DHHS to ensure actuarial soundness in development of the capitated rates.

31.2.17. The MCO's Chief Financial Officer shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate [42 CFR 438.606].

31.2.18. In the event an enrolled Medicaid member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive full capitation payment for that member. The entity responsible for coverage of the member at the time of admission as an inpatient, i.e. either DHHS or another MCO, shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

31.2.19. Payment for behavioral health rate cells shall be determined based on a member's CMHC behavioral certification level and a member having had an encounter at a CMHC in the last 6 months. Changes in the certification level for a member shall be reflected as of the first of each month and does not change during the month.

31.2.20. For Applied Behavioral Analysis (ABA) services incurred on or after September 1, 2015 the MCO shall not be financially responsible for claims for ABA services provided that the MCO obtained prior approval from DHHS of prior authorizations for the services. DHHS shall make payments to the MCO based on DHHS's Medicaid fee schedule for those ABA services approved by DHHS.

31.2.21. Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the New Hampshire Insurance Administrative Fund (Fund) pursuant to R.S.A. 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NH Insurance Department.

31.2.22. For any member with claims exceeding five hundred thousand dollars ($500,000) for the fiscal year, after applying any third party insurance off set, DHHS will reimburse fifty percent (50%) of the amount over five hundred thousand dollars ($500,000) after all claims have been recalculated based on the DHHS fee schedule for the services. For a member whose services may be projected to exceed five hundred thousand dollars ($500,000) in MCO claims, the MCO shall advise DHHS. Prior approval from the Medicaid Director is required for subsequent services provided to the member.

31.3. Medicaid Loss Ratio

31.3.1. The MCO shall determine the Medicaid Loss Ratio ("MLR") experienced in accordance with 42 CFR 438.8.

31.3.2. The MCO shall submit MLR summary reports quarterly to DHHS, which shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year. Specifically, the MCO shall provide separate summary reports for NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program. The MCO must attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. Such summary reports shall be based on a template provided and developed by DHHS within sixty (60) days of the effective date of this Agreement.

31.3.3. The MCO and its subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

31.4. NHHPP Risk Protection Structure

31.4.1. DHHS will implement risk adjustment and risk corridors for the NHHPP Medically Frail and NHHPP Transitional populations.

31.4.1.1. Risk adjustment – (MCO Revenue Reallocation) – Similar to the risk adjustment process for the current Medicaid Step 1 population under the MCM program, risk adjustment will shift revenue from MCOs with lower acuity populations to MCOs with higher acuity populations. The risk adjustment component will only apply to the NHHPP Medically Frail population. The risk adjustment process is revenue neutral. The NHHPP Transitional population is expected to have very short enrollment duration and therefore will not be risk adjusted.

31.4.2. Risk adjustment – Methodology – Acuity will be measured using the CDPS+Rx, a diagnosis and pharmacy based risk adjuster that will also be used for the current Medicaid population. Key differences in the risk adjustment process for the NHHPP Medically Frail population include:

31.4.2.1. DHHS will use concurrent risk adjustment for the NHHPP Medically Frail population. DHHS will use SFY 2018 claims and the standard CDPS+Rx concurrent risk weights to estimate SFY 2018 acuity (as opposed to prospective models that use a prior year's claims to estimate current acuity).

31.4.2.2. Risk adjustment transfer payments will be made as part of the contract period settlement, not as prospective payments.

31.4.3. Risk corridors – DHHS will establish a target medical loss ratio (MLR) of 89.3% based on NHHPP pricing assumptions and perform a separate calculation for the NHHPP Medically Frail and NHHPP Transitional populations:

31.4.3.1. Administrative and margin allowance of 8.9% of the capitation rate prior to state premium tax.

31.4.3.2. New Hampshire state premium tax of 2%.

31.4.3.3. DHHS and each MCO will share the financial risk of actual results that are above or below the MLR target as shown in the table below:

New Hampshire Department of Health and Human Services New Hampshire Health Protection Program Population Risk Corridor Program		
Actual MLR Compared to Target MLR	**MCO Share**	**DHHS Share**
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

31.4.3.4. The NHHPP Medically Frail risk corridor calculation will be applied after the risk adjustment calculation.

31.4.4. For SFY 2018, risk protection settlement will occur after the SFY 2018 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.4.1. June 30, 2018: End of NHHPP contract period

31.4.4.2. December 31, 2018: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2018 dates of service paid through December 31, 2018)

31.4.4.3. January 31, 2019: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.4.4. April 30, 2019: DHHS releases settlement payment report to MCOs

31.4.4.5. May 31, 2019: DHHS makes / receives final settlement payments to / from MCOs

31.4.5. For SFY 2017, risk protection settlement will occur after the SFY 2017 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.5.1. June 30, 2017: End of NHHPP contract period

31.4.5.2. December 31, 2017: Cutoff date for encounter data to be used in the risk protection settlement calculations (SFY 2017 dates of service paid through December 31, 2017)

31.4.5.3. January 31, 2018: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.5.4. April 30, 2018: DHHS releases settlement payment report to MCOs

31.4.5.5. May 31, 2018 DHHS makes / receives final settlement payments to / from MCOs

31.4.6. For SFY 2016, risk protection settlement will occur after the SFY 2016 NHHPP contract period has ended and enough time has passed to collect and validate MCO encounter data and financial data. DHHS will implement the following schedule for the final risk protection settlement:

31.4.6.1. June 30, 2016: End of NHHPP contract period

31.4.6.2. December 31, 2016: Cutoff date for encounter data to be used in the risk protection settlement calculations (January 2016 – June 2016 dates of service paid through December 31, 2016)

31.4.6.3. January 31, 2017: Deadline for MCOs to provide encounter data and supporting financial data to validate the accuracy of the encounter data

31.4.6.4. April 30, 2017: DHHS releases settlement payment report to MCOs

31.4.6.5. May 31, 2017: DHHS makes / receives final settlement payments to / from MCOs

31.4.7. For September 2014 – December 2015 risk protection settlement:

31.4.7.1. August 31, 2016: DHHS intends to release settlement payment report to MCOs

31.4.7.2. September 30, 2017: DHHS intends to make / receive final settlement payments to / from MCOs.

31.5. Financial Responsibility for Dual-Eligibles

31.5.1. The MCO shall pay any Medicare coinsurance and deductible amount up to what New Hampshire Medicaid would have paid for that service, whether or not the Medicare provider is included in the MCO's provider network. These payments are included in the calculated capitation payment.

31.6. Premium Payments

31.6.1. DHHS is responsible for collection of any premium payments from members. If the MCO inadvertently receives premium payments from members, it shall inform the member and forward the payment to DHHS.

31.7. Sanctions

31.7.1. If the MCO fails to comply with the financial requirements in Section 31, DHHS may take any or all of the following actions:

31.7.1.1. Require the MCO to submit and implement a Corrective Action Plan

31.7.1.2. Suspend enrollment of members to the MCO after the effective date of sanction

31.7.1.3. Terminate the Agreement upon forty-five (45) calendar days written notice

31.7.1.4. Apply liquidated damages according to Section 34

31.8. Medical Cost Accruals

31.8.1. The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims.

31.9. Audits

31.9.1. The MCO shall allow DHHS and/or the NHID to inspect and audit any of the financial records of the MCO and its subcontractors. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)].

31.9.2. The MCO shall file annual and interim financial statements in accordance with the standards set forth below. This Section 31.9.2 will supersede any conflicting requirements in Exhibit C of this Agreement.

31.9.3. Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners ("NAIC"), annual audited financial statements that have been audited by an independent Certified Public Accountant. Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

31.9.4. The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the Insurance Department.

31.9.5. The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

31.10.Member Liability

31.10.1.The MCO shall not hold its Medicaid members liable for:

31.10.1.1. The MCO's debts, in the event of the MCO's insolvency [42 CFR 438.116(a); SMM 2086.6];

31.10.1.2. The covered services provided to the member, for which the State does not pay the MCO;

31.10.1.3. The covered services provided to the member, for which the State, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or

31.10.1.4. Payments for covered services furnished under an Agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided those services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(a), (b) and (c); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.2. Subcontractors and referral providers may not bill members any amount greater than would be owed if the entity provided the services directly [§1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMD letter 12/30/97].

31.10.3. The MCO shall cover continuation of services to members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency [SMM 2086.6B].

31.11. Denial of Payment

31.11.1. Payments provided for under the Agreement will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in [§1903(m)(5)(B)(ii) of the SSA; 42 CFR 438.726(b); 42 CFR 438.730(c)].

31.12. Federal Matching Funds

31.12.1. Federal matching funds are not available for amounts expended for providers excluded by Medicare, Medicaid, or Children's Health Insurance Program (CHIP), except for emergency services [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and §1903(i)(2) of the SSA; SMD letter 12/30/97]. Payments made to such providers are subject to recoupment from the MCO by DHHS.

31.13.Health Insurance Providers Fee

31.13.1.Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposed an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

31.13.1.1. To the extent such fees exist:

31.13.1.1.1.The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement no later than 120 days following its review and acceptance of the Contractor's Adjusted Fee.

31.13.1.1.2. To claim reimbursement for the Contractor's Adjusted Fee, the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:

Attn: Medicaid Finance Director

New Hampshire Medicaid Managed Care Program

129 Pleasant Street,

Concord, NH 03304

32. Termination

32.1. Transition Assistance

32.1.1. Upon receipt of notice of termination of this Agreement by DHHS, the MCO 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 vendor or to perform the work itself.

32.1.1.1. Transition Plan

32.1.1.1.1. MCO must prepare a Transition Plan which is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date.

32.1.1.2. Data

32.1.1.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, 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.

32.1.1.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO shall transmit the information and records required 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.

32.2. Service Authorization

32.2.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received. Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS.

32.2.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

32.3. Claims Responsibilities

32.3.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

32.3.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

32.4. Termination for Cause

32.4.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if the MCO [42 CFR 438.610(c)(3); 42 CFR 434.6(a)(6)]:

32.4.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any member, including significant marketing abuses;

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

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

32.4.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS' notice and written request for compliance;

32.4.1.5. Violates state or federal law or regulation;

32.4.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

32.4.1.7. Becomes insolvent;

32.4.1.8. Fails to meet applicable requirements in sections §1932, §1903 (m) and §1905(t) of the SSA [42 CFR 438.708]. In the event of a termination by DHHS pursuant to 42 CFR 438.708, DHHS shall provide the MCO with a pre-termination hearing in accordance with 42 CFR 438.710;

32.4.1.9. 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

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

32.4.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance.

32.4.2. If DHHS terminates this Agreement for cause, the MCO 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 MCO. 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 reasonable attributable to the MCO's failure to perform any service in accordance with the terms of this Agreement.

32.5. Termination for Other Reasons

32.5.1. Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for sixty (60) calendar days after written notice thereof by the other party.

32.5.2. In the event the MCO gives written notice that it does not accept the actuarially sound capitation rates established by DHHS for Year 2 or later of the program, the MCO and DHHS will have thirty (30) days from the date of such notice or thirty (30) calendar days from the expiration of the rates indicated in Exhibit B, whichever comes later, to attempt to resolve the matter without terminating the agreement. If no resolution is reached in the above thirty (30) calendar days period, then the contract will terminate ninety (90) calendar days thereafter, or at the time that all members have been disenrolled from the MCO's plan, whichever date is earlier. In the event of such termination, the MCO shall accept the lesser of the most recently agreed to capitation rates or the new annual capitation rate for each rating category as payment in full for Covered Services and all other services required under this Agreement delivered to Members until all Members have been disenrolled from the MCO's plan consistent with any mutually agreed upon transition plans to protect Members.

32.6. Final Obligations

32.6.1. DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Amounts due to MCO for unpaid premiums, risk settlement, ABA therapies, High Dollar Stop Loss, shall be paid to MCO within one year of date of termination.

32.7. Survival of Terms

32.7.1. 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:

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

32.7.1.2. 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.

32.8. Notice of Hearing

32.8.1. Except because of change in circumstances or in the event DHHS terminates this Agreement pursuant to subsections (1), (2), (3) or (10 of Section 32.3.1, DHHS shall give the MCO ninety (90) days advance, written notice of termination of this Agreement and shall provide the MCO with an opportunity to protest said termination and/or request an informal hearing in accordance with 42 CFR 438.710. This notice shall specify the applicable provisions of this Agreement and the effective date of termination, which shall not be less than will permit an orderly disenrollment of members to the Medicaid FFS program or transfer to another MCO.

33. Agreement Closeout

33.1. Period

33.1.1. A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day the MCO is responsible for coverage of specific beneficiary groups or operating under this Agreement. During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS. Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

33.2. Data

33.2.1. The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including, but not limited to, encounter data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new MCO and/or DHHS shall define the information required during this period and the time frames for submission.

33.2.2. All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The MCO 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.

33.2.3. The MCO shall be responsible for continued submission of data to the Comprehensive Healthcare Information System during and after the transition in accordance with NHID regulations.

33.3. Service Authorizations

33.3.1. Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with the new MCO to process service authorization requests received. Disputes between the MCO and the new MCO regarding service authorizations shall be resolved by DHHS.

33.3.2. The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

33.4. Claims Responsibilities

33.4.1. The MCO shall be fully responsible for all inpatient care services and all related services authorized while the member was an inpatient until the day of discharge from the hospital.

33.4.2. The MCO shall be financially responsible for all other approved services when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge.

34. Remedies

34.1. Reservation of Rights and Remedies

34.1.1. 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 MCO 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.

34.2. Liquidated Damages

34.2.1. DHHS and the MCO agree that it will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards indicated below throughout the life of this Agreement. Any breach by the MCO will delay and disrupt DHHS's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable.

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

34.2.3. DHHS shall make all assessments of liquidated damages. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify the MCO as specified in Section 34.9 of this Agreement.

34.2.4. The MCO shall submit a written Corrective Action Plan to DHHS, within five business days of notification, for review and approval prior to implementation of corrective action.

34.2.5. The MCO agrees that as determined by DHHS, failure to provide services meeting the performance standards below will result in liquidated damages as specified. The MCO agrees to abide by the Performance Standards and Liquidated Damages specified, provided that DHHS has given the MCO data required to meet performance standards in a timely manner. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

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

34.2.7. Liquidated damages may be assessed for each day, incidence or occurrence, as applicable, of a violation or failure.

34.2.8. The amount of liquidated damages assessed by DHHS to the MCO shall not exceed three percent (3%) of total expected yearly capitated payments, based on average annual membership from start date, for the MCO.

34.2.9. Liquidated damages related to timely processing of membership, claims and or/encounters shall be waived until such time as DHHS's file transfer systems and processes are operational.

34.3. Category 1

34.3.1. Liquidated damages up to $100,000 per violation or failure may be imposed for Category 1 events. Category 1 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.3.1.1. Acts that discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll an enrollee, except as permitted under law or under this Agreement, or any practice that would reasonably be expected to discourage enrollment by an enrollee whose medical condition or history indicates probable need for substantial future medical services. [42 CFR 700(b)(3) and 42 CFR 704(b)(2)].

34.3.1.2. A determination by DHHS that a recipient was not enrolled because of a discriminatory practice; $15,000 for each recipient subject to the $100,000 overall limit in 42 CFR 704(b)(2).

34.3.1.3. A determination by DHHS that a member found eligible for CFI services was relocated to a Nursing Facility due to MCO's failure to arrange for adequate in-home services in compliance with this Agreement and He-E801.09.

34.3.1.4. Misrepresentations of actions or falsifications of information furnished to CMS or the State.

34.3.1.5. Failure to comply with material requirements in this Agreement.

34.3.1.6.

34.3.1.7. Failure to meet the Administrative Quality Assurance Standards specified in Section 29 of this Agreement.

34.3.1.8. Failure of the MCO to assume full operation of its duties under this Agreement in accordance with the implementation and transition timeframes specified herein.

34.4. Category 2

34.4.1. Liquidated damages up to $25,000 per violation or failure may be imposed for Category 2 events. Category 2 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.4.1.1. Misrepresentation or falsification of information furnished to a member, potential member, or health care provider.

34.4.1.2. Distribution, directly, or indirectly, through any agent or independent MCO, marketing materials that have not been approved by the State or that contain false or materially misleading information.

34.4.1.3. Violation of any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

34.4.1.4. Imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program; a maximum of $25,000 or double the amount of the charges, whichever is greater. The State will deduct the amount of the overcharge and return it to the affected member.

34.4.1.5. Failure to resolve member Appeals and Grievances within the timeframes specified in Section 19 of this Agreement.

34.4.1.6. Failure to ensure client confidentiality in accordance with 42 CFR 166 and 45 CFR 164; an incident of non-compliance shall be assessed as per member and/or per HIPAA regulatory violation.

34.4.1.7. Violation of a subcontracting requirement in this Agreement.

34.4.1.8. Failure to provide medically necessary services that the MCO is required to provide under law, or under this Agreement, to a member covered under this Agreement.

34.5. Category 3

34.5.1. Liquidated damages up to $10,000 per violation or failure may be imposed for Category 3 events. Category 3 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.5.1.1. Late, inaccurate, or incomplete turnover or termination deliverables.

34.6. Category 4

34.6.1. Liquidated damages up to $5,000 per violation or failure may be imposed for Category 4 events. Category 4 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.6.1.1. Failure to meet staffing requirements as specified in Section 6.

34.6.1.2. Failure to submit reports not otherwise addressed in this Section within the required timeframes.

34.7. Category 5

34.7.1. Liquidated damages as specified below may be imposed for Category 5 events. Category 5 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.7.1.1. Failure to provide a sufficient number of providers in order to ensure member access to all covered services and to meet the geographic access standards and timely access to service delivery specified in this Agreement:

34.7.1.1.1. $1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan;

34.7.1.1.2. $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan.

34.7.1.2. Failure to submit readable, valid health care data derived from Claims, Pharmacy or Encounter data in the required form or format, and timeframes required by the terms of this Agreement:

34.7.1.2.1. $5,000 for each day the submission is late;

34.7.1.2.2. for submissions more than thirty (30) calendar days late, DHHS reserves the right to withhold five percent (5%) of the aggregate capitation payments made to the MCO in that month until such time as the required submission is made.

34.7.1.3. Failure to implement the Disaster Recovery Plan (DRP):

34.7.1.3.1. Implementation of the DRP exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2.

34.7.1.3.2. Implementation of the DRP exceeds the proposed time by more than two (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per day beginning with day 3 and up to day 5.

34.7.1.3.3. Implementation of the DRP exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days: twenty five thousand dollars ($25,000) per day beginning with day 6 and up to day 10.

34.7.1.3.4. Implementation of the DRP exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per day beginning with day 11.

34.7.1.4. Unscheduled system unavailability occurring during a continuous five (5) business day period:

34.7.1.4.1. Greater than or equal to two (2) and less than twelve (12) hours cumulative; up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof.

34.7.1.4.2. Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative; up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof.

34.7.1.4.3. Greater than or equal to twenty-four (24) hours cumulative; up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

34.7.1.5. Failure to correct a system problem not resulting in system unavailability within the allowed timeframe:

34.7.1.5.1. One (1) to fifteen (15) calendar days late; two hundred and fifty dollars ($250) per calendar day for days 1 through 15.

34.7.1.5.2. Sixteen (16) to thirty (30) calendar days late; five hundred dollars ($500) per calendar day for days 16 through 30.

34.7.1.5.3. More than thirty (30) calendar days late; one thousand dollars ($1,000) per calendar day for days 31 and beyond.

34.7.1.6. Failure to meet telephone hotline performance standards:

34.7.1.6.1. One thousand dollars ($1,000) for each percentage point that is below the target answer rate of ninety percent (90%) in thirty (30) seconds.

34.7.1.6.2. One thousand dollars ($1,000) for each percentage point that is above the target of a one percent (1%) blocked call rate.

34.7.1.6.3. One thousand dollars ($1,000) for each percentage point that is above the target of a five percent (5%) abandoned call rate.

34.7.1.7. The MCO shall resolve at least ninety-eight percent (98%) of member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO

34.8. Suspension of Payment

34.8.1. Payment of capitation payments shall be suspended when:

34.8.1.1. The MCO fails to cure a default under this Agreement within thirty (30) days of notification;

34.8.1.2. Failing to act on identified Corrective Action Plan;

34.8.1.3. Failure to implement approved program management or implementation plans;

34.8.1.4. Failure to submit or act on any transition plan, or corrective action plan, as specified in this Agreement; or

34.8.1.5. Upon correction of the deficiency or omission, capitation payments shall be reinstated.

34.9. Administrative and Other Remedies

34.9.1. In addition to other liquidated damages described in Category 1-5 events, DHHS may impose the following other remedies:

34.9.1.1. Appointment of temporary management of the MCO, as provided in 42 CFR 438.706, if DHHS finds that the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

34.9.1.2. Suspending enrollment of new members and/or changing auto-assignment of new members to the MCO.

34.9.1.3. Granting members the right to terminate enrollment without cause and notifying affected members of their right to disenroll.

34.9.1.4. Suspension of payment to the MCO for members enrolled after the effective date of the remedies and until CMS or DHHS is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur.

34.9.1.5. Termination of the Agreement if the MCO 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.

34.9.1.6. Civil monetary fines in accordance with 42 CFR 438.704.

34.9.1.7. Additional remedies allowed under State statute or regulation that address area of non-compliance specified in 42 CFR 438.700.

34.10.Notice of Remedies

34.10.1.Prior to the imposition of either liquidated damages or any other remedies under this Agreement, including termination for breach, with the exception of requirements related to the Implementation Plan, DHHS will issue written notice of remedies that will include, as applicable, the following:

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

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

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

34.10.1.4. Request for a Corrective Action Plan;

34.10.1.5. The timeframe and procedure for the MCO to dispute DHHS's determination. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

34.10.1.6. If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor.

35. Dispute Resolution Process

35.1. Informal Dispute Process

35.1.1. In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) days following the action or decision, the MCO may protest such action or decision by the delivery of a notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. The MCO 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 of the time, format and location of the presentations. At the conclusion of the presentations, the Director will consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation. The Director may appoint a designee to hear and determine the matter.

35.2. No Waiver

35.2.1. The MCO's exercise of its rights under Section 34.1 shall not limit, be deemed a waiver of, or otherwise impact the parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A or any applicable provisions of the N.H. Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

36. Confidentiality

36.1. Confidentiality of Records:

36.1.1. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Agreement shall be confidential and shall not be disclosed by the MCO, 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 Agreement; 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 MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

36.2. MCO Owned or Maintained Data or Information

36.2.1. 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 the MCO. Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. The MCO acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense. If the MCO fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2017 – June 30, 2018
Capitation Payment

Eligibility Category	Capitation Rates
Low Income Children and Adults - Age 2-11 Months	$230.24
Low Income Children and Adults - Age 1-18 Years	130.67
Low Income Children and Adults - Age 19+ Years	398.79
Foster Care / Adoption	319.17
Breast and Cervical Cancer Program	1,612.74
Severely Disabled Children	1,160.71
Elderly and Disabled Adults	1,049.34
Dual Eligibles	227.70
Newborn Kick Payment	3,215.44
Maternity Kick Payment	3,168.61

NF Resident and Waiver Rate Cell	Capitation Rates
Nursing Facility Residents – Medicaid Only – Under 65	$2,118.42
Nursing Facility Residents – Medicaid Only – 65+	1,295.53
Nursing Facility Residents – Dual Eligibles – Under 65	247.69
Nursing Facility Residents – Dual Eligibles – 65+	85.64
Community Residents – Medicaid Only – Under 65	3,072.51
Community Residents – Medicaid Only – 65+	1,432.19
Community Residents – Dual Eligibles – Under 65	1,215.30
Community Residents – Dual Eligibles – 65+	402.14
Developmentally Disabled Adults – Medicaid Only	876.47
Developmentally Disabled Adults – Dual Eligibles	249.87
Developmentally Disabled and IHS Children	1,231.14
Acquired Brain Disorder – Medicaid Only	1,353.25
Acquired Brain Disorder – Eligibles Dual	311.95

Behavioral Health Population Rate Cells	Capitation Rates
Severe / Persistent Mental Illness – Medicaid Only	$2,245.33
Severe / Persistent Mental Illness – Dual Eligibles	1,731.95
Severe Mental Illness – Medicaid Only	1,513.71
Severe Mental Illness – Dual Eligibles	1,010.10
Low Utilizer – Medicaid Only	1,405.84
Low Utilizer – Dual Eligibles	577.39
Serious Emotionally Disturbed Child	933.10

July 1, 2017 – June 30, 2018

Capitation Payment – NH Health Protection Program, Alternative Benefit Plan for Medically Frail

Eligibility Category	Capitation Rate
Medically Frail	$ 1,210.76

July 1, 2017 – June 30, 2018
Capitation Payment – NH Health Protection Program, Transitional Population

Eligibility Category	Capitation Rate
NHHPP Transitional Population	$ 430.22
Maternity Kick Payment	$ 3,499.83

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for State Fiscal Year 2018, to be served among all contracts is 1,588,466. Accordingly, the price limitation for SFY18 among all contracts, for State Fiscal Year 2018, based on the projected members per month is $619,281,945.

3. Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. The State will provide reimbursement within 30 days following its review and acceptance of the Contractor's Adjusted Fee.

To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

Exhibit O – Amendment #08
NH Medicaid Care Management Quality and Oversight Reporting – 2018

The Exhibit O items shall be submitted according to the schedule and method specified and as modified in the NH DHHS's New Hampshire Medicaid Care Management Quality Oversight Reporting Specifications document, related templates, and as specified by the Medicaid Quality Information System specifications using the specifications relevant for each item's data period.

Table Notes:

"Change for 2018" column indicates whether the item is Unchanged, New, Changed, or Retired after final submission.

"Requires Subpopulation Breakout" column indicates measures where reporting requires population subgrouping system as defined by DHHS.

Reporting Reference IDs starting with "CAHPS_CPA_SUP" or "CAHPS_GP_SUP" are for CAHPS supplemental questions, to include the screening questions used.

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
ACCESSREQ.05	U		Member Requests for Assistance Accessing MCO Designated Primary Care Providers per Average Members by County	Measure	Quarterly	2 months after the end of the quarter		
ACCESSREQ.06	U		Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers per Average Members by County	Measure	Quarterly	2 months after the end of the quarter		
ACCIDENT.01	U		Accident and Trauma Claim Log	Table	Monthly	15 calendar days after end of month		
ACCRED.01	N		NCQA Accreditation Submission Overview Report (Provided by NCQA)	Report	Annually	15 Days after MCO receives accreditation report from NCQA	Accreditation reports received in CY 2017	
AMBCARE.10	U	X	Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.11	U	X	Ambulatory Care: Emergency Department Visits for Medical Health Conditions per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		

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Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
AMBCARE.12	U	X	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.13	U	X	Ambulatory Care: Emergency Department Visits for Behavioral Health Conditions per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.14	U	X	Ambulatory Care: Emergency Department Visits for Substance Use Related (Chronic or Acute) Conditions per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
AMBCARE.18	N	X	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter	1/31/2018	
APPEALS.01	U		Resolution of Standard Appeals Within 30 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.02	U		Resolution of Extended Standard Appeals Within 44 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.03	C		Resolution of Expedited Appeals Within 72 Hours	Measure	Quarterly	2 months after the end of the quarter	11/30/2017	
APPEALS.04	U		Resolution of All Appeals Within 45 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.05	U		Resolution of Appeals by Disposition Type	Measure	Quarterly	2 months after the end of the quarter		
APPEALS.09	R		Appeals by Reason Type	Measure	Quarterly			8/31/2017
APPEALS.16	U		Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Table	Monthly	30 days after the end of the month		
APPEALS.17	U		Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Table	Quarterly	2 months after the end of the quarter		
APPEALS.18	N		Reversed Appeals Service Authorization within 72 Hours	Measure	Quarterly	2 months after the end of the quarter	11/30/2017	

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Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
APPEALS.19	N		Percentage of Member Appeals Received during the measure data period.	Measure	Quarter	2 months after the end of the quarter	11/30/2017	
BHCHLDMEDMGT.01	U		Follow-up Psychiatric Consultations for Children Using Behavioral Health Medications	Measure	CY	June 30th	6/30/2016	
BHCONSENT.02	R		Consent for Release of Information for Primary Care - Behavioral Health Care Coordination Annual Report	Narrative Report	Agreement year			7/31/2016
BHCRISIS.01	R		Behavioral Health Crisis Line and Emergency Services Report on Innovative and Cost Effective Models	Narrative Report	N/A			12/31/16
BHDISCHARGE.01	U	X	Community Hospital Discharges for Mental Health Conditions Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
BHDISCHARGE.02	U	X	Community Hospital Discharges for Mental Health Conditions Where Patient Had a Visit With a Mental Health Practitioner Within 30 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
BHHOMELESS.01	U		New Hampshire Hospital Homelessness Reduction Plan	Plan	Agreement year	September 30th		
BHHOMELESS.02	U		New Hampshire Hospital Homelessness Quarterly Report	Narrative Report	Quarterly	Within 30 days of the end of each quarter		
BHPARITY.01	N		Behavioral Health Parity Certification Report	Narrative Report	Annually	TBD	TBD	
BHPARITY.02	N		Behavioral Health Parity Compliance Report	Narrative Report	Annually	TBD	TBD	
BHREADMIT.01	U	X	Readmission to Community Hospital for Mental Health Conditions at 30 days by Subpopulation	Measure	June 1 of prior SFY to June 30 of measurement year. A 13 month period.	September 1st		

Exhibit O – Amendment #08
NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
BHREADMIT.02	U	X	Readmission to Community Hospital for Mental Health Conditions at 180 days by Subpopulation	Measure	January 1 of prior SFY to June 30 of measurement year. An 18 month period	September 1st		
BHSURVEY.01	C		Behavioral Health Satisfaction Survey Annual Report; survey instrument subject to DHHS approval	Narrative Report	Annually	June 30th	6/30/2018	
BOARDCERT.01	C		MCO Network Board Certification Report as Specified by DHHS	Table	Annually	July 31	9/30/2017	
CAHPS_A.01	U		Adult CAHPS: Validated Member Level Data File (VMLDF)	Data File	Standard HEDIS Schedule	June 30		
CAHPS_A.02	U		Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	Data File	Standard HEDIS Schedule	June 30		
CAHPS_A.03	U		Adult CAHPS: Medicaid Adult Survey Results Report	Report	Standard HEDIS Schedule	June 30		
CAHPS_A.04	U		Adult CAHPS: CAHPS Survey Results with Confidence Intervals	Data File	Standard HEDIS Schedule	July 15		
CAHPS_A.05	U		Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Report	Standard HEDIS Schedule	February 28		
CAHPS_A_ALL	U		Adult CAHPS: CAHPS 5.0H Core Survey - Adults	Measure	Standard HEDIS Schedule	July 15th		
CAHPS_C.01	U		Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Data File	Standard HEDIS Schedule	June 30		
CAHPS_C.02	U		Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	Data File	Standard HEDIS Schedule	June 30		
CAHPS_C.03	U		Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	Report	Standard HEDIS Schedule	June 30		
CAHPS_C.04	U		Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	Report	Standard HEDIS Schedule	June 30		
CAHPS_C.05	U		Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	Data File	Standard HEDIS Schedule	July 15		
CAHPS_C.06	U		Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	Data File	Standard HEDIS Schedule	July 15		
CAHPS_C.07	U		Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	Report	Standard HEDIS Schedule	February 28		

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Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CAHPS_C_ALL	U		Child CAHPS: CAHPS 5.0H Core and Children with Chronic Conditions Survey - Children	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_CPA_SUP.101	N		In the last 6 months, did you need any treatment or counseling for a personal or family problem? (Screening Question for CAHPS_CPA_SUP.102)	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_CPA_SUP.102	U		Adult CAHPS®: Ease in Getting Treatment or Counseling: Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_CPA_SUP.112	N		In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment? (Screening Question for CAHPS_CPA_SUP.113)	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_CPA_SUP.113	U		Adult CAHPS®: Ease in Getting Special Medical Equipment: Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_CPA_SUP.231	U		Adult CAHPS®: Days to Get Appointment When Care Needed Right Away	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_CPA_SUP.232	U		Adult CAHPS®: Days to Get Appointment For Check-up or Routine Care	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_CPA_SUP.233	N		In the last 6 months, did you need care during evenings, weekends, or holidays? (Screening Question for CAHPS_CPA_SUP.234)	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_CPA_SUP.234	U		Adult CAHPS®: Getting Needed Care from a Doctor's Office or Clinic During Evenings, Weekends, or Holidays - Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_CPA_SUP.TBD01	N		Adult CAHPS®: Personal Doctor Had Medical Records or Other Information about Care: Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_CPA_SUP.TBD02	N		In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service? (Screener Question #1 for CAHPS_CPA_SUP.TBD04)	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	

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Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
CAHPS_CPA_SUP.TBD03	N		In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services? (Screener Question #1 for CAHPS_CPA_SUP.TBD04)	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_CPA_SUP.TBD04	N		Adult CAHPS®: Personal Doctor Provided Help Needed to Manage Care Among Different Providers and Services: Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_GP_SUP.231	U		Child CAHPS®: Days to Get Appointment When Care Needed Right Away	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_GP_SUP.232	U		Child CAHPS®: Days to Get Appointment For Check-up or Routine Care	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_GP_SUP.233	U		In the last 6 months, did your child need care during evenings, weekends, or holidays? (Screening Question for CAHPS_GP_SUP.234)	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_GP_SUP.234	U		Child CAHPS®: Getting Needed Care from a Doctor's Office or Clinic During Evenings, Weekends, or Holidays - Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_GP_SUP.990096	N		In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (Screening Question for CAHPS_GP_SUP.990097 and CAHPS_GP_SUP.990098)	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	
CAHPS_GP_SUP.990097	U		Child CAHPS®: Who Helped to Coordinate Child's Care	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_GP_SUP.990098	U		Child CAHPS®: Satisfaction with Help Received to Coordinate Child's Care - Satisfied or Very Satisfied	Measure	Standard HEDIS Schedule	July 15th	7/15/2017	
CAHPS_GP_SUP.TBD01	N		Child CAHPS®: Personal Doctor Had Medical Records or Other Information about Child's Care: Usually or Always	Measure	Standard HEDIS Schedule	July 15th	7/15/2018	

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CARECOORD.01	U	X	Percent of Members Receiving Care Management Services by Subgroup	Measure	Quarterly	Two months after the end of the data period	2/29/2016	
CARECOORD.03	U		Quality Assessment: Referral to Case Management for All Infants with a Diagnosis of Neonatal Abstinence Syndrome	Measure	Quarterly	2 months after the end of the quarter	11/30/2015	
CAREMGT.01	C		Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs Including System of Care for Children With Serious Emotional Disturbances	Plan	N/A	May 1st	5/1/2018	
CAREMGT.02	R		Systems of Care for Children With Serious Emotional Disturbance Report	Narrative Report	TBD			No Further Submissions Required
CAREMGT.06	N		Special Needs Assessment Report	Table	Monthly	15 Days after the end of the month	TBD	
CAREMGT.20	C		Medicaid Care Management Program Comprehensive Annual Report	Narrative and Analytic Report	Agreement year	August 30	9/30/2017	
CLAIM.01	U		Timely Professional and Facility Medical Claim Processing	Measure	Numerator and denominator calculated daily / summary measure reported monthly	50 calendar days after end of reporting period	1/19/2017	
CLAIM.05	U		Claims Quality Assurance: Claims Processing Accuracy	Measure	Monthly	50 calendar days after end of reporting period	1/19/2017	
CLAIM.06	U		Claims Quality Assurance: Claims Payment Accuracy	Measure	Monthly	50 calendar days after end of reporting period	1/19/2017	

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CLAIM.07	U		Claims Quality Assurance: Claims Financial Accuracy	Measure	Monthly	50 calendar days after end of reporting period	1/19/2017	
CLAIM.08	U		Interest on Late Paid Claims	Measure	Monthly	50 calendar days after end of reporting period	1/19/2017	
CLAIM.09	U		Timely Professional and Facility Medical Claim Processing: Sixty Days of Receipt	Measure	Numerator and denominator calculated daily / summary measure reported monthly	80 calendar days after end of reporting period	2/18/2017	
CLAIM.10	U		Claims Payment Quality Assurance Corrective Action Plans	Plan	N/A	As needed		
CLAIM.11	U		Professional and Facility Medical Claim Processing Results - Paid, Suspended, Denied	Measure	Numerator and denominator calculated daily / summary measure reported monthly	50 calendar days after end of reporting period	1/19/2017	
CLAIM.17	U		Average Pharmacy Claim Processing Time	Measure	Monthly	50 calendar days after end of reporting period	1/19/2017	
CLAIM.18	N		High Risk Provider - Professional and Facility Medical Claim Processing Results by Provider Subgroup	Table	Monthly	50 calendar days after end of reporting period	TBD	
CMS_A_ABA	U		Adult BMI Assessment (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_AMM.01	U		Antidepressant Medication Management: Effective Acute Phase Treatment (CMS Adult Core Set)	Measure	May 1 of year prior to the measurement year to Oct 31 of measurement year.	September 30th		

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CMS_A_AMM.02	U		Antidepressant Medication Management: Effective Continuation Phase Treatment (CMS Adult Core Set)	Measure	May 1 of year prior to the measurement year to Oct 31 of measurement year.	September 30th		
CMS_A_BCS	U		Breast Cancer Screening (CMS Adult Core Set)	Measure	2 CY	September 30th		
CMS_A_CBP	U		Controlling High Blood Pressure (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_CCP	U		Contraceptive Care – Postpartum (CMS Adult Core Set)	Measure	CY	September 30th	9/30/2017	
CMS_A_CCS	U		Cervical Cancer Screening (CMS Adult Core Set)	Measure	3 CY	September 30th		
CMS_A_CDF	U		Screening for Clinical Depression and Follow-up Plan by Age Group (CMS Adult Core Set) (First submission due 9/2016)	Measure	CY	September 30th		
CMS_A_FUH.01	U		Follow-Up After Hospitalization for Mental Illness: Within 7 Days of Discharge (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_FUH.02	U		Follow-Up After Hospitalization for Mental Illness: Within 30 days of Discharge (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_FUMA	U		Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (CMS Adult Core Set)	Measure	CY	September 30th	9/30/2017	
CMS_A_HA1C	U		Comprehensive Diabetes Care: Hemoglobin A1c Testing (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_HA1C_SMI	U		Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%) (CMS Adult Core Set)	Measure	CY	September 30th	9/30/2017	
CMS_A_HPC	U		Comprehensive Diabetes Care: Hemoglobin A1C Poor Control (>9.0%)	Measure	CY	September 30th		

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CMS_A_IET.01	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_IET.02	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement (CMS Adult Core Set). Age breakout of data collected for HEDIS measure	Measure	CY	September 30th		
CMS_A_INP_PQI01	U		Diabetes Short-Term Complications Admission Rate per 100,000 Member Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_INP_PQI05	U		Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_INP_PQI08	U		Heart Failure Admission Rate per 100,000 Enrollee Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_INP_PQI15	U		Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.01	U		Annual Monitoring for Members on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB) (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.02	U		Annual Monitoring for Members on Digoxin (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.03	U		Annual Monitoring for Members on Diuretic (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MPM.04	U		Annual Monitoring for Patients on Persistent Medications (Total) (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_A_MSC.01	U		CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th		
CMS_A_MSC.02	U		CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th		

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CMS_A_MSC.03	U		CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th		
CMS_A_OHD	U		Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (CMS Adult Core Set)	Measure	CY	September 30th		
CMS_C_BHRA.01	U		Behavioral Health Risk Assessment for Pregnant Women (CMS Child Core Set)	Measure	CY	September 30th		
CMS_C_BHRA.02	U		Behavioral Health Risk Assessment for Pregnant Women (CMS Child Core Set) - Individual Screening Rates	Table	CY	September 30th		
CMS_C_CCP	U		Contraceptive Care – Postpartum (CMS Child Core Set)	Measure	CY	September 30th	9/30/2017	
CMS_C_DEV	U		Developmental Screening in the First Three Years of Life (CMS Child Core Set) (Administrative only data for 9/30/2015 report)	Measure	CY	September 30th		
CMS_C_SRA	U		Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (CMS Child Core Set)	Measure	CY	September 30th	9/30/2017	
COMMUNICATION.01	U		Communications Plan	Plan	N/A	May 1st		
CULTURALCOMP.01	U		Cultural Competency Strategic Plan	Plan	N/A	September 30th		
CULTURALCOMP.02	R		Cultural Competency Annual Report	Narrative Report	Agreement year			9/30/2016
DEMGPROF.01	U		Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language	Measure	July 1 (for initial submission use any date prior to due date) Annually	September 30th		
DEMGPROF.03	U		Community Demographic, Cultural, and Epidemiologic Profile: Ethnicity	Measure	July 1 (for initial submission use any date prior to due date)	September 30th		
DEMGPROF.04	U		Community Demographic, Cultural, and Epidemiologic Profile: Race	Measure	July 1 (for initial submission use any date prior to due date)	September 30th		

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DSH.01	N		Disproportionate Hospital Claims Report	Table	Hospital Fiscal Year	December 10th	12/10/2017	
DUR.01	U		Drug Utilization Review (DUR) Annual Report	Report	Federal Fiscal Year	June 15th	6/15/2019	
EMERGENCYRESPONSE.01	U		Emergency Response Plan	Plan	N/A	May 1st		
EPSDT.20	U		Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	Plan	N/A	May 1st		
FINANCIALSTATEMENT.01	R		Audited Financial Statement	Narrative Report	Annually	Within 120 days after the end of MCOs fiscal year		
FWA.02	C		Fraud Waste and Abuse Log: FWA Related to Providers	Table	Monthly	30 days after the end of the month	TBD	
FWA.03	R		Fraud Waste and Abuse Log: Court Ordered Treatment Report	Table	Monthly			No Submissions Required
FWA.04	U		Fraud Waste and Abuse Log: Date of Death Report	Table	Monthly	30 days after the end of the month		
FWA.05	U		Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Table	Quarterly	30 days after the end of the quarter		
FWA.07	N		Provider Inappropriate Use of Modifier 59	Table	Quarterly	50 calendar days after end of reporting period	TBD	
FWA.20	C		Comprehensive Annual Fraud Waste and Abuse Summary Annual Report	Narrative Report	Agreement Year	September 30th	TBD	
GRIEVANCE.01	U		Grievance Dispositions Made Within 45 Calendar Days	Measure	Quarterly	2 months after the end of the quarter		
GRIEVANCE.02	U		Grievance Log Including State Plan / 1915B Waiver Flag	Table	Quarterly (Last Monthly Submission Due 7/15/2016)	15 calendar days after the end of the quarter	10/15/2016	
GRIEVANCE.03	N		Percentage of member grievances received during the measure data period.	Measure	Quarterly	2 Months following the end of the measurement quarter	11/30/2017	
HEDIS.01	U		HEDIS Roadmap	Report	Standard HEDIS Schedule	February 5		

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HEDIS.02	U		HEDIS Data Filled Workbook	Data File	Standard HEDIS Schedule	June 30		
HEDIS.03	U		HEDIS Comma Separated Values Workbook	Data File	Standard HEDIS Schedule	June 30		
HEDIS.04	U		NCQA HEDIS Compliance Audit™ Final Audit Report	Report	Standard HEDIS Schedule	July 31		
HEDIS.05	R		HEDIS: List of measures required for NCQA Accreditation and by Exhibit O	Report	Standard HEDIS Schedule			2/1/2017
HEDIS_AAB	U		Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Measure	CY	June 30th		
HEDIS_AAP	U		Adults' Access to (use of) Preventive/Ambulatory Health Services	Measure	CY	June 30th		
HEDIS_ABA	U		Adult BMI Assessment	Measure	CY	June 30th		
HEDIS_ADD.01	U		Follow Up Care for Children Prescribed ADHD Medication – Initiation	Measure	A year starting March-April 1 of year prior to the measurement year and ending February 28 of measurement year.	June 30th		
HEDIS_ADD.01_SUB	U	X	Follow Up Care for Children Prescribed ADHD Medication – Initiation by Subpopulation	Measure	A year starting March-April 1 of year prior to the measurement year and ending February 28 of measurement year.	July 31st		
HEDIS_ADD.02	U		Follow Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase	Measure	A year starting March-April 1 of year prior to the measurement year and ending February 28 of measurement year.	June 30th		

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HEDIS_ADD.02_SUB	U	X	Follow Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase by Subpopulation	Measure	A year starting March-April 1 of year prior to the measurement year and ending February 28 of measurement year.	July 31st		
HEDIS_AMB-1a	U		Outpatient and Emergency Dept. Visits/1000 Member Months – Total Population	Measure	CY	June 30th		
HEDIS_AMB-1b	U		Outpatient and Emergency Dept. Visits/1000 Member Months – Medicaid/Medicare Dual-Eligibles	Measure	CY	June 30th		
HEDIS_AMB-1c	U		Outpatient and Emergency Dept. Visits/1000 Member Months – Disabled	Measure	CY	June 30th		
HEDIS_AMB-1d	U		Outpatient and Emergency Dept. Visits/1000 Member Months – Other Low Income	Measure	CY	June 30th		
HEDIS_AMM.01	U		Antidepressant Medication Management – Effective Continuation Phase Treatment – Adults	Measure	May 1 of year prior to the measurement year to Oct 31 of measurement year.	June 30th		
HEDIS_AMM.01_SUB	U	X	Antidepressant Medication Management – Effective Continuation Phase Treatment – Adults by Subpopulation	Measure	May 1 of year prior to the measurement year to Oct 31 of measurement year.	July 31st		
HEDIS_AMM.02	U		Antidepressant Medication Management – Effective Acute Phase Treatment – Adults	Measure	May 1 of year prior to the measurement year to Oct 31 of measurement year.	June 30th		

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HEDIS_AMM.02_SUB	U	X	Antidepressant Medication Management – Effective Acute Phase Treatment – Adults by Subpopulation	Measure	May 1 of year prior to the measurement year to Oct 31 of measurement year.	July 31st		
HEDIS_AMR.A	N		Asthma Medication Ratio (AMR)	Measure	CY	June 30th	6/30/2018	
HEDIS_APC	U		Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Measure	CY	June 30th	6/30/2017	
HEDIS_APM	U		Metabolic Monitoring for Children and Adolescents on Antipsychotics	Measure	Annually	June 30th		
HEDIS_APP	U		Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Measure	CY	June 30th		
HEDIS_APP_SUB	U	X	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics by Subpopulation	Measure	CY	July 31st		
HEDIS_AWC	U		Adolescent Well Care Visits	Measure	CY	June 30th		
HEDIS_BCR.01	R		Board Certification – Percent of Family Medicine Physicians	Measure	CY			6/30/2017
HEDIS_BCR.02	R		Board Certification – Percent of Internal Medicine Physicians	Measure	CY			6/30/2017
HEDIS_BCR.03	R		Board Certification – Percent of Pediatricians	Measure	CY			6/30/2017
HEDIS_BCR.04	R		Board Certification – Percent of OB/GYNs	Measure	CY			6/30/2017
HEDIS_BCR.05	R		Board Certification – Percent of Geriatricians	Measure	CY			6/30/2017
HEDIS_BCR.06	R		Board Certification – Percent of Other Physician Specialists	Measure	CY			6/30/2017
HEDIS_BCS	U		Breast Cancer Screening – Age 50-74	Measure	2 CY	June 30th		
HEDIS_BCS_SUB	U	X	Breast Cancer Screening – Age 50-74 by Subpopulation	Measure	2 CY	July 31st		
HEDIS_CAP	U		Children and Adolescents' Access To PCP – Age 12 Months – 19 Years	Measure	CY	June 30th		
HEDIS_CBP	U		Controlling High Blood Pressure – Age 18 to 85	Measure	CY	June 30th		

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HEDIS_CCS	U		Cervical Cancer Screening – Age 24-64	Measure	See HEDIS Specification	June 30th		
HEDIS_CDC.01	U		Comprehensive Diabetes Care – HbA1c Testing	Measure	CY	June 30th		
HEDIS_CDC.02	U		Comprehensive Diabetes Care – HbA1c Poor Control (>9%)	Measure	CY	June 30th		
HEDIS_CDC.03	U		Comprehensive Diabetes Care – HbA1c Control (<8%)	Measure	CY	June 30th		
HEDIS_CDC.04	U		Comprehensive Diabetes Care – HbA1c Control (<7%) for a Selected Population	Measure	CY	June 30th		
HEDIS_CDC.05	U		Comprehensive Diabetes Care – Eye Exam	Measure	CY	June 30th		
HEDIS_CDC.08	U		Comprehensive Diabetes Care – Medical Attention for Nephropathy	Measure	CY	June 30th		
HEDIS_CDC.10	U		Comprehensive Diabetes Care – BP Control (<140/90)	Measure	CY	June 30th		
HEDIS_CHL	U		Chlamydia Screening in Women – Age 16 to 24	Measure	CY	June 30th		
HEDIS_CIS.01	U		Childhood Immunization Status – Combo 2	Measure	CY	June 30th		
HEDIS_CIS.02	U		Childhood Immunization Status – Combo 3	Measure	CY	June 30th		
HEDIS_CIS.03	U		Childhood Immunization Status – Combo 4	Measure	CY	June 30th		
HEDIS_CIS.04	U		Childhood Immunization Status – Combo 5	Measure	CY	June 30th		
HEDIS_CIS.05	U		Childhood Immunization Status – Combo 6	Measure	CY	June 30th		
HEDIS_CIS.06	U		Childhood Immunization Status – Combo 7	Measure	CY	June 30th		
HEDIS_CIS.07	U		Childhood Immunization Status – Combo 8	Measure	CY	June 30th		
HEDIS_CIS.08	U		Childhood Immunization Status – Combo 9	Measure	CY	June 30th		
HEDIS_CIS.09	U		Childhood Immunization Status – Combo 10	Measure	CY	June 30th		
HEDIS_CIS.10	U		Childhood Immunization Status – DtaP	Measure	CY	June 30th		
HEDIS_CIS.11	U		Childhood Immunization Status – IPV	Measure	CY	June 30th		
HEDIS_CIS.12	U		Childhood Immunization Status – MMR	Measure	CY	June 30th		
HEDIS_CIS.13	U		Childhood Immunization Status – HiB	Measure	CY	June 30th		
HEDIS_CIS.14	U		Childhood Immunization Status – Hepatitis B	Measure	CY	June 30th		
HEDIS_CIS.15	U		Childhood Immunization Status – VZV	Measure	CY	June 30th		
HEDIS_CIS.16	U		Childhood Immunization Status – Pneumococcal Conjugate	Measure	CY	June 30th		
HEDIS_CIS.17	U		Childhood Immunization Status – Hepatitis A	Measure	CY	June 30th		
HEDIS_CIS.18	U		Childhood Immunization Status – Rotavirus	Measure	CY	June 30th		

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HEDIS_CIS.19	U		Childhood Immunization Status – Influenza	Measure	CY	June 30th		
HEDIS_CWP	U		Appropriate Testing for Children With Pharyngitis	Measure	July 1 of year prior to the measurement year and ends on June 30 of measurement year.	June 30th		
HEDIS_FPC	U		Frequency of Ongoing Prenatal Care by Percent of Expected Number of Visits (<21%, 21-40%, 41-60%, 61-80%, >=81%)	Measure	CY	June 30th		
HEDIS_FUA.01	U		Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (within 30 days of the ED visit)	Measure	CY	June 30th	6/30/2017	
HEDIS_FUA.02	U		Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (within 7 days of the ED visit)	Measure	CY	June 30th	6/30/2017	
HEDIS_FUH.01	U		Follow Up After Hospitalization For Mental Illness – 7 days	Measure	January 1 through December 1 of measurement year	June 30th		
HEDIS_FUH.02	U		Follow Up After Hospitalization For Mental Illness – 30 days	Measure	January 1 through December 1 of measurement year	June 30th		
HEDIS_FUM.01	U		Follow-Up After Emergency Department Visit for Mental Illness (within 30 days of the ED visit)	Measure	CY	June 30th	6/30/2017	
HEDIS_FUM.02	U		Follow-Up After Emergency Department Visit for Mental Illness (within 7 days of the ED visit.)	Measure	CY	June 30th	6/30/2017	
HEDIS_HPV	R		Human Papillomavirus (HPV) Vaccine for Female Adolescents	Measure	CY			6/30/2016
HEDIS_IET.01	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation	Measure	CY	June 30th		

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HEDIS_IET.01_SUB	U	X	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation by Subpopulation	Measure	CY	July 31st		
HEDIS_IET.02	U		Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement	Measure	CY	June 30th		
HEDIS_IET.02_SUB	U	X	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement by Subpopulation	Measure	CY	July 31st		
HEDIS_IMA.01	U		Immunizations for Adolescents – Combination 1	Measure	CY	June 30th		
HEDIS_IMA.02	U		Immunizations for Adolescents – Meningococcal	Measure	CY	June 30th		
HEDIS_IMA.03	U		Immunizations for Adolescent – Tdap/Td	Measure	CY	June 30th		
HEDIS_IMA.04	N		Immunizations for Adolescent – HPV	Measure	CY	June 30th	6/30/2017	
HEDIS_LBP	U		Use of Imaging Studies for Low Back Pain	Measure	CY	June 30th		
HEDIS_MMA.01	U		Medication Management for People with Asthma – At Least 75% of Treatment Period	Measure	CY	June 30th		
HEDIS_MMA.02	U		Medication Management for People with Asthma – At Least 50% of Treatment Period	Measure	CY	June 30th		
HEDIS_MPM.01	U		Annual Monitoring for Patients on Persistent Medications – Adults – ACE or ARB	Measure	CY	June 30th		
HEDIS_MPM.01_SUB	U	X	Annual Monitoring for Patients on Persistent Medications – Adults – ACE or ARB by Subpopulation	Measure	CY	July 31st		
HEDIS_MPM.02	U		Annual Monitoring for Patients on Persistent Medications – Adults – Digoxin	Measure	CY	June 30th		
HEDIS_MPM.02_SUB	U	X	Annual Monitoring for Patients on Persistent Medications – Adults – Digoxin by Subpopulation	Measure	CY	July 31st		
HEDIS_MPM.03	U		Annual Monitoring for Patients on Persistent Medications – Adults – Diuretics	Measure	CY	June 30th		
HEDIS_MPM.03_SUB	U	X	Annual Monitoring for Patients on Persistent Medications – Adults – Diuretics by Subpopulation	Measure	CY	July 31st		
HEDIS_MPM.04	U		Annual Monitoring for Patients on Persistent Medications – Adults – Total Rate	Measure	CY	June 30th		

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HEDIS_NCQA	U		MCO Submission of Audited HEDIS Results as Submitted to NCQA in NCQA Format	Measure	CY	June 30th		
HEDIS_PCE	U		Pharmacotherapy Management of COPD Exacerbation	Measure	CY	June 30th		
HEDIS_PCE.01_SUB	U	X	Pharmacotherapy Management of COPD Exacerbation by Subpopulation	Measure	CY	July 31st	7/31/2017	
HEDIS_PCE.02_SUB	U	X	Pharmacotherapy Management of COPD Exacerbation by Subpopulation	Measure	CY	July 31st	7/31/2017	
HEDIS_PPC.01	U		Prenatal and Postpartum Care – Timeliness of Prenatal Care	Measure	CY	June 30th		
HEDIS_PPC.02	U		Prenatal and Postpartum Care – Postpartum Care	Measure	CY	June 30th		
HEDIS_SAA	U		Adherence to Antipsychotics for Individuals with Schizophrenia – Adults Age 19-64	Measure	CY	June 30th		
HEDIS_SMC	U		Statin Therapy for Patients with Cardiovascular Disease	Measure	Annual	June 30th		
HEDIS_SMD	U		Statin Therapy for Patients with Diabetes	Measure	Annual	June 30th		
HEDIS_SPR	R		Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Measure	CY			6/30/2017
HEDIS_SSD	U		Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Measure	CY	June 30th		
HEDIS_URI	U		Appropriate Treatment for Children With Upper Respiratory Infection	Measure	July 1 of year prior to the measurement year and ends on June 30 of measurement year.	June 30th		
HEDIS_W15	U		Well-Child Visits in the first 15 Months of Life (0 visits, 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, 6 or more visits)	Measure	CY	June 30th		
HEDIS_W34	U		Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life – Total Population	Measure	CY	June 30th		

Exhibit O – Amendment #08
NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
HEDIS_WCC.01	U		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile documentation	Measure	CY	June 30th		
HEDIS_WCC.02	U		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	Measure	CY	June 30th		
HEDIS_WCC.03	U		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	Measure	CY	June 30th		
HNA.01	U		New Member Health Needs Assessment – Best Effort to Have Member Conduct a Health Needs Self-Assessment	Measure	Quarterly	Four months after the end of the quarter	1/31/2017	
HNA.06	R		New Member Health Needs Assessment – Barriers to Successful Completion of Health Needs Assessment	Narrative Report	Agreement Year			3/31/2017
HNA.07	U		New Member Health Needs Assessment – Member Successfully Completed MCO's Health Needs Self-Assessment	Measure	Quarter	4 Months after end of measure data source time period		
INPASC.03	U	X	Inpatient Hospital Utilization by Adults for Ambulatory Care Sensitive Conditions by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
INPUTIL.02	U	X	Inpatient Hospital Utilization for All Conditions Excluding Maternity/Newborns by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
INTEGRITY.01	U		Program Integrity Plan	Plan	N/A	Upon revision		
LOCKIN.01	U		Pharmacy Lock-In Member Enrollment Log	Table	Monthly	30 calendar days after end of month		
LOCKIN.03	U		Pharmacy Lock-in Activity Summary	Table	Monthly	30 calendar days after end of month		
MAINTMED.02	U		Maintenance Medication Gaps by Age Group	Measure	Quarterly	3 months after the end of the quarter		

Exhibit O – Amendment #08
NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
MCISPLANS.01	U		Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	Plan	N/A	June 1st		
MEMCOMM.01	U		Member Communications: Speed to Answer Within 30 Seconds	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.03	U		Member Communications: Calls Abandoned	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.05	U		Member Communications: Voice Mails Returned by Next Business Day	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.06	U		Member Communications: Reasons for Telephone Inquiries	Measure	Monthly	20 calendar days after end of reporting period		
MEMCOMM.11	R		Member Communications: New Members Who Had a Successfully Completed New Member Welcome Call or Received at Least Three Welcome Call Attempts	Measure	Monthly			7/20/2017
MEMCOMM.12	R		Member Communications: New Member Welcome Calls	Measure	Monthly			7/20/2017
MLR.01	N		Medical Loss Ratio Report: NHHPP Medically Frail, NHHPP Transitional, and for the Medicaid Care Management Program	Table	Quarterly	9 months after the end of the quarter	6/30/2018	
NEMT.12	U		NEMT Requests Delivered by Mode of Transportation	Measure	Quarterly	2 month after end of reporting period		
NEMT.13	U		NEMT Request Authorization Approval Rate by Mode of Transportation	Measure	Quarterly	2 months after end of reporting period		
NEMT.15	U		NEMT Services Delivered by Type of Medical Service	Measure	Quarterly	2 months after end of reporting period		
NEMT.17	U		NEMT Scheduled Trip Member Cancellations by Reason for Member Cancellation for Contracted Providers	Measure	Quarterly	2 months after end of reporting period		

Exhibit O – Amendment #08
NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
NEMT.18	U		Non-Emergent Transportation Contracted Transportation & Wheelchair Van Provider Scheduled Trip Results by Outcome	Measure	Quarterly	2 months after end of reporting period		
NEMT.19	U		Non-Emergent Transportation - Contracted Transportation & Wheelchair Van Provider Scheduled Trips (Excluding Rides for Methadone Treatment) - Timeliness	Measure	Quarterly	2 months after end of reporting period		
NETWORK.01	C		Comprehensive Provider Network and Equal and Timely Access Semi-Annual Filing	Narrative Report	Semi-annual	45 days after the end of the semi-annual period	2/15/2018	
NETWORK.02	U		Corrective Action Plan for Non-Compliance With Timely Access Standards	Plan	N/A	As needed		
NETWORK.03	U		Plan to Recruit and Maintain Sufficient Networks of SUD Service Providers and Member Access	Plan	Agreement Year	May 1st	5/1/2017	
NETWORK.10	C		Corrective Action Plan to Restore Provider Network Adequacy	Plan	N/A	45 days after the end of the semi-annual period	2/15/2018	
NHHDISCHARGE.01	U		New Hampshire Hospital Discharges Where Members Received Discharge Instruction Sheet	Measure	Quarterly	2 months after the end of the quarter		
NHHDISCHARGE.10	U	X	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.12	U	X	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 30 Calendar Days of Discharge by Subpopulation	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.13	U		New Hampshire Hospital Discharges With Discharge Plan Provided to Aftercare Provider Within 7 Days of Member Discharge	Measure	Quarterly	4 months after the end of the quarter		
NHHDISCHARGE.16	U		New Hampshire Hospital Discharges - NEW CMHC Patient Had An Intake Appointment With A CMHC Within 7 Calendar Days of Discharge	Measure	Quarterly	4 months after the end of the quarter	1/31/2017	

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
NHHDISCHARGE.17	U		New Hampshire Hospital Discharges - MCO Contacts and Contact Attempts	Measure	Quarterly	Two months after the end of the data period	11/30/2016	
NHHREADMIT.01	R		New Hampshire Hospital Reductions in Readmission Plan	Plan	N/A			6/30/2016
NHHREADMIT.05	U	X	Readmission to New Hampshire Hospital at 30 days by Subpopulation	Measure	June 1 of prior SFY to June 30 of measurement year. A 13 month period.	September 1st		
NHHREADMIT.06	U	X	Readmission to New Hampshire Hospital at 180 days by Subpopulation	Measure	January 1 of prior SFY to June 30 of measurement year. An 18 month period	September 1st		
PAYREFORM.01	U		Payment Reform Plan	Plan	N/A	May 1st	5/1/2017	
PAYREFORM.02	R		Payment Reform Annual Report	Narrative Report	Agreement year			9/30/2016
PAYREFORM.03	U		Payment Reform Quarterly Update Report	Narrative Report	Quarterly	30 days after end of reporting period		
PDN.01	R		Private Duty Nursing: RN-Level Hours Delivered and Billed	Measure	Monthly			6/30/2017
PDN.02	R		Private Duty Nursing: LPN-Level Hours Delivered and Billed	Measure	Monthly			6/30/2017
PDN.04	U		Private Duty Nursing: RN-Level Hours Delivered and Billed (replaces monthly measure)	Measure	Quarterly	2 months after the end of the reporting period		
PDN.05	U		Private Duty Nursing: LPN-Level Hours Delivered and Billed (replaces monthly measure)	Measure	Quarterly	2 months after the end of the reporting period		
PDN.07	U		Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Table	Quarterly	2 months after the end of the reporting period		
PHARMMGT.22	R		Pharmacy Management Utilization Controls Summary Semi-Annual Report	Narrative and Analytic Report	Semi-Annual			3/1/2017

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
PHARMQI.01	U		Pharmacy Quality Improvement Initiative Plans	Plan	Annual Plan	September 30th	9/30/17	
PHARMQI.02	R		Pharmacy Quality Improvement Initiatives Annual Summary Report	Narrative Report	Annual			9/30/2016
PHARMQI.03	R		Pharmacy Quality Improvement Initiatives Semi-Annual Summary Update Report	Narrative Report	Semi-Annual			No Further Submissions Required
PHARMQI.08	U		Safety Monitoring - Use of at Least One High-Risk Medication in the Elderly, Excluding Medicare/Medicaid Dual Enrollees	measure	quarterly	2 months after the end of the quarter		
PHARMQI.09	U		Safety Monitoring Prior Authorized Fills for Opioid Prescriptions With a Dosage Over 100 mg	measure	quarterly	2 months after the end of the quarter		
PHARMQI.10	U		Safety monitoring of psychotropics: polypharmacy; ADHD, antipsychotics (typical and atypical), antidepressants, mood stabilizers	Table	Quarterly	2 months after the end of the quarter		
PHARMQI.11	R		Completion of an Annual Comprehensive Medication Review in Prior Twelve Months for Polypharmacy Members	measure	Annual			No Further Submissions Required
PHARMQI.12	U		Safety Monitoring - Use of at Least Two High-Risk Medications in the Elderly, Excluding Medicare/Medicaid Dual Enrollees	measure	quarterly	2 months after the end of the quarter		
PHARMQI.13	C		Polypharmacy Members Offered an Annual Comprehensive Medication Review, by Completion Status and Age Group	Measure	semi-annually	2 months after the end of semi-annual period	2/28/2018	
PHARMUTLMGT.02	U		Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Measure	Quarterly	2 months after the end of the quarter		
PHARMUTLMGT.03	U		Pharmacy Utilization Management: Generic Drug Substitution	Measure	Quarterly	2 months after the end of the quarter		
PHARMUTLMGT.04	U		Pharmacy Utilization Management: Generic Drug Utilization	Measure	Quarterly	2 months after the end of the quarter		
PIP.01	U		Performance Improvement Project Semi-Annual Report	Narrative Report	Semi-Annual	July 31st and January 31st		
PMP.01	U		Program Management Plan	Plan	N/A	August 1st	8/1/2016	
POLYPHARM.04	U		Polypharmacy: Children >=4 Drugs	measure	quarterly	2 months after the end of the quarter		

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
POLYPHARM.05	U		Polypharmacy: Adults ≥ 10 Drugs	measure	quarterly	2 months after the end of the quarter		
PRIVACYBREACH.01	U		Privacy Breach Notification	Narrative Report	As Needed	Preliminary notice within one (1) day of breach and final detailed notice after MCO assessment		
PROVCOMM.01	U		Provider Communications: Speed to Answer Within 30 Seconds	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMM.03	U		Provider Communications: Calls Abandoned	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMM.05	N		Provider Communications: Voice Mails Returned by Next Business Day	Measure	Monthly	20 calendar days after end of reporting period	9/30/2017	
PROVCOMM.06	U		Provider Communications: Reasons for Telephone Inquiries	Measure	Monthly	20 calendar days after end of reporting period		
PROVCOMPLAINT.01	N18		Provider Complaint and Appeals Log	Table	Quarterly	1 month after the end of the reporting quarter	11/30/2017	
PROVQUAL.01	U		MCO Provider Quality Report Card	Table	N/A	Upon request		
PROVSATISFACTION.01	U		Provider Satisfaction Survey	Narrative Report	Semi-Annual First Year, Then Annual	September 30th		
PROVTERM.01	U		Provider Termination Log	Table	As needed or weekly	Within 15 calendar days of the notice of termination or effective date, whichever is sooner		
PROVTERM.02	N		Provider Termination Report	Table	Quarterly	2 months after the end of the reporting quarter	TBD	
PROVTRAINING.01	R		Provider Training Annual Report	Narrative Report	Agreement Year			9/30/2016

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
PROVTRAINING.03	U		Community Mental Health Center Staff Training Plan	Plan	N/A	April 1st		
PROVTRAINING.04	R		Community Mental Health Center Staff Training Annual Report	Narrative Report	Agreement Year			9/30/2016
QAPI.01	C		Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	Narrative Report	Annual	September 30th	9/30/2017	
QAPI.02	C		Quality Assessment and Performance Improvement (QAPI) Semi-Annual Update Report	Narrative Report	Semi-Annual	March 31st	3/31/2018	
QAPI.03	C		Quality Assessment and Performance Improvement (QAPI) Annual Program Description and Annual Work Plan	Plan	Annual	December 31st	12/31/2017	
SERVICEAUTH.01	U		Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.02	U		Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Continued/Extended Urgent Services	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.03	U		Medical Service, Equipment and Supply Service Authorization Timely (14 Day) Determination Rate: New Routine Requests (excludes NEMT and Complex Diagnostic Radiology)	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.04	U		Pharmacy Service Authorization Timely Determination Rate	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.05	U		Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Table	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.06	U		Service Authorization Denial Detail Log	Table	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.08	U		Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests That Were Extended	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.09	U		Number of Pharmacy Prior Authorizations Stratified By Behavioral Health and Other Drugs	Measure	quarterly	2 months after the end of the quarter		

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
SERVICEAUTH.12	U		Complex Diagnostic Radiology Authorization Timely (2 Day) Determination Rate: Routine Requests	Measure	Quarterly	2 months after the end of the quarter		
SERVICEAUTH.13	U		Medical Service, Equipment and Supply Post Delivery Service Authorization Timely (30 Day) Determination Rate	Measure	Quarterly	2 months after the end of the quarter		
STAFFINGPLAN.01	C		MCO Staffing Contingency Plan	Plan	Annually	August 1	8/1/2017	
SUD.01	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Any SUDSM Specific Service, by Age Group	Measure	Quarterly	4 months after the end of the quarter		
SUD.02	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using One or More Opioid Treatment Center Services, by Age Group	Measure	Quarterly	4 months after the end of the quarter		
SUD.03	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Buprenorphine Through Point of Service Pharmacy, by Age Group	Measure	Quarterly	4 months after the end of the quarter		
SUD.04	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using General Acute Care Inpatient Hospital Withdrawal Services, by Age Group	Measure	Quarterly	4 months after the end of the quarter		
SUD.06	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Outpatient Non-Facility Individual, Family, or Group SUDSM Counseling Service, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.07	U		Substance Use Disorder and Substance Misuse Services: Average Number of Outpatient Non-Facility Individual, Family, or Group SUDSM Counseling Services Used Per Service User, By Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.08	R		Substance Use Disorder and Substance Misuse Services: Average Number of Opioid Treatment Center Services Used Per Service User, by Age Group	Measure	Quarterly			10/31/2017

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
SUD.09	R		Substance Use Disorder and Substance Misuse Services: Average Number of Day's Supply of Buprenorphine Through a Point of Service Pharmacy Per Buprenorphine User, by Age Group	Measure	Quarterly			10/31/2017
SUD.10	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Partial Hospitalization for SUDSM, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.11	U		Substance Use Disorder and Substance Misuse Services: Average Number of Partial Hospitalizations for SUDSM Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.12	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Intensive Outpatient Treatment for SUDSM, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.13	U		Substance Use Disorder and Substance Misuse Services: Average Number of Intensive Outpatient Treatment Services for SUDSM Using Specific Service Per Member Per Month, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.14	U		Substance Use Disorder and Substance Misuse Services: Average Number of General Acute Care Inpatient Hospital Withdrawal Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.15	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using SUDSM Rehabilitation Facility Service, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.16	U		Substance Use Disorder and Substance Misuse Services: Average Number of SUDSM Rehabilitation Facility Services Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
SUD.17	U		Substance Use Disorder and Substance Misuse Services: Percent of Population Using Outpatient Crisis Intervention Services (in Provider Office or Community) for SUDSM, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.18	U		Substance Use Disorder and Substance Misuse Services: Average Number of Outpatient Crisis Intervention Services (in Provider Office or Community) for SUDSM Used Per Service User, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.19	U	X	Substance Use Disorder and Substance Misuse ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses per Member per Month by Subpopulation	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.20	U		Substance Use Disorder and Substance Misuse ED Use: Rate of ED Visits for Substance Abuse Disorder and Substance Misuse Diagnoses per 1,000 Member Months, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.21	U		Substance Use Disorder and Substance Misuse ED Use: Rate of ED Visits for Substance Use Disorder and Substance Misuse Diagnoses for the Population Using Any SUDSM Service Per 1,000 Member Months, by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
SUD.22	U		Substance Use Disorder and Substance Misuse ED Use: Rate of ED Use for Any Diagnosis (SUDSM or Other) for Members Using Any SUDSM Service in Quarter per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter		
TERMINATIONPLAN.01	U		MCO Termination Plan	Plan	N/A	As needed		
TIMELYNOTICE.02	U		Timeliness of Notice Delivery: Standard Service Authorization Denial	Measure	Quarterly	2 months after the end of the quarter		
TIMELYNOTICE.03	U		Timeliness of Notice Delivery: Standard Service Authorization Denial With Extension	Measure	Quarterly	2 months after the end of the quarter		
TIMELYNOTICE.04	U		Timeliness of Notice Delivery: Expedited Process	Measure	Quarterly	2 months after the end of the quarter		

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NH Medicaid Care Management Quality and Oversight Reporting – 2018

Reporting Reference ID	Change for 2018	Requires Subpopulation Breakout	Name	Type	Measure Data Period	Standard Due Date	First Date Required for New or Change	Date of Last Required Submission for Retired
TPLCOB.01	U		Coordination of Benefits: Costs Avoided	Table	Quarterly	2 months after the end of the quarter		
TPLCOB.02	U		Coordination of Benefits: Medical Costs Recovered Claim Log	Table	Quarterly	2 months after the end of the quarter		
TPLCOB.03	U		Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Table	Quarterly	2 months after the end of the quarter		
TRANSFORM.XX	U		Measures to Support 1115 Transformation Waiver Monitoring (Specifics TBD; measures will be claims, survey, & operations based)	Measure	N/A	TBD		
UMSUMMARY.02	R		Utilization Management Impact Annual Report	Narrative Report	Agreement Year	September 30th		9/30/2016

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID SERVICES

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Commissioner

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September 28, 2016

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

G&C Approved
Date 10/5/16
Item # 12A

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend the existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to extend the operation of these agreements for one year from June 30, 2017 to June 30, 2018. Also, this amendment makes no changes to the SFY 2017 price limitation of $672,617,075 and adds a SFY 2018 price limitation of $672,617,075 to the contracts for a cumulative contract value of $2,957,756,199.08 for all Medicaid Care Management contracts effective upon Governor and Executive Council approval through June 30, 2018. Funds to support this request are available in the following accounts in SFY 2017 and are anticipated to be available in SFY 2018 upon availability and continued appropriation of funds in future operating budgets. The Department will seek an additional amendment to the price limitation to reflect SFY 2018 rates prior to the beginning of SFY 2018.

Governor and Executive Council approved the original agreements on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), December 23, 2014 (Item #11), June 24, 2015 (Item #30), August 5, 2015 (Tabled Item #A), December 16, 2015 (Late Item #A3), January 27, 2016 (Item #7B), March 9, 2016 (Item #10A) and June 29, 2016 (Late Item #A2). 50% Federal and 50% General Funds for the currently eligible Medicaid population. NH Health Protection Program services are 100% Federal through 12/31/16 at which time the program changes to 95% Federal and 5% Other for Calendar Year 2017 and 94% Federal and 6% Other for Calendar Year 2018.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000.00	$460,000,000.00	$490,897,701.00	$538,601,671.35	$538,601,671.35	$2,278,101,043.70
New Hampshire Health Protection Program: 010-047-3099-102	$0	$0.00	$193,000,000.00	$218,624,347.94	$134,015,403.72	$134,015,403.72	$679,655,155.38
Total	$0	$250,000,000.00	$653,000,000.00	$709,522,048.94	$672,617,075.17	$672,617,075.17	$2,957,756,199.08

EXPLANATION

The purpose of this amendment is to extend the existing individual agreements with the state's two managed care health plans by an additional year from June 30, 2017 to June 30, 2018 to better align the length of the operations of the program with original intent of the authorizing legislation, to allow vital work with stakeholders and carriers around the development of Step 2 services to be completed, and to provide the state a year to plan for and implement a robust and open re-procurement process for the Medicaid managed care program.

The Department commenced the Medicaid Care Management Program in December 2013, providing acute care medical services primarily to low-income children and adults, people living with disabilities, pregnant women, newborns, and those receiving breast and cervical cancer treatments. While not all Medicaid-eligible individuals are required to obtain their health care coverage through the Medicaid Care Management Program, at the present time, approximately 128,565 individuals receive their health care through this program.

The Medicaid managed care authorizing legislation SB 147, enacted in 2011, contemplated a five year agreement between the state and participating Medicaid managed care health plans. However, as noted above, the administration of Medicaid through the managed care delivery system did not begin until December of 2013. As a result, as of the present, the program has not yet run for 3 years. The contract extension will allow the operational span of the program to more accurately reflect the intent of the authorizing legislation for the program to run for five years, as well as to provide additional information on the outcomes and value of the program.

In addition, SB 553, enacted in 2016, initiated a public process involving carriers and a variety of stakeholders to support the development of a plan for the incorporation of Medicaid long-term services and supports into the Medicaid managed care delivery system. The initial meeting of SB553 commission was held in August, 2016. The work of this commission will continue throughout the next several months. The one year extension will allow the work of this commission to be concluded and fully inform the next request for proposal through which the state will solicit bids for the continuation of the Medicaid managed care program.

As noted above, the state will be undertaking a re-procurement process to continue the Medicaid managed care program after June 30, 2018. This procurement process will be open to any potential bidders, not just those companies currently under contract to administer Medicaid state plan services in New Hampshire. Toward that end, the additional year of operations with the current Medicaid managed care organizations will permit New Hampshire to take advantage of learning from the experience of several other state Medicaid programs which have, in the intervening three years since the initiation of the program, procured Medicaid managed care contracts. To this end, the department will issue soon a request for proposals for a qualified national consultant to advise the department on the re-procurement. This one year extension provides the state with critically needed time to develop and issue the most effective requests for proposals that will advance the operation and goals of the managed care program under a model that is responsive to the needs of the people who are served.

There are no changes to the capitation rates listed in Exhibit B. Exhibit O to the Agreement is unchanged. The only changes to the agreement beside the extension of the contract completion date are:

1.) The inclusion in Section 31.1.2 of language that addresses any prospective increase in the capitation rate. This language provides that any increase in the capitation rate will not exceed the

historic average trend of 3.8%, provided that the final capitation rate is actuarially sound and approvable by CMS; and

2). The amendment of language in Section 31.3.4 on the reconciliation of MCO payments to reflect the extension period which will result in the standard reconciliation process for 2018 payments to be made in 2019.

There are no changes to the information technology components of these Agreements. As a result, an approval letter from the Department of Information Technology's Chief Information Officer is not included, and the Department has instead provided written notification of the amendment to the Chief Information Officer for his records.

The June 29, 2016, Late Item #A2 Governor and Council submission has been attached to this request as background information. Please note that only one copy of Exhibit A has been attached as the Exhibits were voluminous but were identical for both vendors.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services are 95% federal funds in 2017 and 94 percent federal funds in 2018 as appropriated by Congress.

In the event that Federal funds become no longer available or are decreased below the 95% and 94% FFP level for the New Hampshire Health Protection population, as provided under HB 1696, General Funds will not be requested to support this program and medical services for the new adult population would end consistent with HB 1696 and the Special Terms and Conditions of the Premium Assistance Program Demonstration.

Respectfully submitted,

Deborah Fournier
Medicaid Director

Approved:

Jeffrey A. Meyers
Commissioner

A2

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

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Jeffrey A. Meyers
Commissioner

Kathleen A. Dunn
Associate Commissioner
Medicaid Director

June 14, 2016

G&C Approved
Date 6/29/16
Item # LATE Item-A2

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements **retroactively and prospectively** with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to:

(i) Adjust rates to reflect the actuarially certified rate structure retroactively and prospectively for the inclusion of the New Hampshire Health Protection Program's Transitional Population, **retroactively** from January 1, 2016 to June 30, 2016 and prospectively from July 1, 2016 through June 30, 2017, as described in Exhibit B – Amendment #12. The new rate structures provide decreased capitation payment rates that are reflective of program changes, including the Managed Care Organizations' management of a preferred drug list;

(ii) Adjust rates to reflect the actuarially certified rate structure for the standard Medicaid and medically frail populations through June 30, 2017. Adjustments include:

a. Adjust rates to reflect the actuarially certified rate structure for the inclusion of program changes the Department implemented this year, such as: a new substance use disorder benefit beginning July 1, 2016; continued mental health services expansion under the Community Mental Health Agreement; and implementation of the Managed Care Organizations' management of a preferred drug list, through June 30, 2017, as described in Exhibit B – Amendment #12; and

b. Adjust rates to reflect certain high cost drugs that will be managed by the Medicaid Pharmacy Benefit Manager. The adjustments are reflective of changes the Department made to pre-authorization criterion in response to advice received from the Centers for Medicare and Medicaid Services. The also specifically include the

removal of Hepatitis C medications, hemophilia medications, and other high cost medications like Carbaglu and Ravicti, for managing high blood ammonia levels.

These agreements, if approved, would be effective retroactive to January 1, 2016, in the case of New Hampshire Protection Program's Transitional Population and in all other cases effective July 1, 2016, upon approval of the Governor and Council, through June 30, 2017. These amendments make no changes to the SFY 2016 price limitation of $709,522,049 and add a SFY 2017 price limitation of $672,617,075 to the contracts for a cumulative contract value of $2,285,139,124 for all Medicaid Care Management contracts, subject to the approval of the Governor and Executive Council and subject to the continued availability and continued appropriation of funds.

Governor and Executive Council approved the original agreements on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), December 23, 2014 (Item #11), June 24, 2015 (Item #30), August 5, 2015 (Tabled Item #A), December 16, 2015 (Late Item #A3), January 27, 2016 (Item #7B), and March 9, 2016 (Item #10A). 100% Federal Funds for the New Hampshire Health Protection Program, 50% Federal and 50% General Funds for the currently eligible Medicaid population.

Fund Name and Account Number	SFY13	SFY14	SFY15	Revised SFY16	SFY17	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000.00	$460,000,000.00	$490,897,701.00	$538,601,671.35	$1,739,499,372.35
New Hampshire Health Protection Program: 010-047-3099-102	$0	$0.00	$193,000,000.00	$218,624,347.94	$134,015,403.72	$545,639,751.66
TOTAL	$0	$250,000,000.00	$653,000,000.00	$709,522,048.94	$672,617,075.07	$2,285,139,124.01

EXPLANATION

The purpose of these amendments to amend **retroactively and prospectively** the existing individual agreements with the state's two managed care health plans to reflect the actuarially certified rate structure.

The retroactive element of these amendments is required because all parties to the contract became aware that the NH Health Protection Program's Transitional Population rates were inadvertently dropped from the previous contract amendment. This amendment corrects that error. There is no need to adjust the SFY 2016 price limitation, as the previous amendment accurately accounted for funding this item. The amendment also provides a prospective rate structure to adjust rates to reflect the actuarially certified rate structure prospectively from July 1, 2016 through June 30, 2017. The new rate structures provide decreased capitation payment rates that are reflective of program changes, including the Managed Care Organizations' management of a preferred drug list;

Also included in these amendments are adjustments to rates to reflect the actuarially certified rate structure for the standard Medicaid and medically frail populations through June 30, 2017. Adjustments include:

a. Adjust rates to reflect the actuarially certified rate structure for the inclusion of program changes the Department implemented this year, such as: a new substance use disorder benefit beginning July 1, 2016; continued mental health services expansion under the Community Mental Health Agreement; and implementation of the Managed Care Organizations' management of a preferred drug list, through June 30, 2017, as described in Exhibit B – Amendment #12; and

b. Adjust rates to reflect certain high cost drugs that will be managed by the Medicaid Pharmacy Benefit Manager. The adjustments are reflective of changes the Department made to pre-

authorization criterion in response to advice received from the Centers for Medicare and Medicaid Services, and specifically include the removal of Hepatitis C medications, hemophilia and other high cost medications like Carbaglu and Ravicti for managing high blood ammonia levels.

The Department commenced the Medicaid Care Management Program in December 2013, providing acute care medical services primarily to low income children and adults, pregnant women, newborns, and those receiving breast and cervical cancer treatments. While not all Medicaid-eligible individuals are required to obtain their health care coverage through the Medicaid Care Management Program, at the present time, approximately 128,565 individuals receive their health care through this program.

These amendments:

- Incorporate a new rate structure for the New Hampshire Health Protection Program Transitional Population. This structure reflects the provision of health care coverage to individuals that lose eligibility for standard Medicaid but gain eligibility for the New Hampshire Health Protection Program. The coverage supports individuals during the period in which they are finalizing enrollment into a Qualified Health Plan under the Premium Assistance Program;
- Incorporate program changes regarding mental health and substance use disorder benefits, and Hepatitis C pre-authorization criterion;
- Reflect the effects of Managed Care Organizations' management of a preferred drug list; and
- Support the effectiveness of the above changes to capitated payments through the inclusion of additional reporting requirements.

Exhibit B to the Agreement reflects the adjusted capitated rate information through June 30, 2017. The rates are identified by subsets of the Medicaid population that participate in the health plan. These include: acute care medical services rates for ten subsets, such as low income children, children in foster care, elderly and disabled adults, and dual eligible individuals; rates specific to Behavioral Health services; the Medically Frail; and *Step I acute care medical services only* rates for four populations – nursing home residents, community (Choices for Independence) residents, developmentally disabled persons, and persons with acquired brain disorders. Rate cell categories and their subsets are based on age and eligibility categories, and reflect the Department's emphasis on establishing rate categories determined on a whole person approach to health care.

Exhibit O to the Agreement pertaining to quality measures has also been revised to ensure that the Department has in place the most appropriate quality metrics for all persons receiving services. As the Department continues to phase in or adjust services provided under the managed care health plans, Exhibit O, as well as other sections of the agreement, will continue to be revised to reflect best practices that ensure the protection and rights of New Hampshire's citizens receiving Medicaid services.

There are no changes to the information technology components of these Agreements. As a result, an approval letter from the Department of Information Technology's Chief Information Officer is not included, and the Department has instead provided written notification of the amendment to the Chief Information Officer for his records.

The March 9, 2016, Item #10A Governor and Council submission has been attached to this request as background information. Please note that only one copy of Exhibit A and Exhibit O have been attached as those Exhibits were voluminous but were identical for both vendors.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level for the New Hampshire Health Protection population, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

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

Jeffrey A. Meyers
Commissioner

Kathleen A. Dunn
Associate Commissioner

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February 22, 2016

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, NH 03301

G&C Approved
Date 3/9/16
Item # 10A

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to:

(i) Adjust rates to reflect the actuarially certified rate structure for the inclusion of increased private duty nursing services, through June 30, 2016, as described in Exhibit B – Amendment #11. The new rate structure provides increased capitation payment rates to reflect this additional cost; and to

(ii) Ensure increased access to private duty nursing services is being achieved through data reporting specific to this service need.

These agreements, if approved, would be effective April 1, 2016, upon approval of the Governor and Council, through June 30, 2017. These amendments increase the SFY 2016 price limitation by $623,698 from $708,898,351 to $709,522,049 for a cumulative contract value of $1,612,522,049 for all Medicaid Care Management contracts, subject to the approval of the Governor and Executive Council and subject to the continued availability and continued appropriation of funds.

Governor and Executive Council approved the original agreements on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), December 23, 2014 (Item #11), June 24, 2015 (Item #30), August 5, 2015 (Tabled Item #A), December 16, 2015 (Late Item #A3), and January 27, 2016 (Item #7B). 100% Federal Funds for the New Hampshire Health Protection Program, 50% Federal and 50% General Funds for the currently eligible Medicaid population.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY16 Increase (Decrease)	Revised SFY16	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000	$460,000,000	$490,274,003	$623,698	$490,897,701	$1,200,897,701
New Hampshire Health Protection Program: 010-047-3095-102	$0	$0	$193,000,000	$218,624,348	$0	$218,624,348	$411,624,348
TOTAL	$0	$250,000,000	$653,000,000	$708,898,351	$623,698	$709,522,049	$1,612,522,049

EXPLANATION

The purpose of these amendments with the two managed care health plans is to amend services through June 30, 2017, and to amend associated capitation rates through June 30, 2016, effective February 1, 2016. The original agreements were competitively bid.

The Department commenced the Medicaid Care Management Program in December 2013, providing acute care medical services primarily to low income children and adults, pregnant women, newborns, and those receiving breast and cervical cancer treatments. While not all Medicaid-eligible individuals are required to obtain their health care coverage through the Medicaid Care Management Program, at the present time, approximately 123,000 individuals receive their health care through this program.

These amendments:

- Incorporate improved pediatric nursing salary rates, with rate reimbursement increases depending on nursing level and time of day by acuity, for skilled nurses during the day, night, and weekends into the capitated payment model;
- Incorporate a competitive level of compensation for intensive nursing skills for acute care in the home into the capitated payment model; and
- Support the effectiveness of the above changes to capitated payments through the inclusion of additional reporting requirements.

These amendments serve to strengthen the network of available providers to meet the complex health care needs of those needing skilled nursing services in the home, and those requiring intensive nursing services in the home.

Exhibit B to the Agreement reflects the adjusted capitated rate information through June 30, 2016. The rates are identified by subsets of the Medicaid population that participate in the health plan. These include: acute care medical services rates for ten subsets, such as low income children, children in foster care, elderly and disabled adults, and dual eligible individuals; rates specific to Behavioral Health services; the Medically Frail; and *Step I acute care medical services only* rates for four populations -- nursing home residents, community (Choices for Independence) residents, developmentally disabled persons, and persons with acquired brain disorders. Rate cell categories and

their subsets are based on age and eligibility categories, and reflect the Department's emphasis on establishing rate categories determined on a whole person approach to health care.

Exhibit O to the Agreement pertaining to quality measures has also been revised to ensure that the Department has in place the most appropriate quality metrics for all persons receiving services. The revised version of Exhibit O includes specific quality metrics for the full inclusion of private duty nursing services, and for assuring network adequacy in meeting this service demand. As the Department continues to phase in or adjust services provided under the managed care health plans, Exhibit O, as well as other sections of the agreement, will continue to be revised to reflect best practices that ensure the protection and rights of New Hampshire's citizens receiving Medicaid services.

There are no changes to the information technology components of these Agreements. As a result, an approval letter from the Department of Information Technology's Chief Information Officer is not included, and the Department has instead provided written notification of the amendment to the Chief Information Officer for his records.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level for the New Hampshire Health Protection population, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:

Jeffrey A. Meyers
Commissioner

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

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Jeffrey A. Meyers
Acting Commissioner

Kathleen A. Dunn
Associate Commissioner

January 20, 2016

G&C Approved
Date 1/27/16
Item # 7B

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to:

(i) Adjust rates to reflect the actuarially certified rate structure for the full inclusion of behavioral health services, through June 30, 2016, as described in Exhibit B – Amendment #10. The new rate structure provides supplemental capitation payment rates to reflect the cost above the base rates for all covered services (not only for enhanced behavioral health services), including hospital inpatient, hospital outpatient, professional, pharmacy, and other covered services;

(ii) Removes the requirement for the Managed Care Organizations to process payments, on an administrative services level, to Community Mental Health Centers who provided behavioral health services under the Agreements on a fee for service basis; and

(iii) Ensure increased capacity among the Community Mental Health Centers is achieved to fulfill the Managed Care Plan's network adequacy requirements.

These agreements, if approved, would be effective February 1, 2016, upon approval of the Governor and Council, through June 30, 2017. These amendments decrease the SFY 2016 price limitation by $5,041,533 from $713,939,884 to $708,898,351 for a cumulative contract value of $1,611,898,351 for all Medicaid Care Management contracts, subject to the approval of the Governor and Executive Council and subject to the continued availability and continued appropriation of funds.

Governor and Executive Council approved the original agreements on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), December 23, 2014 (Item #11), June 24, 2015 (Item #30), August 5, 2015 (Tabled Item #A), and December 16, 2015 (Late Item #A3). 100% Federal Funds for the New Hampshire Health Protection Program, 50% Federal and 50% General Funds for the currently eligible Medicaid population.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY16 Increase (Decrease)	Revised SFY16	Total
Medicaid Care Mgmt: 010-047-75480000-101	$0	$250,000,000	$460,000,000	$495,315,536	($5,041,533)	$490,274,003	$1,200,274,003
New Hampshire Health Protection Program: 010-047-3095-102	$0	$0	$193,000,000	$218,624,348	$0	$218,624,348	$411,624,348
TOTAL	$0	$250,000,000	$653,000,000	$713,939,884	($5,041,533)	$708,898,351	$1,611,898,351

EXPLANATION

The purpose of these amendments with the two managed care health plans is to amend services through June 30, 2017, and to amend associated capitation rates through June 30, 2016, effective February 1, 2016. The original agreements were competitively bid.

The Department commenced the Medicaid Care Management Program in December 2013, providing acute care medical services primarily to low income children and adults, pregnant women, newborns, and those receiving breast and cervical cancer treatments. While not all Medicaid-eligible individuals are required to obtain their health care coverage through the Medicaid Care Management Program, at the present time, approximately 123,000 individuals receive their health care through this program.

These amendments:

- Fully incorporate a robust array of behavioral health services in a capitated payment model;
- Improve care coordination between primary care and Community Mental Health Center providers;
- Support the implementation of Medicaid-funded services described in the Class Action Settlement Agreement in the case of Amanda D. et al. v. Hassan, et al. US v State of New Hampshire, Civ. No. 1:12-cv-53-SM;
- Continue implementation of New Hampshire's 10-year Olmstead Plan, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration;" and ensures the Medicaid Managed Care health plans work collaboratively with the Department in its various efforts to improve the State's mental health system; and
- Ensures that regionally based crisis lines and emergency services are in place 24 hours a day, 7 days a week for individuals in crisis.

These amendments also serve to strengthen the network of available providers to meet the complex health care needs of individuals accessing the State's mental health system. The Agreements require the Managed Care Organizations to enter into binding provider agreements with the Community Mental Health Centers. In the event that a Managed Care Organization is unsuccessful in demonstrating that network adequacy requirements are met, the respective Agreement, as amended by the Governor and Executive Council on December 16, 2015, will remain in effect until the first of the month that the network adequacy requirement is met. This contingency ensures that increased capitated payment rates are not implemented until the Managed Care Organization demonstrates it has the capacity to provide the behavioral health services incorporated into its respective Agreement.

Additionally, these amendments lower the threshold for which a prior authorization will be required to prescribe Morphine Equivalent Doses of opioids for plan participants, and strengthens care coordination requirements for individuals diagnosed with substance use disorder dependence and all infants with a diagnosis of neonatal addiction syndrome.

Exhibit B to the Agreement reflects the adjusted capitated rate information through June 30, 2016. The rates are identified by subsets of the Medicaid population that participate in the health plan. These include: acute care medical services rates for ten subsets, such as low income children, children in foster care, elderly and disabled adults, and dual eligible individuals; rates specific to Behavioral Health services; the Medically Frail; and *Step I acute care medical services only* rates for four populations – nursing home residents, community (Choices for Independence) residents, developmentally disabled persons, and persons with acquired brain disorders. Rate cell categories and their subsets are based on age and eligibility categories, and reflect the Department's emphasis on establishing rate categories determined on a whole person approach to health care.

Exhibit O to the Agreement pertaining to quality measures has also been revised to ensure that the Department has in place the most appropriate quality metrics for all persons receiving services. The revised version of Exhibit O includes specific quality metrics for the full inclusion of behavioral health services, and for assuring network adequacy within the Community Mental Health system. As the Department continues to phase in or adjust services provided under the managed care health plans, Exhibit O, as well as other sections of the agreement, will continue to be revised to reflect best practices that ensure the protection and rights of New Hampshire's citizens receiving Medicaid services.

There are no changes to the information technology components of these Agreements. As a result, an approval letter from the Department of Information Technology's Chief Information Officer is not included, and the Department has instead provided written notification of the amendment to the Chief Information Officer for his records.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level for the New Hampshire Health Protection population, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:

Jeffrey A. Meyers
Acting Commissioner

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

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Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

A3

December 14, 2015

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, NH 03301

G&C Approved
Date 12/16/15
Item # LATE Item A3

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to:

(i) Limit the New Hampshire Health Protection Program population, that is currently covered in managed care medical services, to include only those individuals who are "Medically Frail" and choose to participate in the New Hampshire Health Protection Program Alternative Benefit Plan.

(ii) Adjust rates to reflect the actuarially certified rate structure for the inclusion of the Medically Frail population, through June 30, 2016, as described in Exhibit B – Amendment #9. For convenience of reference, the actuarially certified rate structure for the balance of populations served through June 30, 2016, previously approved by the Governor and Council, is restated in Exhibit B; and

(iii) Revise the targeted implementation date for phasing into the Care Management program Step II waiver services for those persons receiving nursing facility care services and for those persons on the Choices for Independence Waiver.

These agreements, if approved, would be effective January 1, 2016, upon approval of the Governor and Council, through June 30, 2017. These amendments decrease the SFY 2016 price limitation by $12,370,652 from $726,310,536 to $713,939,884 for a cumulative contract value of $1,616,939,884 for all Medicaid Care Management contracts, subject to the approval of the Governor and Executive Council and subject to the continued availability and continued appropriation of funds.

Governor and Executive Council approved the original agreements on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), December 23, 2014 (Item #11), June 24, 2015 (Item #30), and August 5, 2015 (Tabled Item #A). 100% Federal Funds for the New Hampshire Health Protection Program, 50% Federal and 50% General Funds for the currently eligible Medicaid population.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY16 Increase	Revised SFY16	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000	$460,000,000	$495,315,536	$0	$495,315,536	$1,205,315,536
New Hampshire Health Protection Program: 010-047-3099-102	$0	$0	$193,000,000	$230,995,000	($12,370,652)	$218,624,348	$411,624,348
TOTAL	$0	$250,000,000	$653,000,000	$726,310,536	($12,370,652)	$713,939,884	$1,616,939,884

EXPLANATION

The purpose of these amendments with the two managed care health plans is to amend services through June 30, 2017, and to amend associated capitation rates through June 30, 2016, effective January 1, 2016. The original agreements were competitively bid.

The Department commenced the Medicaid Care Management Program in December 2013, providing acute care medical services primarily to low income children and adults, pregnant women, newborns, and those receiving breast and cervical cancer treatments. While not all Medicaid-eligible individuals are required to obtain their health care coverage through the Medicaid Care Management Program, at the present time, approximately 123,000 individuals do. Additionally, over 45,000 individuals receive coverage through the managed care health plans under the New Hampshire Health Protection Act at 100% federal cost through December 31, 2016.

Consistent with legislative intent under the New Hampshire Health Protection Act, New Hampshire Health Protection Program participants initially began receiving health care coverage and services through a bridge – the managed care health plans addressed in this request. This health care bridge is set to remain in place until alternative benefit plans are made available through commercial insurers in 2016. Beginning January 1, 2016, individuals receiving health care coverage pursuant to the New Hampshire Health Protection Act will instead receive coverage under the Marketplace Premium Assistance Program, effectively ending the need for a bridge to the managed care health plans. Accordingly, the managed care health plan agreements' scope carves these individuals out of the managed care contracts beginning January 1, 2016.

Similarly, legislative intent addressed the unique and complex health care needs of Medically Frail individuals eligible for participation in the New Hampshire Health Protection Program. These individuals are not required to receive their health care coverage through the managed care program. As such, many enrolled in the more traditional Medicaid fee-for-service model. However, with the New Hampshire Health Protection Program's population soon moving to commercial insurance coverage, the Department negotiated amendments to the managed care contracts to ensure that the Medically Frail still have access to the managed care health plans through an "opt in" provision. The Department anticipates that up to 5,000 Medically Frail individuals, within the New Hampshire Health Protection Program's eligible population, will choose to "opt in" to the managed care health plan.

In addition, these amendments revise the implementation date for including certain subsets of the Medicaid population in the Medicaid Care Management Program. Specifically, these amendments delay the inclusion of persons receiving nursing facility care services by eight months, from January 1, 2016 to September 1, 2016, and delays the inclusion of persons on the Choices for Independence Waiver by two months, from July 1, 2016 to September 1, 2016. These subsets are part of the Step 2 implementation of the program and were previously approved by Governor and Executive Council for inclusion in the program.

These agreements do not fully implement managed care services for those persons receiving waivered services under the Developmental Disabled Services Waiver, the Acquired Brain Syndrome Waiver and the In Home Supports Waiver. The Department will establish implementation dates for those services at a later date and after further public input.

Exhibit A to the Agreement describes the obligations of the managed care health plans in providing services to the Medicaid population subsets that participate in the health plans. Although Exhibit A establishes the target date for incorporating nursing services into the Care Management Program, the detailed obligations of the managed care health plans for nursing services is not included and will be brought forth in a further amendment to the Governor and Council in advance of its scheduled start date.

Exhibit B to the Agreement reflects the adjusted capitated rate information through June 30, 2016. The rates are identified by subsets of the Medicaid population that participate in the health plan. These include: acute care medical services rates for ten subsets, such as low income children, children in foster care, elderly and disabled adults, and dual eligible individuals; rates specific to Behavioral Health services; the Medically Frail; and *Step I acute care medical services only* rates for four populations – nursing home residents, community (Choices for Independence) residents, developmentally disabled persons, and persons with acquired brain disorders. Rate cell categories and their subsets are based on age and eligibility categories, and reflect the Department's emphasis on establishing rate categories determined on a whole person approach to health care.

Exhibit B reflects the extension of previously approved capitated rates, through June 30, 2016, for the subsets for *Step I acute care medical services only* rates for four populations – nursing home residents, community (Choices for Independence) residents, developmentally disabled persons, and persons with acquired brain disorders. Due to the aforementioned delayed commencement of Step II services for Choices for Independence Waiver program, Exhibit B no longer includes previously projected capitated rates, that were inclusive of Step II services for these four populations, for the for the period of January 1, 2016 through June 30, 2016.

Exhibit O to the Agreement pertaining to quality measures has also been revised to ensure that the Department has in place the most appropriate quality metrics for all persons receiving services. The revised version of Exhibit O includes specific quality metrics for Medically Frail individuals. As the Department continues to phase in Step II services, Exhibit O, as well as other sections of the agreement, will continue to be revised to reflect best practices that ensure the protection and rights of New Hampshire's citizens receiving Medicaid services.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level for the New Hampshire Health Protection population, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

JUL17'15 PM 4:02 DAS

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

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July 16, 2015

Approved

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, NH 03301

Date 8/5/15

Item: Tabled Item A

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the state's two managed care health plans, Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110 and Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116, in order to:

(i) Extend the agreements for the remainder of the two-year extension period through June 30, 2017 as contemplated by Section 1.3 of the original agreement;

(ii) Expand the population covered in Step 1 managed care medical services to include those persons who previously were permitted to "opt out," the so-called "mandatory population."

(iii) Expand the services covered to include Step 2 Phase 2 waiver services provided to those persons on the Choices for Independence Waiver with a targeted implementation date of January 1, 2016.

(iv) Adjust rates to reflect the actuarially certified rate structure for the current Medicaid population and for those persons receiving Step II services under the Choices for Independence Waiver through June 30, 2016 as described in Exhibit B. For convenience of reference, the actuarially certified rate structure for the New Hampshire Health Protection Program population through December 31, 2015, previously approved by the Governor and Executive Council, is restated in Exhibit B, and

(v) Identify the targeted implementation date for phasing into the Care Management program Step II waiver services for those persons receiving nursing care services.

This agreement, if approved, would, effective September 1, 2015, replace the extension approved by the Governor and Council on June 24, 2015 and authorize managed care services to the two managed care organizations through June 30, 2017. This amendment increases the price SFY 2016 price limitation by $314,265,536 from $412,045,000 to 726,310,536 for a cumulative contract value of $1,629,310,536 for all Medicaid Care Management contracts, subject to the approval of the Governor and Executive Council and subject to the continued availability and continued appropriation of funds.

Governor and Executive Council approved the original agreement on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), December 23, 2014 (Item #11), and June 24, 2015 (Item #30). 100% Federal Funds for the New Hampshire Health Protection Program, 50% federal and 50% General Funds for the currently eligible Medicaid population.

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	SFY16 Increase	Revised SFY16	Total
Medicaid Care Mgmt: 010-047-79480000-101	$0	$250,000,000	$460,000,000	$181,050,000	$314,265,536	$495,315,536	$1,205,315,536
New Hampshire Health Protection Program: 010-047-3099-102	$0	$0	$193,000,000	$230,995,000	$0	$230,995,000	$423,995,000
TOTAL	$0	$250,000,000	$653,000,000	$412,045,000	$314,265,536	$726,310,536	$1,629,310,536

EXPLANATION

The purpose of this amendment with the two managed care health plans is to replace, effective September 1, 2015, the extension approved by the Governor and Council on June 24, 2015 and extend the agreement for the remainder of the 24-month extension through June 30, 2017, as provided for by the original agreements; to expand the Care Management Program to cover the remaining eligible population; to begin providing Step II waiver services within the program, and to amend capitation rates for the program through June 30, 2016. The original agreements were competitively bid.

The department commenced the Medicaid Care Management Program in December 2013 providing acute care medical services primarily to low income children and adults, pregnant women, newborns, and those receiving breast and cervical cancer treatments. Several population groups were eligible to "opt out" of Step 1 managed care services until the program was made mandatory. The populations that could voluntarily opt out include: persons in foster care, children with severe disabilities (Katy Beckett kids), and those who are eligible for both Medicare and Medicaid (dual eligible). A few populations are and remain exempt under federal law for managed care. These populations are: persons with Veterans benefits, persons who exceed the Medicaid threshold based on income only (spend downs), persons receiving family planning benefits only; and those new adults enrolled in the Health Insurance Premium Program accessing benefits through employer sponsored insurance. At the present time, there are approximately 137,000 persons in New Hampshire accessing benefits in the

traditional Medicaid program. Additionally, just over 40,000 are now receiving coverage under the New Hampshire Health Protection Act at 100% federal cost through December 31, 2016.

In addition to extending the agreement by two years and establishing the actuarially certified rates for managed care services through SFY 2016, the amendment also expands the delivery of managed care services to cover those persons who had previously "opted out" and expands the program to provide managed care waiver services to persons receiving services under the Choices for Independence waiver program.

Specifically, the amendment establishes a target date of September 1, 2015 for the commencement of services for all persons now mandated into Care Management; a target date of January 1, 2016 for the commencement of managed care services for the Choices for Independence waiver population and a target date of July 1, 2016 for the incorporation of nursing services into managed care.

The timing of the enrollment of the mandatory population will depend on the timing of federal approval (by the Centers for Medicare and Medicaid Services "CMS") of the waiver required for that action.

The department is separately formulating and will submit to CMS later this year after a public review and comment process an application for an additional federal waiver necessary to provide services under the Choices for Independence Waiver in managed care.

This agreement does not implement manage care services for those persons receiving waivered services under the Developmental Disabled Services Waiver, the Acquired Brain Syndrome Waiver and the In Home Supports Waiver. The Department will establish implementation dates for those services in managed care at a later date and after further public input.

Exhibit A to the Agreement describes the obligations of the managed care health plans in providing services to the existing Medicaid population, the new mandatory population and the Choices For Independence population. Although Exhibit A establishes the target date for the incorporation of nursing services into the Care Management Program on July 1, 2016, the detailed obligations of the managed care health plans for nursing services is not included and will be brought forth in a further amendment to the Governor and Council in advance of that date.

Exhibit B to the Agreement reflects the adjusted rate information for SFY 2016. Exhibit B is comprised of two pages. The first page identifies the capitated rates for medical care and behavioral health services for the existing Medicaid population through June 30, 2016. As noted above, this page also restates for convenience the capitated rates for the New Hampshire Health Protection population through December 31, 2015. Services for the New Hampshire Health Protection program are paid with 100% federal funds through December 31, 2016.

The second page of Exhibit B identifies the capitated rates for complex enrollees for Step 1 acute care medical services for the period through December 31, 2015 and for the following period of January 1 through June 30, 2016.

The rate cell categories have been changed from prior amendments. The capitated rates for the period of July 1, 2015 through December 31, 2015 on page two reflect rates for *Step I acute care medical services only* for four populations – nursing home residents; community (CFI) residents; developmentally disabled persons and persons with acquired brain disorders. These four population categories and their subgroups based on age and eligibility categories reflect the department's emphasis on establishing rate categories determined on a whole person approach to health care. The rates for a particular group or subgroup on page one for July 1, 2015 through December 31, 2015 reflect the acute care medical services being provided to those populations.

The rate cells on page two for the period of January 1 through June 30, 2016 reflect the Step I medical services for nursing residents, developmentally disabled and those with acquired brain disorder. However, the rate cells for the Community (CFI) residents reflect *both* the Step I services *and* the Step II services provided under the Care Management Program beginning in January 2016. This is reflected in the higher capitated rate numbers for Community residents in the January 1 through June 30, 2016 period over the 2015 period.

For example, the capitated rate for Community residents – Medicaid Only- Under 65 for the period September 1, 2015 through December 31, 2015 is $3,075.09. But for the time period of January 1, 2016 through June 30, 2016, after the commencement of Step II services for CFI, the capitated rate for that same population increases to $4,835.44. The increase reflects the incorporation of Step II CFI waiver services for that population.

Exhibit A has been significantly revised and updated to ensure the continuity of services and care for persons transitioning into managed care, as well as those transitioning to Step II services. For example:

- Medicaid state plan services in place at the time a member transitions to an MCO will be honored for a 60 day period
- Prescribed medications for a member transitioning to an MCO will also be continued for 60 days from enrollment or until completion of a medical necessity review
- For CFI participants enrolled prior to January 1, 2016, the existing care plan will remain in effect until expiration or until a new plan has been developed and signed by the member
- Persons in a nursing facility who will start receiving medical care from an MCO will be visited personally by a care coordinator for a personal assessment of needs
- MCOs must honor member relationships with Service Link providers to support the members successful integration into the community
- MCOs must provide continuity of care for current members after transition by the MCOs to their own preferred drug lists (PDLs)
- Compliance metrics have been established for substance use disorder services, including time frames for providers response to member inquiries and completion of screenings for services within established times
- Specific procedures for continuation of benefits during appeals have been established

Exhibit O to the Agreement pertaining to quality measures has also been significantly revised to ensure that the department has in place the most appropriate quality metrics for all persons receiving services. The revised version of Exhibit O includes specific quality metrics for the persons receiving CFI waiver services through Care Management. As the department continues to phase in Step II services, Exhibit O, as well as other sections of the agreement, will continue to be revised to reflect best practices that ensure the protection and rights of New Hampshire's citizens receiving Medicaid services.

The department looks forward to briefing the Governor and Executive Council on the important provisions of these agreements.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level for the New Hampshire Health Protection population, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

JUL 17 '15 PM 2:43 RCVD

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

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Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

June 12, 2015

G&C Approved
Date 6/24/15
Item # 30

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the State's two managed care health plans listed below in order to amend certain provisions and extend the current agreements from June 30, 2015 to October 31, 2015 for the traditional Medicaid population and December 31, 2015 for the New Hampshire Health Protection population and increase the price limitation by $412,005,000 from $653,000,000 to $1,315,005,000 effective upon approval of the Governor and Executive Council.

Governor and Executive Council approved the original agreement on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), July 16, 2014 (Late Item "A"), and December 23, 2014 (Item #11). 100% Federal Funds for the New Hampshire Health Protection Program, 50% federal and 50% General Funds for the currently eligible Medicaid population.

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116

Fund Name and Account Number	SFY13	SFY14	SFY15	SFY16	Total
Medicaid Care Mgmt: 010-047-79480000-102	$0.00	$250,000,000	$460,000,000	$181,050,000	$891,050,000
New Hampshire Health Protection Program: 010-047-30990000-102	$0.00	$0.00	$193,000,000	$230,995,000	$423,995,000
Total	$0.00	$250,000,000	$653,000,000	$412,005,000	$1,315,005,000

EXPLANATION

The purpose of this amendment is to extend the current agreements to allow for a 4-month extension of healthcare coverage to the traditional Medicaid population at the current rates and continues authorization of services to the New Hampshire Health Protection population through December 31, 2015. This amendment identifies the Department's publically targeted dates for the enrollment and coverage of the additional 10,000 persons who previously opted out of Step 1 services and the targeted dates for the commencement of coverage for CFI and nursing services. Changes to the agreements that would implement these changes and establish rates for the Step II services will be incorporated into a further amendment for the remaining 20-month extension.

This extension enables the Department to advance waiver applications with the Centers for Medicare and Medicaid Services (CMS) that are required for the mandatory coverage of Step I medical services for those persons who were previously allowed to "opt-out" of the Medicaid Care Management Program and for the implementation of Step II waiver services to persons receiving nursing home services and persons receiving in-home long-term care services under the Choices for Independence Waiver. This brief extension period will also enable the Department and the managed care plans to review proposed new federal managed care regulations just released by the federal Centers for Medicare and Medicaid Services (CMS) and to review additional information that may inform the determination of capitated rates for Step 1 medical services for the balance of the agreement extension period.

This amendment also provides that in the absence of concluding an agreement for the additional 20 months of services by July 31, 2015 with either or both of the managed care plans, the Department may invoke the termination provisions of the agreement to ensure a 90-day transition plan for the plan enrollees.

Section 1.3 of the current agreements with the managed care plans specify a term of 36 months with the option of the Department to extend the agreements for an additional 24 months with the approval of the Governor and Council. The initial 36-month period expires on June 30, 2015.

The purpose of this amendment is to (i) amend Section 1.3 of the existing agreements to allow for more than one extension of the agreement, provided that the total period of extensions remains unchanged at 24 months and (ii) enable the Department to extend the current agreement at the current capitated rates for an additional four (4) months for the traditional Medicaid population in order to allow the Department to advance waiver applications with CMS that are required to expand the Care Management Program to cover an additional 10,000 persons who were previously allowed to "opt-out" of the Step 1 medical services, as well as to advance waivers needed to begin the phase-in of Step II services for persons receiving home and community based services under the Choices for Independence Waiver and those receiving nursing home services.

This amendment also authorizes the continuation of medical services provided by the managed care plans to the New Hampshire Health Protection population through December

31, 2015, which is funded at 100% of federal financial participation. The New Hampshire Health Protection population will be transitioned into Qualified Health Plans on the federal marketplace beginning on January 1, 2016.

The Department and the managed care plans have been negotiating a contract amendment that would extend the agreements for the remaining 24-month period; establish new capitated rates for SFY 16 for Step 1 medical services; incorporate all remaining eligible Medicaid populations into managed care, and establish capitated rates for and implement Step II waiver services for persons under the Choices for Independence waiver. Implementing mandatory enrollment for Step 1 medical services and providing Step II waiver services for CFI require approval of waivers by CMS. The Department and the managed care plans need additional time to advance the waiver applications with CMS and to continue work on establishing capitated rates for the balance of the 24-month extension period. Should the Department and either or both of the plans be unable to agree upon the terms for the remaining 20-months of the program for the traditional Medicaid population, the 4-month period would also allow for a transition of the Medicaid enrollees.

The targeted dates for the inclusion of the mandatory population and phase-in of Step II services, as reflected in Exhibit A to the agreement, are as follows:

Phase 1. Mandatory Enrollment of "opt-out" population-
Program target start date: September 1, 2015;

Phase 2. Choices For Independence Waiver ("CFI")-
Program target start date: January 1, 2016;

Phase 3. Nursing Facility services ("NF") and DCYF services-
Program target start date: July 1, 2016;

Phase 4. Developmental Disabilities, Acquired Brain Disorder and In Home Supports for Children with Developmental Disabilities waivers ("Waiver Services") will commence on a date to be determined by DHHS in consultation with the MCOs.

Exhibit A to the Agreement describes the obligations of the managed care health plans in providing services to the existing Medicaid population. This exhibit remains unchanged in the 4-month extension, except that it identifies the targeting phase-in of Step II CFI and nursing services as noted above.

Exhibit B to the Agreement reflects the capitated rate information for the four month period of SFY 2016 and for the continuation of services for the New Hampshire Health Protection population through December 31, 2015.

Area Served: Statewide

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by Congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal Funds become no longer available or are decreased below the 100% FFP level for the New Hampshire Health Protection population, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

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

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December 8, 2014

G&C Approved

Date 12/23/14

Item # 11

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

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the health plans listed below to adjust rates to reflect the actuarially certified rate structure for both the current Medicaid population and the new Health Protection Program population. This amendment decreases the SFY 2015 price limitation by $99,543,000 from $752,543,000 to $653,000,000 effective January 1, 2015, or upon Governor and Executive Council approval, whichever is later, with no change to the contract end date of June 30, 2015, based upon the availability and continued appropriation of funds, with authority to adjust encumbrances between fiscal years if needed and justified through the Budget Office. Governor and Executive Council approved the original agreement on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25), April 9, 2014 (Item #44), June 18, 2014 (Item #65A), and July 16, 2014 (Late Item "A"). Funds for services provided under this Amendment to the New Hampshire Health Protection population will be 100% federal funds appropriated by Congress.

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116

Fund Name and Account Number	SFY13	SFY14	SFY15	Total
Medicaid Care Mgmt: 010-047-79480000-102	$0.00	$250,000,000	$460,000,000	$710,000,000
New Hampshire Health Protection Program: 010-095-30990000-102	$0.00	$0.00	$193,000,000	$193,000,000
Total	$0.00	$250,000,000	$653,000,000	$903,000,000

EXPLANATION

The purpose of this amendment is to amend the existing agreements with the two health plans to amend capitation rates for the currently eligible population, effective January 1, 2015. The original agreements with Granite State Health Plan and Boston Medical Center Health-Net Plan approved by the Governor and Executive Council on May 9, 2012, allow for such amendments. The original agreements were competitively bid.

These amendments reflect adjusted rate information for SFY 2015 in Exhibit B.

Similar to contract Amendment 5, which was approved by the Governor and Council on July 16, 2014, specialty services for the long term care population, including nursing home services and services for the developmentally disabled are not incorporated into the scope of services provided by these vendors, pending the stakeholder engagement process. Future amendments to this contract are anticipated to incorporate the long term care services.

The first amendment approved by Governor and Executive Council on June 19, 2013 was a zero cost amendment that updated and adjusted rate information as well as made clarifications and adjustments to Exhibit A and Exhibit C.

The original price limitation for SFY 2014 of $900,000,000 was reduced in the second amendment approved by the Governor and Executive Council on February 12, 2014 to reflect seven months of coverage (December 1, 2013 through June 30, 2014).

The third amendment approved by the Governor and Executive Council on April 9, 2014 increased the SFY 2014 price limitation by $10,363,689 to $250,000,000 to assure contract resources were adequate to cover the remainder of the contract period.

The fourth amendment approved by the Governor and Executive Council on June 18, 2014, reduced the SFY 2015 price limitation by $485,000,000 to $460,000,000 to reflect the annual actuarially certified rate structure and adjustments to the scope of services.

The fifth amendment approved by the Governor and Executive Council on July 16, 2014 increased the SFY 2015 price limitation by $115,477,500 to reflect the addition of the new population and substance use disorder services to the new adult group.

A scanned copy of this item, including the G&C letters and accompanying documentation from the original agreement and subsequent amendments will be available online once posted to the meeting agenda for the Governor and Executive Council.

Should Governor and Council determine to not approve this request, the new adult population up to 138% of the federal poverty level would not be provided health coverage under the New Hampshire Health Protection Program.

Performance measures, including but not limited to the following, will be used to evaluate these agreements.

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;
- Quality Performance Incentives focused on four areas: Timeliness of Prenatal Care, Follow-Up After Hospitalization for Mental Illness, Parental Satisfaction With Children Getting Appointments for Care and Satisfaction with Getting Appointments for Care; and
- Claims Payment and Processing Accuracy.

Area served: Statewide.

Source of funds: Federal financial participation rates for the currently eligible population will be 50% federal funds as appropriated by congress for the entire period of this amendment. Federal financial participation rates for the New Hampshire Health Protection services are will be 100% federal funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:

Nicholas A. Toumpas
Commissioner

G&C Approved

Date 7/16/14

Item # (ATE Item A

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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

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July 14, 2014

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

Retroactive
65% Federal funds
35% General funds

REQUESTED ACTION

Authorize the Department of Health and Human Services to **retroactively** amend existing individual agreements with the health plans listed below to provide Medicaid Managed Care medical services to the new adult population under the New Hampshire Health Protection Program. The purpose of these contract amendments is to adjust the scope of services to include services the New Hampshire Health Protection population and to adjust rates to reflect the actuarially certified rate structure for both the current Medicaid population and the new Health Protection Program population. This amendment increases the SFY 2015 price limitation by $292,543,000 from $460,000,000 to $752,543,000 effective retroactive to July 1, 2014 upon Governor and Executive Council approval, with no change to the contract end date of June 30, 2015, based upon the availability and continued appropriation of funds, with authority to adjust encumbrances between fiscal years if needed and justified through the Budget Office. Governor and Executive Council approved the original agreement on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #87A), February 12, 2014 (Item #25), April 9, 2014 (Item #44) and June 18, 2014 (Item #65A). Funds for services provided under this Amendment to the New Hampshire Health Protection population will be 100% federal funds appropriated by Congress.

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116

Fund Name and Account Number	SFY13	SFY14	SFY15	Total
Medicaid Care Mgmt: 010-047-79480000-102	$0.00	$250,000,000	$460,000,000	$710,000,000
New Hampshire Health Protection Program: 010-095-30990000-102	$0.00	$0.00	$292,543,000	$292,543,000
Total	$0.00	$250,000,000	$752,543,000	$1,002,543,000

EXPLANATION

The purpose of this amendment is to retroactively amend the existing agreements with the two health plans to provide health coverage to the new adult population that will be served under the New Hampshire Health Protection Program, effective September 1, 2014. This amendment also amends capitation rates for the currently eligible population, effective July 1, 2014. This latter purpose results to no change to the contract price limitation. The original agreements with Granite State Health Plan and Boston Medical Center Health Net Plan approved by the Governor and Executive Council on May 9, 2012, allow for such amendments. The original agreements were competitively bid.

These amendments reflect updated scope of services in Exhibit A; adjusted rate information for SFY 2015 for services and a fee schedule in Exhibit B; an updated Exhibit O, which outlines quality and oversight reporting requirements relative to the new adult population and Exhibit P, which documents the new substance use disorder services that are required to be provided to the new adult group as part of the Essential Health Benefits under the Patient Protection and Affordable Care Act.

Similar to contract Amendment 4, which was approved by the Governor and Council on June 18, 2014, specialty services for the long term care population, including nursing home services and services for the developmentally disabled are not incorporated into the scope of services provided by these vendors, pending the stakeholder engagement process. Future amendments to this contract are anticipated to incorporate the long term care services.

The first amendment approved by Governor and Executive Council on June 19, 2013 was a zero cost amendment that updated and adjusted rate information as well as made clarifications and adjustments to Exhibit A and Exhibit O.

The original price limitation for SFY 2014 of $900,000,000 was reduced in the second amendment approved by the Governor and Executive Council on February 12, 2014 to reflect seven months of coverage (December 1, 2013 through June 30, 2014).

The third amendment approved by the Governor and Executive Council on April 9, 2014 increased the SFY 2014 price limitation by $10,363,689 to $250,000,000 to assure contract resources were adequate to cover the remainder of the contract period.

The fourth amendment approved by the Governor and Executive Council on June 18, 2014, reduced the SFY 2015 price limitation by $485,000,000 to $460,000,000 to reflect the annual actuarially certified rate structure and adjustments to the scope of services.

A scanned copy of this item, including the G&C letters and accompanying documentation from the original agreement and subsequent amendments will be available online once posted to the meeting agenda for the Governor and Executive Council.

Should Governor and Council determine to not approve this request, the new adult population up to 138% of the federal poverty level would not be provided health coverage under the New Hampshire Health Protection Program.

Performance measures, including but not limited to the following will be used to evaluate these agreements.

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;
- Quality Performance Incentives focused on four areas: Timeliness of Prenatal Care, Follow-Up After Hospitalization for Mental Illness, Parental Satisfaction With Children Getting Appointments for Care and Satisfaction with Getting Appointments for Care; and
- Claims Payment and Processing Accuracy.

Area served: Statewide.

Source of funds:
Federal financial participation rates range from 50% to 100%. Average funding sources are estimated to be as follows:

Currently eligible population (Step 1): 50.5% Federal Funds and 49.5% General Funds

New Hampshire Health Protection Program: 100% Federal Funds as appropriated by Congress for the entire period of this Amendment.

In the event that Federal funds become no longer available or are decreased below the 100% FFP level, as provided under the New Hampshire Health Protection Act, General Funds will not be requested to support this program and the medical services for the new adult population would end within 90 days.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:

Nicholas A. Toumpas
Commissioner

65A

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
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Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

June 11, 2014

G&C Approved
Date 6/18/14
Item # 65A

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

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the Managed Care Organizations listed below to provide Medicaid Managed Care medical and long-term care services to Medicaid clients by adjusting rates to reflect the annual actuarially certified rate structure and adjust the scope of services. This amendment reduces the SFY 2015 price limitation by $485,000,000 from $945,000,000 to $460,000,000, effective July 1, 2014 or upon Governor and Executive Council Approval, whichever is later, with no change to the contract end date of June 30, 2015, based upon the availability and continued appropriation of funds, with authority to adjust encumbrances between fiscal years if needed and justified through the Budget Office. Governor and Council approved the original agreement on May 9, 2012 (Item #54A) and then approved subsequent amendments on June 19, 2013 (Item #67A), February 12, 2014 (Item #25) and April 9, 2014 (Item #44).

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116

Funds are anticipated to be available in the following accounts in State Fiscal Years 2014 and 2015 pending approval of transfers by the Fiscal Committee and Governor and Executive Council.

Fund Name and Account Number	SFY13	SFY14	SFY15	Total
Medicaid Care Mgmt: 010-047-79480000-102	$0.00	$250,000,000	$460,000,000	$710,000,000
Total	$0.00	$250,000,000	$460,000,000	$710,000,000

EXPLANATION

The purpose of these amendments is to amend the existing agreements with the three Managed Care Organizations specifically as they relate to the Centers of Medicare and Medicaid Services requirements that rates be updated annually and subject to actuarial certification. The original agreements approved by Governor and Executive Council on May 9, 2012 allow for such amendments. The original agreements were competitively bid.

These amendments reflect updated and adjusted rate information for SFY 2015 for services provided under the agreements, clarifications and adjustments to Exhibit A, Scope of Work, and an updated Exhibit O, which outlines quality and oversight reporting requirements. Because a program of specialty services for the long term care population, including nursing home services and services for the developmentally disabled has yet to be incorporated into the scope of services provided by these vendors, there has been a reduction in the price limitation for SFY 2015.

The Department intends to incorporate services for the long term care population into future amendments to these contracts.

The first amendment approved by Governor and Executive Council on June 19, 2013 was a zero cost amendment that updated and adjusted rate information as well as made clarifications and adjustments to Exhibit A and Exhibit O.

The original price limitation for SFY 2014 of $900,000,000 was reduced in the second amendment approved by the Governor and Executive Council on February 12, 2014 to reflect seven months of coverage (December 1, 2013 through June 30, 2014).

The third amendment approved by the Governor and Executive Council on April 9, 2014 increased the SFY 2014 price limitation by $10,363,689 to $250,000,000 to assure contract resources were adequate to cover the remainder of the contract period.

A scanned copy of this item, including the G&C letters and accompanying documentation from the original agreement and subsequent amendments will be available online once posted to the meeting agenda for the Governor and Executive Council.

Should Governor and Council determine to not approve this request New Hampshire citizens will not benefit from improved and cost efficient medical care available to them under the Managed Care Program.

Performance Measures, including but not limited to the following will be used to evaluate these agreements.

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;
- Quality Performance Incentives focused on four areas: Timeliness of Prenatal Care, Follow-Up After Hospitalization for Mental Illness, Parental Satisfaction With Children

Getting Appointments for Care and Satisfaction with Getting Appointments for Care; and

- Claims Payment and Processing Accuracy.

Area served: Statewide.

Source of funds: Federal financial participation rates range from 50% to 75%. Average funding sources are estimated to be as follows:

State Fiscal Year 2014 and 2015: 50.5% Federal Funds and 49.5% General Funds

In the event that Federal or other funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:

Nicholas A. Toumpas
Commissioner

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

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G&C Approved

March 26, 2014

Date 4/9/14

Item # 44

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

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend existing individual agreements with the Managed Care Organizations listed below to correct a scrivener's error in Table 1 of the October 23, 2013 actuarial report provided by Milliman, Inc. and increase the SFY 2014 price limitation by $10,363,689 to $250,000,000 to assure contract resources are adequate to cover the remainder of the contract period, effective upon Governor and Executive Council Approval through June 30, 2014, based upon the availability and continued appropriation of funds, with authority to adjust encumbrances between fiscal years if needed and justified through the Budget Office. Governor and Council approved the original agreement on May 9, 2012 and then approved subsequent amendments on June 19, 2013 and February 12, 2014.

A second transfer is being planned to sweep funds from various Medicaid related accounts to Care Management Account #7948 to adequately fund the Medicaid Care Management contract expenses. This transfer is planned for May Fiscal and Governor and Council submission.

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116
- Granite Care – Meridian Health Plan of New Hampshire, d/b/a Meridian Health Plan of New Hampshire, 900 Elm Street, Manchester, NH 03101

Fund Name and Account Number	SFY13	SFY14	SFY15	Total
Medicaid Care Mgmt: 010-047-79480000-102	$0.00	$250,000,000.00	$945,000,000.00	$1,195,000,000
Total	$0.00	$250,000,000.00	$945,000,000.00	$1,195,000,000

EXPLANATION

The purpose of this amendment with the three Managed Care Organizations is to correct a scrivener's error in Table 1 of the actuarial report provided by Milliman, Inc. (State of New Hampshire Department of Health and Human Services, December 2013- June 2014 Capitation Rate Development for Medicaid Care Management Program, dated October 23, 2013). The figures inserted in Table 1 should have reflected the base rate of each Base Rate Capitation Rate cell, but instead were amounts that included both the base rate and the supplemental behavioral health rate. This error is corrected with this amendment.

The original price limitation for SFY 2014 of $900,000,000 was reduced in the amendment approved by the Governor and Executive Council on February 12, 2014 to reflect seven months of coverage (December 1, 2013 through June 30, 2014). After careful review of current and projected member months, the Department is requesting to increase that price limitation by $10,363,689 to $250,000,000 to assure contract resources are adequate to cover the remainder of the contract period.

Should Governor and Council determine to not approve this request New Hampshire citizens will not benefit from improved and cost efficient medical care available to them under the Managed Care Program.

The following Performance Measures, including but not limited to the following, will be used to evaluate these agreements.

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;
- Quality Performance Incentives focused on four areas: Timeliness of Prenatal Care, Follow-Up After Hospitalization for Mental Illness, Parental Satisfaction With Children Getting Appointments for Care and Satisfaction with Getting Appointments for Care; and
- Claims Payment and Processing Accuracy.

Area served: Statewide.

Source of funds: Federal financial participation rates range from 50% to 75%. Average funding sources are estimated to be as follows:

State Fiscal Year 2014: 50.5% Federal Funds and 49.5% General Funds; and
State Fiscal Year 2015: 50.2% Federal Funds, 37.7% General Funds and 12.1% Other Funds (County).

In the event that Federal or other funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

MST
25

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

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January 30, 20[illegible]

G&C Approved
Date 2-12-14
Item # 25 50.5% Federal funds
49.5% General funds

Her Excellency, Governor Margaret Wood Hassan
~~and the Honorable Council~~
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health & Human Services to amend existing individual agreements with the Managed Care Organizations listed below to provide Medicaid Managed Care medical and long-term care services to Medicaid clients by adjusting rates to reflect the annual actuarially certified rate structure, effective December 1, 2013, through June 30, 2014. These are zero cost amendments, specific to the rate structure update for SFY14 and do not have an impact on the contract period.

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116
- Granite Care – Meridian Health Plan of New Hampshire, d/b/a Meridian Health Plan of New Hampshire, 900 Elm Street, Manchester, NH 03101.

Funds for the services are anticipated to be available in the following account:

Fund Name and Account Number	SFY13	SFY14	SFY15	Total
Medicaid Care Management: 010-047-79480000-102	$0.00	$239,636,311.00	$945,000,000.00	$1,184,636,31
Total	$0.00	$239,636,311.00	$945,000,000.00	$1,184,636,31

EXPLANATION

The purpose of this amendment with the three Managed Care Organizations is to adjust the payments rates to incorporate changes that have occurred in the Medicaid program since the current rates were set in July 2013. The original contract envisioned $900,000,000 for SFY 2014. However, due to a delayed start, the price limitation is adjusted to $239,636,311 to represent the partial year of SFY14, December 1, 2013 through June 30, 2014, and does not include the contract amount for SFY15. The Department is planning to bring a new amendment for G&C approval for SFY15.

These amendments reflect an adjustment to the per member per month rates paid to the managed care organizations to incorporate additional capacity and rate increase for designated receiving facility beds (involuntary psychiatric treatment beds located in private hospitals) in the State, update to DRG and FQHC rates, as well as an adjustment to reflect the start date of Care Management as December 1, 2013. The original agreements approved by Governor and Executive Council on May 9, 2012 allow for such amendments.
These original agreements were competitively bid.

Should Governor and Council determine to not approve this request New Hampshire citizens will not benefit from improved and cost efficient medical care available to them under the Managed Care Program.

The following Performance Measures, including but not limited to the following, will be used to evaluate these agreements.

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;
- Quality Performance Incentives focused on four areas: Timeliness of Prenatal Care, Follow-Up After Hospitalization for Mental Illness, Parental Satisfaction With Children Getting Appointments for Care and Satisfaction with Getting Appointments for Care; and
- Claims Payment and Processing Accuracy.

Area served: Statewide.

Source of funds: Federal financial participation rates range from 50% to 75%. Average funding sources are estimated to be as follows:

State Fiscal Year 2014: 50.5% Federal Funds and 49.5% General Funds; and
State Fiscal Year 2015: 50.2% Federal Funds, 37.7% General Funds and 12.1% Other Funds (County).

In the event that Federal or other funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

67A

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
[illegible] FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964
New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

June 12, 2013

G&C Approved
Date 6/19/13
Item # 67A

Her Excellency, Governor Margaret Wood Hassan
And the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health & Human Services to amend existing individual agreements with the Managed Care Organizations listed below to provide Medicaid Managed Care medical and long-term care services to Medicaid clients by adjusting rates to reflect the annual actuarially certified rate structure, effective July 1, 2013, through June 30, 2014. These are zero cost amendments.

- Granite State Health Plan, d/b/a New Hampshire Healthy Families, 264 South River Road, Bedford, NH 03110
- Boston Medical Center HealthNet Plan, d/b/a Well Sense Health Plan, 2 Copley Place, Suite 600, Boston, MA 02116
- Granite Care - Meridian Health Plan of New Hampshire, 900 Elm Street, Manchester, NH 03101

EXPLANATION

The purpose of these amendments is to amend the existing agreements with the three Managed Care Organizations specifically as they relate the Centers of Medicare and Medicaid Services requirement that rates be updated annually and subject to actuarial certification. The original agreements approved by Governor and Executive Council on May 9, 2012 allow for such amendments. The original agreements were competitively bid.

These amendments reflect updated and adjusted rate information for SFY 2014 for services provided under the agreements, clarifications and adjustments to Exhibit A, and an updated Exhibit C.

The new rate structure provides supplemental capitation payment rates for Behavioral Health Services, reflecting the cost above the base rates for all covered services (not only for enhanced behavioral health services), including hospital inpatient, hospital outpatient, professional, pharmacy, and other covered services. The SFY2014 update also allows for improved reimbursement to the providers by the MCOs. The updated rate information used within the amendments was derived using the professional assistance of an actuarial firm to analyze cost details and verify actuarial certification, just as it had been done prior to the approval of the original agreements. Subsequent

to Governor and Council approval, implementation of the amended agreements is contingent upon approval by Centers for Medicare & Medicaid Services.

Changes to Exhibits A and O coordinate performance and quality measures in the agreement with the goals and requirements of the NH Quality Strategy.
Components of the Quality Strategy in Exhibit A include:

Performance Measures such as:

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;

Quality Performance Incentives focused on four areas:

- Timeliness of Prenatal Care.
- Follow-Up After Hospitalization for Mental Illness.
- Parental Satisfaction With Children Getting Appointments for Care and
- Satisfaction with Getting Appointments for Care; and

Claims Payment and Processing Accuracy.

Exhibit O indicates the Quality and Oversight measures/measure sets, logs and narrative reports the MCOs must provide to the Department.

Area served: Statewide.

Source of funds: Federal financial participation rates range from 50% to 75%. Average funding sources are estimated to be as follows:

State Fiscal Year 2014: 50.5% Federal Funds and 49.5% General Funds; and
State Fiscal Year 2015: 50.2% Federal Funds, 37.7% General Funds and 12.1% Other Funds (County).

In the event that Federal or other funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Nicholas A. Toumpas
Commissioner

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964
New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

March 21, 2012

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED BY _____
DATE 3/28/12 4/18/12
PAGE 7 5/9/12
ITEM # 34A

REQUESTED ACTION

Authorize the Department of Health & Human Services to enter into individual agreements with the Managed Care Organizations listed below to provide Medicaid Managed Care medical and long-term care services to Medicaid clients at an estimated cost, based on clients' choices of enrollment into a single Managed Care Organization following program implementation, not to exceed $2,226,923,030.00 in the aggregate between all vendors effective July 1, 2012, or date of Governor and Council approval, whichever is later, through June 30, 2015.

- Granite State Health Plan, Inc., c/o Centene Corp. 7700 Forsyth Blvd., St. Louis, MO 63105, Vendor # TBD
- Boston Medical Center Health Plan, Inc., 2 Copley Place, Suite 600, Boston, MA 02116, Vendor # TBD
- Granite Care – Meridian Health Plan of New Hampshire, 777 Woodward Ave., Suite 600, Detroit, MI 48226, Vendor # TBD

Funds are available in the following accounts in State Fiscal Year 2013 and are anticipated to be available in State Fiscal Years 2014 and 2015 upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts if needed and justified between State Fiscal Years and encumbrance amounts between vendors through the Budget Office as necessary.

Fund Name and Account Number	SFY 2013	SFY 2014	SFY 2015	Total
Health and Social Services, Dept of Health and Human Services, HHS: Commissioner, Off of Medicaid Business & Policy, Provider Payments 05-95-95-956010-61470000-101-500729	$381,923,030	$401,000,000	$421,000,000	$1,203,923,030
HHS: Developmental Serv-Div of Developmental Svcs, Developmental Services 05-95-93-930010-71000000-101-500729 Or To Be Determined	$0.00	$238,000,000	$250,000,000	$488,000,000
HHS: Elderly-Adult Services, Nursing Services County Participation 05-95-48-480015-59420000-101-500729 Or To Be Determined	$0.00	$261,000,000	$274,000,000	$535,000,000
Total	$381,923,030	$900,000,000	$945,000,000	$2,226,923,030

The table below shows the amount to be encumbered for each vendor. A detailed worksheet with accounting details for amounts to be encumbered by each vendor is attached for use by the Department of Administrative Services, Bureau of Accounting.

	MCO #1	MCO #2	MCO #3	Total
SFY 2013	$190,961,515	$95,480,758	$95,480,758	$381,923,030
SFY 2014	$450,000,000	$225,000,000	$225,000,000	$900,000,000
SFY 2015	$472,500,000	$236,250,000	$236,250,000	$945,000,000
Total	$1,113,461,515	$556,730,758	$556,730,758	$2,226,923,030

EXPLANATION

The purpose of these agreements is to provide improved and cost efficient medical and long-term care services to New Hampshire Medicaid clients through the implementation of a Managed Care Program beginning July 1, 2012, through June 30, 2015. These agreements provide for a one two-year extension pending the successful performance of the vendor and approval by Governor and Council.

Total spending for all three agreements in State Fiscal Year 2013 will not exceed $381,923,030 and contracts are executed with this not-to-exceed amount. As rates are negotiated for State Fiscal Years 2014 and 2015, contracts will be renegotiated increasing the not-to-exceed amounts, but the total spending for all three agreements from July 1, 2012, through June 30, 2015, will not exceed $2,226,923,030 as requested. The reason these amounts are stated as "not to exceed" is that the Managed Care Program permits clients to self-select the vendor of their choice, which in turn will determine the amount expended on any one contract. Clients' selections will not be known until after implementation of the Program. In any event, actual spending on all approved contracts will not exceed $2,226,923,030 in the aggregate over the three-year term of the agreements. For purposes of encumbering funds by Managed Care Organizations, the allocation described in the Request For Proposals for auto-enrollment was used. If a client fails to select a Managed Care Organization, the process for auto-assignment if the client's provider is under contract with more than one Managed Care Organization or no usual source of primary care can be determined, will be that the Managed Care Organization with the highest technical score will be assigned 50% of the auto-assigned members and the other two Managed Care Organizations receiving 25% of the remaining auto-assignments. Costs for State Fiscal Years 2014 and 2015 were derived by adjusting previous years estimates upward by five percent to account for inflation.

Pursuant to Chapter 125, Laws of 2011 (Senate Bill 147), the Department is required to develop a managed care model for administering the Medicaid program to provide medical and long-term care services for all Medicaid populations throughout New Hampshire consistent with the provisions of Federal Regulation 42 U.S.C. 1396u-2. It also requires the Department to submit final contracts to Governor and Council no later than March 15, 2012, unless the date is extended by the Fiscal Committee. On March 9, 2012, FIS12-094, Fiscal Committee extended the date to March 28, 2012. The law also requires that the capitated rates set by the Department be approved by the Fiscal Committee. The Fiscal Committee approved the rates on March 9, 2012, FIS12-094 as amended. The Department's State Fiscal Years 2012-2013 budget approved in June 2011 includes anticipated savings in the Medicaid Program of thirty million dollars following the implementation of a Managed Care Program.

Pursuant to the language of Chapter 125, Laws of 2011 (Senate Bill 147), the Department developed a three-phased approach to implementing a Managed Care Program:

- Step 1 includes the July 1, 2012, implementation of a program for all Medicaid State Plan medical, pharmacy and mental health services for most populations.
- Step 2 includes the July 1, 2013, implementation of a program for specialty services for the long-term care populations, including nursing home services and services for the developmentally disabled. It includes the State's option to manage financing for specialty services for those dually eligible for Medicaid and Medicare.
- Step 3 includes the January 2014 Medicaid expansion population under the Affordable Care Act.

The "public process" used for development and procurement of a managed care model included the following process:

- The Department of Health and Human Services conducted a Request For Information released July 28, 2010, report published January 14, 2011;
- Public legislative process regarding SB 147 (2011);
- Regional stakeholder forums and focus groups conducted by Louis Kamo & Associates and Pontifax; Stakeholder forums were held: 9/13/11 in Keene, NH; 9/14 in Nashua, NH; 9/21 in Littleton, NH with remote sites from Lebanon and Berlin participating; 9/22 in Somersworth, NH; 9/23 in Manchester, NH; 9/29 in Concord, NH.
- Focus groups were held in the fall of 2011 in Littleton, Berlin, Dover, Concord, Claremont, Somersworth, Portsmouth, Salem and Nashua, NH. Participants in the focus groups included consumers with physical disabilities, severe mental health issues, substance abuse issues, developmental disabilities, elderly needing long-term care assistance, low-income who receive public assistance and consumers with limited English proficiency or other cultural barriers to health access;
- Monthly updates of Medical Care Advisory Committee commencing in 2011;
- Newspaper public notices February 3, 2012; and
- Public engagement of long-term care populations will continue by Louis Kamo throughout the development of Step II.

These agreements were competitively bid. A Request For Proposals was posted on the Department of Health and Human Services website on October 17, 2011, through December 16, 2011. Eighteen vendors submitted Letters of Intent. A Bidders' Technical Proposal Conference was held on November 3, 2011, and a Cost Proposal Conference on November 17, 2011. Six vendors submitted proposals by the December 14, 2011, deadline specified in the Request For Proposals. The Requests for Proposals stated that members shall have a choice between two or three Managed Care Organizations operating in the State.

Eight high-level Department of Health and Human Services staff and one from the New Hampshire Department of Justice were assigned to the Technical Evaluation Team. Team members reviewed the proposals individually and then met as a group to collectively score the proposals, using a consensus model. The technical merits of each proposal were reviewed and scored consistent with the criteria for evaluation of Technical Proposals as specified in the Request For Proposals. Technical Proposals were evaluated in each of the following areas: Services and Populations; Pharmacy Management; Member Enrollment; Member Services and Cultural Considerations; Access and Network Management; Payment Reform; Behavioral Health; Care Management; Quality Management; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Utilization Management; and Administrative Functions. Technical Proposals were awarded a maximum of 70 points out of a possible total evaluation score of 100.

The Cost Evaluation Team consisted of four high-level Department of Health and Human Services staff. Following professional assistance of an actuarial firm to analyze cost details and verify actuarial certification, the Team scored the cost proposals by consensus consistent with the criteria for evaluation as specified in the Request For Proposals. Cost Proposals were awarded a maximum of 30 points out of a possible total evaluation score of 100. Attached is a bid summary including the bidders' scores and participants on the evaluation teams.

The contract negotiation process was started with the three bidders receiving the highest evaluation scores. Contract negotiations were conducted by the Contract Negotiation Team, consisting of four high ranking Department of Health and Human Services employees and two Department of Justice employees, individually with each of the bidders so that the terms and conditions in each of the agreements for which approval is requested are identical. Rate structure was negotiated by the Department and approved by the Fiscal Committee on March 9, 2012, FIS12-094 as amended. The Department of Information Technology has approved that the Department of Health and Human Services enter into these agreements. Their approval is attached. As a result of this process the Department requests Governor and Council approval to enter into agreements with the Medicaid Managed Care Organizations named in the Requested Action. Subsequent to Governor and Council approval, implementation of the agreements is contingent upon approval by Centers for Medicare & Medicaid Services.

Should Governor and Council determine to not approve this request New Hampshire citizens will not benefit from improved and cost efficient medical care available to them under the Managed Care Program. They will face uncertainty over which Medicaid services are available due to the likelihood of the elimination or reduction to services that will be necessitated by the reduced State Fiscal Years 2012-2013 appropriated budget amounts that anticipate savings resulting from the implementation of the Managed Care Program. Additionally, the Department will be in violation of Senate Bill 147 that mandates implementation of a Managed Care Program.

The following Performance Measures, including but not limited to the following, will be used to evaluate these agreements.

- Access Standards, including, but not limited to: provider network, geographic distance, timely access to services and access to special services;
- Quality Performance Incentives focused on four areas: Adolescent Well Care visits, Re-admissions to New Hampshire Hospital, Getting Needed Care Composite (member satisfaction) and Maternal Smoking Cessation; and
- Claims Payment and Processing Accuracy.

Area served: Statewide.

Source of funds: Federal financial participation rates range from 50% to 75%. Average funding sources are estimated to be as follows:

- State Fiscal Year 2013: 50.5% Federal Funds and 49.5% General Funds; and
- State Fiscal Years 2014 and 2015: 50.2% Federal Funds, 38.4% General Funds and 11.4% Other Funds (County).

In the event that Federal or other funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Nicholas A. Toumpas
Commissioner

BID SUMMARY

Medicaid Managed Care Organization Proposals

	Technical Proposal	Cost Proposal	Total Score
Maximum Possible Score	**70**	**30**	**100**
Vendor			
Granite State Health Plan, Inc.	69.9	27.7	97.6
Boston Medical Center Health Plan, Inc.	70.0	25.9	95.9
Granite Care – Meridian Health Plan of New Hampshire	63.3	30.0	93.3
Anthem Health Plans of New Hampshire Inc.- Matthew Thornton Health Plan, Inc.	60.2	27.0	87.2
Network Health, LLC	47.3	25.8	73.1
Aetna Better Health Inc.	40.4	25.3	65.7

Technical Proposal Evaluation Team

- Andrew Chalsma, Administrator, Bureau of Healthcare Analytics and Data Systems, Office of Medicaid Business & Policy, DHHS
- Matthew Ertas, Director, Bureau of Development Services, Division of Community Based Care Services, DHHS
- Doris Lotz, Medicaid Medical Director, DHHS
- Stephen Mosher, Chief Financial Officer, DHHS
- Joyce St. Onge, Administrator, Program Operations, Division of Family Assistance, DHHS
- Erik Riera, Director, Bureau of Behavioral Health, Division of Community Based Care Services, DHHS
- Nancy Rollins, Associate Commissioner, Director of Division of Community Based Care Services, DHHS
- Lisabritt Solsky, Deputy Director, Office of Medicaid Business & Policy, DHHS.
- Rebecca Woodard, Assistant Attorney General, Civil Bureau, NH Department of Justice

Cost Proposal Evaluation Team

- Walter Faasen, Contracts and Procurement Director, Office of Business Operations, DHHS
- Marilee Nihan, Finance Director, Office of Medicaid Business & Policy, DHHS
- Sheri Rockburn, Finance Director, Division of Community Based Care Services, DHHS
- Christine Shannon, Bureau Chief, Planning & Research, Office of Medicaid Business & Policy, DHHS

Contract Negotiation Team

- Kathleen Dunn-Medicaid Director, DHHS
- Walter Faasen, Contracts and Procurement Director, Office of Business Operations, DHHS
- Marilee Nihan, Finance Director, Office of Medicaid Business & Policy, DHHS
- John Wallace, Associate Commissioner, DHHS
- Michael Brown, Senior Assistant Attorney General, Civil Bureau, NH Department of Justice
- Jeanne Herrick, Civil Bureau, NH Department of Justice

Accounting Details For Contract Encumbrance
Medicaid Managed Care
SFY 2013 - SFY 2015

	Boston Medical Center	Granite State	Granite Care – Meridian	Total
SFY2013				
05-95-95-956010-61470000-5000729				
101 Medical Payments to Providers	$190,961,515	$95,480,758	$95,480,758	$381,923,030
05-95-93-930010-71000000-101-500729 (Or To Be Determined)				
Payments to Providers-Disabled				$0
05-95-48-480015-59420000-101-500729 Or To Be Determined				
Payments to Providers-Elderly				$0
	$190,961,515	$95,480,758	$95,480,758	$381,923,030
SFY2014				
05-95-95-956010-61470000				
101 Medical Payments to Providers	$200,500,000	$100,250,000	$100,250,000	$401,000,000
05-95-93-930010-71000000-101-500729 (Or To Be Determined)				
Payments to Providers-Disabled	$119,000,000	$59,500,000	$59,500,000	$238,000,000
05-95-48-480015-59420000-101-500729 Or To Be Determined				
Payments to Providers-Elderly	$130,500,000	$65,250,000	$65,250,000	$261,000,000
	$450,000,000	$225,000,000	$225,000,000	$900,000,000
SFY2015				
05-95-95-956010-61470000				
101 Medical Payments to Providers	$210,500,000	$105,250,000	$105,250,000	$421,000,000
05-95-93-930010-71000000-101-500729 (Or To Be Determined)				
Payments to Providers-Disabled	$125,000,000	$62,500,000	$62,500,000	$250,000,000
05-95-48-480015-59420000-101-500729 Or To Be Determined				
Payments to Providers-Elderly	$137,000,000	$68,500,000	$68,500,000	$274,000,000
	$472,500,000	$236,250,000	$236,250,000	$945,000,000
Total	**$1,113,461,515**	**$556,730,758**	**$556,730,758**	**$2,226,923,030**

Class 101 does not exist today but needs to be established/budgeted for SFY 2014 & 2015