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

Jeffrey A. Meyers
Commissioner

Deborah H. Fournier
Medicaid Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 4344
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

January 13, 2017

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

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Services, to enter into an agreement with Health Services Advisory Group, Inc., Vendor # 226207, 3133 East Camelback Road, Suite 300, Phoenix, Arizona, to implement an evaluation plan for New Hampshire's Medicaid Premium Assistance Program in an amount not to exceed $1,597,777.00, effective upon Governor and Executive Council approval through December 31, 2019. 50% Federal/ 50% Other Funds.

Other Funds being used are non-general funds, including voluntary contributions deposited into the New Hampshire health protection trust fund from the Foundation for Healthy Communities and any other contributing charitable foundation as outlined at RSA 126-A:5-c and assessments collected by the New Hampshire Health Plan as outlined at RSA 404-G:2 and RSA 404-G:5-a, IV(b) and (c).

Funds are available in State Fiscal Year 2017, and are anticipated to be available in State Fiscal Years 2018, 2019, and 2020 upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts between State Fiscal Years through the Budget Office without further approval of the Governor and Executive Council, if needed and justified.

05-095-047-470010-30990000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, NH HPP TRUST FUND

State Fiscal Year	Class/ Object	Class Title	Budget
2017	102-500731	Contracts for Program Services	$258,437.00
2018	102-500731	Contracts for Program Services	$529,497.00
2019	102-500731	Contracts for Program Services	$540,451.00
2020	102-500731	Contracts for Program Services	$269,392.00
		Total:	**$1,597,777.00**

EXPLANATION

The purpose of this request is to fund the evaluation of New Hampshire's Health Protection Program Premium Assistance Demonstration waiver, 11-W-00298/1, which is required by the Special Terms and Conditions of the Demonstration. The Premium Assistance Program was authorized by state law on March 27, 2014 and the subsequent Demonstration Waiver was approved by the Centers for Medicare and Medicaid Services (CMS) on March 3, 2015. The Premium Assistance Demonstration is currently authorized to run through December 31, 2018 and permits New Hampshire to purchase health insurance coverage for low-income, Medicaid-eligible adults from commercial Qualified Health Plans certified for sale on New Hampshire's federally facilitated Marketplace. The Centers for Medicare and Medicaid Services approved New Hampshire's Demonstration evaluation plan on August 22, 2016.

The Contractor must implement the approved evaluation plan, which will explore and explain the effectiveness of the Premium Assistance Program by addressing a range of hypotheses in the Special Terms and Conditions that relate to four broad goals of the Demonstration, which are: continuity of coverage, plan variety, cost-effective coverage, and uniform provider access. The results of the evaluation will be prepared by the vendor in a series of reports required by the Centers for Medicare and Medicaid Services.

This contract was competitively bid. A request for proposals for this service was released on March 31, 2016 and posted to the Department's website. One proposal was received by Health Services Advisory Group, Inc. The vendor's proposal was reviewed and scored by an evaluation team consisting of the Department's Medicaid Director, Chief Medical Officer, and Director of Data Analytics.

Heath Services Advisory Group, Inc. will administer two (2) surveys, one of which will be completed no later than June 30, 2017. The vendor will calculate all measures in the Evaluation Plan, utilizing analytical methods with a rigor that meets the research standards of leading academic institutions and academic journal peer reviews. The vendor will provide recommendations to revise measure specifications where feasible in order to facilitate measure calculations.

The vendor will provide a detailed work plan within 30 calendar days of the contract effective date that includes, but is not limited to all related and accompanying tasks for each activity; timeframes for completing each activity; and identification of the party responsible for completing the activity.

The Contractor will ensure an adequate number of staff are available to perform all required contract services. Personnel will be professionally qualified to perform assigned tasks, and will include a project manager, technical staff, actuarial staff, reporting staff and staff who manage and develop work plans for all reports required in the contract.

Health Services Advisory Group Inc. is certified by the Centers for Medicare and Medicaid Services as an External Quality Review Organization and provides quality evaluation services to 17 different state Medicaid programs. The vendor is also a National Committee for Quality Assurance certified survey vendor and certified compliance auditor. Both of these certifications will enable the vendor to conduct core elements of implementing the evaluation plan for the Premium Assistance Program.

The Division reserves the right to renew the Contract for up to one (1) additional year, subject to the continued availability of funds, satisfactory performance of services, and approval by the Governor and Executive Council.

Based on the vendor's technical expertise and past Medicaid experience, the Department is confident in this organization's ability to successfully implement the evaluation plan within the timeline allotted by the Centers for Medicare and Medicaid Services.

Should the Governor and Executive Council not approve this request, the Department would not be able to meet Centers for Medicare and Medicaid Services requirements for 1115 waiver evaluations for the Premium Assistance Waiver.

Area Served: Statewide

Source of Funds: 50% Other
50% Federal (CFDA #93.778)

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Deborah H. Fournier, Esq.
Medicaid Director

Approved by:

Jeffery Meyers
Commissioner

New Hampshire Department of Health and Human Services
Office of Business Operations
Contracts & Procurement Unit
Summary Scoring Sheet

Premium Assistance Program Evaluation Plan Implementation	RFP-2016-OQAI-01-PREMI
RFP Name	RFP Number

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Health Services Advisory Group		300	278
2. 0			
3. 0			
4. 0			
5. 0			
6. 0			
7. 0			

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

February 13, 2017

Jeffrey A. Meyers
Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301-3857

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 contract with Health Services Advisory Group, Inc. for the implementation of an evaluation plan for New Hampshire's Medicaid Premium Assistance Program, as described below and referenced as DoIT No. 2017-054:

> The purpose of this contract is to evaluate the Department of Health and Human Services' Premium Assistance Program, as required by the Centers for Medicare and Medicaid Services. The Premium Assistance Program authorizes low income adults to receive health insurance benefits from a Qualified Health Plan on the insurance marketplace. The program evaluation will measure program costs, member quality of care and member access to care.
>
> The total funding amount is not to exceed $1,597,777.00, and is effective upon the date of Governor and Executive Council approval through December 31, 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/ik
Contract # 2017-054
CC: Bruce Smith, DHHS IT Lead

Subject: Premium Assistance Program Evaluation Plan Implementation (RFP-2016-OQAI-01-PREMI)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name Department of Health & Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301	
1.3 Contractor Name Health Services Advisory Group, Inc.		1.4 Contractor Address 3133 E. Camelback Road, Suite 100 Phoenix, AZ 85016	
1.5 Contractor Phone Number (602) 801-6600	1.6 Account Number 05-095-047-470010-7937	1.7 Completion Date December 31, 2019	1.8 Price Limitation $1,597,777
1.9 Contracting Officer for State Agency Jonathan V. Gallo, Esq Interim Director, Bureau of Contracts and Procurements		1.10 State Agency Telephone Number (603) 271-9246	
1.11 Contractor Signature Mary Ellen Dalton		1.12 Name and Title of Contractor Signatory Mary Ellen Dalton, PhD, MBA, RN Chief Executive Officer	

1.13 Acknowledgement: State of Arizona, County of Maricopa

On Dec 22, 2016, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

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

1.13.2 Name and Title of Notary or Justice of the Peace

Alexandra Lemmer (Bassanetti), Notary Public

1.14 State Agency Signature Date: 1/5/17	1.15 Name and Title of State Agency Signatory Deborah Fournier, Medicaid Director

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

By: Director, On:

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

By: Megan A. Yorke - Attorney On: 1/17/17

1.18 Approval by the Governor and Executive Council *(if applicable)*

By: On:

FORM NUMBER P-37 (version 5/8/15)

Subject: Premium Assistance Program Evaluation Plan Implementation (RFP-2016-OOAI-01-PREMI)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

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

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1.11 Contractor Signature Mary Ellen Dalton		1.12 Name and Title of Contractor Signatory Mary Ellen Dalton, PhD, MBA, RN Chief Executive Officer	

1.13 Acknowledgment: State of Arizona, County of Maricopa

On Dec 28, 2016, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

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

1.13.2 Name and Title of Notary or Justice of the Peace

Alexandra Lemmer (Bassanetti), Notary Public

1.14 State Agency Signature Date: 1/5/17	1.15 Name and Title of State Agency Signatory Deborah Fournier, Medicaid Director
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:	Director, On:
1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: Megan A. York-Kenney	On: 1/17/17
1.18 Approval by the Governor and Executive Council *(if applicable)* By:	On:

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

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

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

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials MED
Date 12-22-16

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

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.
9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

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

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

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

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

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials MED
Date 12-22-16

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

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

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

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

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

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

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

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

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

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

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

Contractor Initials MED
Date 12-22-16

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

1.2. For the purposes of this contract, the study population consists of all beneficiaries covered under Title XIX of the Social Security Act in the State of New Hampshire, ages 19 through 64 years, who are not:

1.2.1. Medically frail.

1.2.2. Incarcerated.

1.2.3. Enrolled in cost-effective employer sponsored insurance.

1.3. For the purposes of this contract, the study populations shall consist of two groups as indicated in Table 1, Study Populations, below.

Table 1, Study Populations

Population	Baseline Period	Evaluation Periods (Interim and Summative Evaluations)
Treatment Group	Bridge Program Members	NHHPP PAP Program Members
Control Group	Medicaid MCO Members	Medicaid MCO Members

1.3.1. **Treatment Group:** For the purposes of this contract, the Contractor shall ensure the **Treatment Group** includes individuals enrolled in the New Hampshire Health Protection Program (NHHPP) Premium Assistance Program (PAP), preferably for a minimum of three (3) consecutive months, as members who are either:

1.3.1.1. Childless adults between the ages of 19 through 64 with incomes at or below 133% of the Federal Poverty Level (FPL) who are not:

1.3.1.1.1. Enrolled in, or eligible for, Medicare;

1.3.1.1.2. Incarcerated;

1.3.1.1.3. Medically frail; or

1.3.1.1.4. Eligible for cost-effective employer sponsored insurance;

1.3.1.2. Parents between the ages of 19 through 64 with a child receiving NH Medicaid, with incomes at or below 133% of the FPL who are not:

1.3.1.2.1. Eligible for standard NH Medicaid under the Parent Caretaker Relative Category;

1.3.1.2.2. Enrolled in, or eligible for, Medicare;

1.3.1.2.3. Incarcerated;

1.3.1.2.4. Medically frail; or

1.3.1.2.5. Eligible for cost-effective employer sponsored insurance;

1.3.2. **Control Group:** For the purposes of this contract, the Contractor shall ensure a propensity score-based matching analysis is performed to identify a non- Bridge/PAP population for comparison purposes, as described in Exhibit A-1, **Control Group** Identification. The control group shall include managed care plan (MCP) member who were:

1.3.2.1. Never enrolled in Bridge or PAP programs.

1.3.2.2. Continuously enrolled in a single MCP for a minimum of three (3) months during the evaluation period(s).

1.4. For the purposes of this contract, the Department shall provide data from the following sources to the Contractor:

1.4.1. New Hampshire's Comprehensive Health Care Information System (CHIS), NH's all payer claims database—commercial data and QHP data;

1.4.2. New Hampshire's Medicaid Management Information System (MMIS)—fee for service and MCO encounter data;

1.4.3. All-payer Hospital Data;

1.4.4. New Hampshire Medicaid financial data; and

1.4.5. Consumer Assessment of Healthcare Providers and Systems (CAHPS) results for the baseline of newly eligible members of the Bridge Program, provided by DHHS.

1.5. For the purposes of this contract, the Contractor shall ensure appropriate data use agreements are in place to access the data referenced in Section 1.4, above.

1.6. The Contractor shall not release and make public statements or press releases concerning the program without prior consent of the Department.

1.7. The Contractor shall comply will all Federal and State Medicaid Statutes, Regulations, and Policies including but not limited to:

1.7.1. The assurance of 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].

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

1.7.3. Related rules: Title 42 Chapter IV;

1.7.4. 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);

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

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

1.7.7. Regulations promulgated thereunder: 42 CFR 457;

1.7.8. 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;

1.7.9. Patient Protection and Affordable Care Act of 2010;

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

1.7.11. State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26; and

1.7.12. American Recovery and Reinvestment Act.

2. Statement of Work

2.1. The Contractor shall utilize the Waiver Evaluation Design Plan to evaluate the NHHPP PAP in accordance with Exhibit A-2, 2016 New Hampshire Health Protection Program Premium Assistance Program Waiver (NHHPP PAP) Waiver Evaluation Design Plan.

2.2. The Contractor shall provide support to the Department in order for the Department to be in compliance with the Centers for Medicare and Medicaid Services (CMS) General Reporting, Evaluation, and Monitoring requirements, as outlined in the Special Terms and Conditions (STC), of the CMS approved Section 1115 Demonstration, entitled "New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration" (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf) .

2.3. The Contractor shall review, analyze, and organize available data described in Section 1.4, above.

2.4. ***DATA COLLECTION:*** The Contractor shall administer two (2) CAHPS surveys, one of which shall be completed no later than June 30, 2017 and the other of which shall be completed no later than June 30, 2018, both of which shall be administered in coordination with the timeframes of Medicaid Managed Care Organization CAHPS surveys. The Contractor shall:

2.4.1. Administer adult surveys for the Premium Assistance Population and the Medicaid Managed Care Population, utilizing a CAHPS certified vendor.

2.4.2. Ensure surveying and reporting conforms to National Committee for Quality Assurance (NCQA) CAHPS protocols, as appropriate.

2.4.3. Comply with Department policies and procedures that outline the CAHPS survey and reporting process.

2.4.4. Manage the actual timeline for the survey project in partnership with the Department and in consideration of any changes mandated by NCQA.

2.4.5. Ensure survey staff work closely with the Department to:

2.4.5.1. Review the supplemental questions detailed in the evaluation plan.

2.4.5.2. Ensure appropriate question wording, response options, and placement to minimize bias.

2.4.6. Implement enhancements to the mail protocol to maximize response rates by using a mixed (mail/Consumer Assisted Telephone Interviewing [CATI]) mode in accordance with the CMS document identified in Section 2.2, above.

2.4.7. Use custom software within the CATI system to review the calling history of each number and analyze the patterns of call dispositions.

2.4.8. Ensure all CATI interviewers are trained in refusal conversion techniques, in order to increase response rates and provide additional reliable and valid data.

2.4.9. Provide the Department with weekly survey disposition reports that contain information about the survey responses received to date, which include but are not limited to the number of:

2.4.9.1. Mail responses.

2.4.9.2. Bad addresses.

2.4.9.3. Ineligible clients.

2.4.9.4. Telephone responses.

2.4.10. Produce stand-alone reports with tables that indicate response rates and demographic characteristics of the respondent samples.

2.4.11. Collaborate with the Department to determine the preferred survey format and content, including geographical comparisons of the program-level results to NCQA's national data and overall star ratings, where appropriate.

2.5. ***Transferring, Receiving, Protecting, and Storing Data*** The Contractor shall preserve the confidentiality, integrity, and accessibility of State of NH data with administrative, technical, and physical information security controls and measures that conform to all applicable federal, state, and industry standards, such as NIST 800-53v4; which the Contractor applies to its own information processing environment; and ensures the same is applied any other subcontractor information processing environments utilized to process or store State of NH protected data. The Contractor shall:

2.5.1. Understand Medicaid data and processing protocols and ensure that all resources assigned to perform contract services follow federal regulations and shall not use Medicaid data for any purposes outside the scope of this contract without the express written consent of the Department.

2.5.2. Comply with appropriate security to include procedures defined in HIPAA and the Health Information Technology for Economic and Clinical Health Act. All transactions designed for the storage and retrieval of the information shall meet these requirements.

2.5.3. Ensure any and all electronic transmission or exchange of any State of NH data shall be secured using Secure File Transfer Protocols using no less than 128bit encryption and appropriate transfer mechanisms.

2.5.4. Provide a secure FTP Site for Data Exchange between the Department and the Contractor.

2.5.5. Provide a data portal for secure data exchange which shall provide role-based access designed for the secure transfer of data, files, and reports.

2.5.6. Ensure all current employees are trained in HIPAA compliance and are aware of their responsibilities to protect PHI and other confidential information. Prior to gaining access to confidential information and each year thereafter, all Contractor employees and subcontractors who have access to confidential information shall be required to sign a confidentiality/nondisclosure agreement as part of the Contractor's assignment to provide contract services.

2.5.7. Ensure the secure storage of the Department-provided data, ensuring any storage media is encrypted, locked, and retains control of access of any storage areas and or facility.

2.5.8. Ensure all facilities and offices have appropriate layers of physical access controls and monitoring ensuring access is restricted to authorized personnel only.

2.5.9. Ensure daily operations include policies for ensuring that confidential information is secured at the end of the duty day to prevent inadvertent disclosure to unauthorized personnel.

2.5.10. Ensure confidential information in paper form is stored in a separate, secure room or in locked file cabinets, accessible to authorized personnel only. Any data authorized for destruction shall be destroyed according to Federal, State, and industry standards and certified and documented in writing by the data destruction agent.

2.5.11. Ensure all data, and any copies thereof, is returned to the Department upon Department request, or no later than contract expiration, whichever occurs first, unless otherwise instructed by the Department to destroy copied data.

2.5.12. Ensure continuous control of security access to confidential or protected information, and to ensure that individual accesses are immediately removed or adjusted for any individual whose employment status or positions have changed.

2.6. ***MEASURE CALCULATION:*** The Contractor shall calculate all measures in the Evaluation Plan, utilizing analytical methods described in Exhibit A-3, Analytic Methods, with a rigor that meets the research standards of leading academic institutions and academic journal peer reviews. The Contractor shall:

2.6.1. Provide recommendations to revise measure specifications where feasible in order to facilitate measure calculation.

2.6.2. Recommend selection of different measures in lieu of limited measures to support the goals of the waiver evaluation, as necessary.

2.6.3. Consider Department recommendations to select different measures in lieu of the limited measures to support the goals of the waiver evaluation.

2.7. ***REPORTING:*** The Contractor shall prepare and deliver the following reports to the Department, in accordance with the schedule described in Exhibit A-4:

2.7.1. **Quarterly Reports for CMS (STC 80)** – The Contractor shall provide quarterly reports on all contract activities. The Contractor shall ensure:

2.7.1.1. The reports provide sufficient information so that CMS is able to understand implementation progress of the demonstration and the progress toward the goals of the demonstration.

2.7.1.2. Each report addresses key operational and other challenges, reason for the challenges, and how the challenges will be addressed for the following quarter.

2.7.1.3. Each report identifies key achievements and the reason (e.g. conditions & efforts) for the achievements.

2.7.1.4. Quarterly report drafts are submitted to the Department no less than two (2) calendar weeks prior to the CMS deadline for Department review.

2.7.1.5. The first quarterly report for the July to September 2016 period.

2.7.2. **CAHPS Reports** – The Contractor shall develop a stand-alone CAHPS report for each of the surveys outlined in Section 2.4 following the timeframes for CAHPS surveys conducted by the NH Medicaid Managed Care Organizations;

2.7.3. **Rapid Cycle Reports to CMS (STC 82)** The Contractor shall develop a rapid cycle reporting consistent with the Evaluation Plan. The Contractor shall submit:

2.7.3.1. An outline of the report to the Department no later than two (2) months prior to the CMS deadline.

2.7.3.2. A draft of the report to the Department no less than thirty (30) calendar days prior to the CMS deadline.

2.7.4. **Interim Evaluation Report for CMS (STC 70)** – The Contractor shall develop an interim evaluation report that includes the core components identified in the Final Summative Evaluation Report in Section 2.7.5. The Contractor shall:

2.7.4.1. Submit a detailed outline of this report to the Department at least six (6) months prior to the CMS deadline.

2.7.4.2. Submit the first draft of the report to the Department no less than three (3) months prior to the CMS deadline.

2.7.4.3. Follow the methodology of the PAP Evaluation Interim Evaluation below, unless otherwise specified by the Department:

PAP Evaluation Interim Evaluation	
Baseline Year Dates	**Evaluation Year Dates**
Non-Survey Based: 1/1/2015 – 12/31/2015 **Survey Based:** Results from CAHPS 2015 administration	**Non-Survey Based:** 1/1/2016 – 12/31/2016 **Survey Based:** Results from CAHPS 2017 administration

2.7.5. **Summative Evaluation Report for CMS (STC 71)** – The Contractor shall develop a report that includes analysis of data from the Demonstration. The Contractor shall:

2.7.5.1. Submit a detailed outline of this report to the Department at least six (6) months prior to the CMS deadline.

2.7.5.2. Submit the first draft of the report to the Department no less than three (3) months prior to the CMS deadline.

2.7.5.3. Follow the methodology of the PAP Evaluation Summative Evaluation below, unless otherwise specified by the Department:

PAP Evaluation Summative Evaluation	
Baseline Year Dates	**Evaluation Year Dates**
Non-Survey Based: 1/1/2015 – 12/31/2015 **Survey Based:** Results from CAHPS 2015 administration (some survey based measures will require the use of CAHPS 2017 administration for purposes of comparison	**Non-Survey Based:** 1/1/2017 – 12/31/2017 **Survey Based:** Results from CAHPS 2018 administration

2.7.6. **Final Summative Evaluation Report for CMS (STC 72)** – The Contractor shall develop a final summative evaluation report. The Contractor shall:

2.7.6.1. Submit the first draft of the report to the Department no less than three (3) months prior to the CMS deadline, which shall include but is not limited to the following sections:

2.7.6.1.1. Executive Summary.

2.7.6.1.2. Demonstration Description.

2.7.6.1.3. Study Design.

2.7.6.1.4. Discussion of Findings and Conclusions.

2.7.6.1.5. Policy Implications.

2.7.6.1.6. Interactions with Other State Initiatives.

2.7.6.2. Follow the methodology of the PAP Evaluation Final Summative Evaluation below, subject to change by DHHS:

PAP Evaluation Final Summative Evaluation	
Baseline Year Dates	**Evaluation Year Dates**
Non-Survey Based: 1/1/2015 – 12/31/2015 **Survey Based:** Results from CAHPS 2015 administration (some survey based measures will require the use of CAHPS 2017 administration for purposes of comparison	**Non-Survey Based:** 1/1/2017 – 12/31/2017 **Survey Based:** Results from CAHPS 2018 administration

2.7.7. **Reporting Technical Specifications**: The Contractor shall ensure all reports include:

2.7.7.1. A clearly stated purpose.

2.7.7.2. A clear and logical organizational structure.

2.7.7.3. A logical and orderly presentation of complex ideas.

2.7.7.4. Definitions of medical terms.

2.7.7.5. Explanations of technical language.

2.7.7.6. Definitions of acronyms and initials on first reference.

2.7.7.7. The use of short, clear, concise sentences.

2.7.7.8. The use of active voice.

2.7.7.9. Accurate and complete material.

2.7.8. **CMS Comments** – DHHS will provide CMS comments to the Contractor. The Contractor shall provide drafts to DHHS in response to CMS comments on all reports no less than fifteen (15) calendar days prior to the CMS deadline for responses;

2.7.9. **Analytic and Summary Data Files** – The Contractor shall provide DHHS with its summary and analytic data files used to conduct the evaluation upon request, which shall be:

2.7.9.1. Organized.

2.7.9.2. Clearly labeled.

2.7.9.3. Accompanied by a data dictionary.

2.7.10. **CMS Presentations** – The Contractor shall coordinate with the Department to present the interim, summative and all other requested evaluation reports to CMS during the contract period, as notified by the Department.

2.8. ***PROJECT MANAGEMENT & SUPPORT:*** The Contractor shall provide a work plan, no later than 30 calendar days after the beginning of the contract, which shall include, but not be limited to:

2.8.1. All related and accompanying tasks for each activity.

2.8.2. Timeframes for completing each activity.

2.8.3. The party responsible for completing the activity.

2.9. The Contractor shall host weekly conference calls with Department staff throughout the project period, or as needed upon mutual agreement of the parties.

2.10. The Contractor shall participate in conference calls with CMS, as needed.

2.11. The Contractor shall provide written monthly progress status reports to the Department that include, but are not limited to:

2.11.1. Accomplishments.

2.11.2. Tasks currently being addressed.

2.11.3. Open issues.

2.11.4. Updated decision log.

2.12. The Contractor shall respond to all Department inquiries by email no later than two (2) business days of receiving the inquiry.

3. Staffing

3.1. The Contractor shall ensure an adequate number of staff are available to perform all required contract services. Personnel shall be professionally qualified to perform their assigned tasks and possess the professional certification and licensing that may be legally required. Staff shall include but not be limited to:

3.1.1. A Project Manager who shall to oversee all activities of the contract and be the primary point of contact for all Department inquiries and requests for responsive action.

3.1.2. Technical staff who shall provide oversight and expertise regarding information technology systems and processes.

3.1.3. Actuarial staff who shall produce the cost neutrality evaluation.

3.1.4. Reporting staff who shall compile, prepare and draft technical reports for publication in accordance with the terms of this agreement.

3.1.5. Staff who shall manage and develop work plans for all reports required under this agreement.

3.2. The Contractor shall notify the Department, in writing, of any permanent or temporary changes to or deletions from the Contractor's management, supervisory, and key professional personnel, who directly impact the provision of required services.

3.3. The Contractor shall obtain Department approval prior to enacting any permanent or temporary changes in personnel described in Section 3.2, above.

Exhibit A-1
Control Group Identification

1. IDENTIFYING THE CONTROL GROUP (MCO MEMBERS)

1.1. In order to determine the expected cost and rates for the Bridge population in the absence of the PAP program, a propensity score-based matching analysis will be performed to identify a non- Bridge/PAP population for comparison purposes. The control group (i.e., the non- Bridge/PAP population) will be drawn from managed care plan members who were never enrolled in Bridgeor PAP programs and were continuously enrolled in a single MCP for three months or more during the evaluation period(s).

2. PROPENSITY SCORE-BASED MATCHING STATISTICAL ANALYSIS

2.1. For purposes of determining the expected rates and costs of the treatment group, a non-Bridge/PAP population with characteristics similar to the Bridge/PAP population must be identified. Propensity score-based matching is a common methodology used to select a comparison group that is statistically similar to a treatment group. The following describes the methodology for generating propensity scores, and using those scores to match members in the treatment group (i.e., the Bridge/PAP population) with members in the control group (i.e., the non- Bridge/PAP population).

2.1.1. COVARIATE IDENTIFICATION

2.1.1.1. Demographic and disease covariates will be identified for each member. The following provides a description of each of the covariates and the methods that will identify the covariates. All covariates will be identified during the baseline period, and are expected to be related to the likelihood of a member being enrolled in PAP. It is important to note that the covariates listed in Table 4 and Table 5 provide a starting point for the analysis. The final selection of covariates in the analysis may be refined and could exclude certain covariates identified in Table 4 or Table 5 for a variety of statistical reasons, such as poor predictive capability.

Contractor Initials: MED

Date: 12-22-16

Table 4 – Demographic Covariates

(A list of demographic covariates & methods to be used to identify each covariate)

Covariate	Identification Method
Age	
Age	Member's date of birth will be used to identify the member's age at the end of the baseline period.
Gender	
Male Female	Member's gender in the demographic file.
Geography	
County	County codes in demographic data.
Race	
White Black Other	Members flagged races in demographic data.
Enrollment	
Number of months a member was enrolled in PAP/Medicaid	Eligibility/enrollment files will be used to determine number of months a member was enrolled in PAP/Medicaid.

Table 5 – Disease Covariates

(List of the possible disease covariates that will be incorporated into the propensity scoring methodology. Encounter data will be used to identify members who had a primary diagnosis for any of the diseases listed in Table 5. Each disease will be represented separately as an indicator variable. For example, a member diagnosed with both asthma and hypertension will be flagged as having two disease covariates.)

Disease Covariates			
Asthma	Chronic Obstructive Pulmonary Disease (COPD)	Congestive Heart Failure (CHF)	Coronary Artery Disease (CAD)
Diabetes Mellitus	Hypertension	Obesity	Stroke

Contractor Initials: MEL

Date: 12-22-16

2.1.2. PROPENSITY SCORE MATCHING

2.1.2.1. Propensity scores will be derived to match individuals in the Bridge/PAP and non- Bridge/PAP populations. This will allow the construction of a control group that is most similar to the treatment group (i.e., the Bridge/PAP population) without the use of randomized selection. Thus, the propensity score will be used to reduce biased results and control for multiple confounders. A sensitivity analysis will be conducted to determine the impact of using all the named covariates above on the sample size, relative to using subsets of covariates. The sensitivity analysis will consist of determining the frequency of missing data for each covariate in the Bridge/PAP sample and the potential comparison group. Also, the sensitivity analysis will determine the frequency of missing data among all the covariates. Combinations may be examined to determine the optimal list of covariates to include in order to preserve the sample.

2.1.2.2. The covariates will be used to determine a propensity score for each member. Logistic regression will be used to calculate the propensity score. The equation used for the logistic regression is as follows:

$$\Pr(Y_i = 1) = \frac{1}{1 + \exp[-(\beta_0 + \beta_1 X_{i1} + \beta_1 X_{i2} + \ldots + \beta_k X_{ik})]}$$

(Where $\Pr(Yi = 1)$ is the propensity score, the βs are parameters to be estimated, and the Xs are the covariates.)

Contractor Initials: MGD

Date: 12-22-16

2.1.2.3. After using logistic regression to determine the propensity scores for each member in the Bridge/PAP and non-Bridge/PAP population, a greedy algorithm will be used to match individuals' scores in the Bridge/PAP population to individuals in the non-Bridge/PAP population. This matching methodology will make "best" matches first (i.e., matches on the greatest degree of precision using the most decimal places) and then matches on successive "next-best" matches. This is done in a top-down sequence until no more matches can bemade. A Greedy 5→1 digit match will be used for purposes of matching the populations.6 The Greedy 5→1 digit match means that the populations first will be matched on the propensity score out to the fifth decimal place. For those that do not match, the populations will then be matched on the propensity score out to the fourth decimal place. This will continue down to a one-digit match. Any ties will be matched randomly, and once matched, cases will not be reconsidered.

2.1.3. EVALUATING MATCHED POPULATIONS

2.1.3.1. Matching on propensity scores has been shown to create a "covariate balance," such that the matched population will be similar for all the covariates included in calculating the propensity score.7 Once populations have been matched, the matches will be evaluated to determine that the populations were matched appropriately, meaning that the propensity scoring process improved covariate balance as anticipated. Covariate balance will be assessed by comparing the entire distribution of each covariate for the control group before and after matching against the distribution of each covariate for the treatment group using standardized bias coefficients.

Contractor Initials: MAD

Date: 12-22-16

EXHIBIT A-2, 2016
NEW HAMPSHIRE HEALTH PROTECTION PROGRAM - *PREMIUM ASSISTANCE PROGRAM* WAIVER (NHHPP PAP)

WAIVER EVALUATION DESIGN PLAN

This program is operated under an 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare & Medicaid Services (CMS) on March 4, 2015.

Contractor Initials: MED
Date: 12/22/16

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Contractor Initials: MKD

Date: 12-22-16

Synopsis of New Hampshire Health Protection Program – Premium Assistance Waiver

On March 4, 2015, the New Hampshire Department of Health and Human Services (DHHS) received approval from the Center for Medicare & Medicaid Services (CMS) to develop the New Hampshire Health Protection Program's Premium Assistance Program component as an 1115 Medicaid Demonstration Waiver program. The New Hampshire Health Protection Program (NHHPP) Act includes three components: (1) a mandatory Health Insurance Premium Payment Program (HIPP) for individuals with access to cost-effective employer-sponsored insurance; (2) a bridge program to cover the new adult group in Medicaid managed care plans from August 15, 2014 through December 31, 2015; and (3) a mandatory individual qualified health plan (QHP) premium assistance program (PAP) beginning on January 1, 2016.

In accordance with CMS' waiver requirement, DHHS must develop an evaluation plan for the NHHPP PAP Demonstration waiver no later than 90 days following waiver approval from CMS. The proposed PAP evaluation plan is built on monitoring both process and outcome performance measures that increase in number over the three years potentially available for the waiver due to data varying in collection, processing, and finalization cycles. This increase in available evaluation data over time means that the data available towards the end of 2016 (i.e., first year of the NHHPP PAP) will not be complete and should be considered a first approximation for the first set of monitoring measures, rather than definitive results.

Enrollment activities for the PAP adult population will begin on or before November 1, 2015, depending on whether beneficiaries are enrolled in the Bridge Program. However, regardless of prior enrollment status, Medicaid eligible adults can enroll into health coverage under QHPs and receive premium assistance beginning November 1, 2015, for coverage effective January 1, 2016. This Demonstration will sunset after December 31, 2016 consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5, XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the State to continue the Demonstration and the State provides notice to CMS, as described in the Special Terms and Conditions.[1]

Key Components and Objectives of the QHP PAP

The NHHPP PAP Demonstration will assist the State in its goals to ensure:

[1] Special Terms and Conditions (STC) Document #11-W-00298/1.

1. **Continuity of coverage**—***For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks;***[2]
2. **Plan variety**—***The Demonstration will encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and will encourage QHP carriers to seek Medicaid managed care contracts;***
3. **Cost-effective coverage**—***The premium assistance approach will increase QHP enrollment and result in greater economies of scale and competition among QHPs; and***
4. **Uniform provider access**—***The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.***

New Hampshire's Demonstration evaluation will include an assessment of the following research hypotheses that address the four goals just described:[3]

1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
4. The Demonstration could lead to an increase in plan variety by encouraging health plans in the Medicaid Care Management Program to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management Program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

[2] The NHHPP PAP Demonstration does not include the medically frail population. Members who self-identify as medically frail will be dropped from the program and enrolled in traditional Medicaid. As such, they will be excluded from the evaluation using appropriate methods but will be counted to report on the frequency of self-declaration.

[3] Reordered from STC #69.1 i-xii to correspond with the content and ordering of four goals of the waiver, delineated on pages 2-3 of the Special Terms and Conditions document (pa_termsandconditions.pdf), and consistent with Appendices A, B, and D.

5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.
6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
7. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
9. Premium assistance beneficiaries will have equal or better access to preventive care services.
10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
11. Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.
12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.

The evaluation design, taking into account the four goals and 12 hypotheses outlined above, considers through its performance measures and analysis plan the coverage for the following dimensions of access and quality, as shown in Appendix A:

- Comparisons of provider networks;
- Consumer satisfaction and other indicators of consumer experience;
- Provider experience; and
- Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes.

Each of these four aspects of access and quality is associated with specific measures tied to the 12 research hypotheses and are listed in Appendix A. Appendix A illustrates the relationship between the research hypotheses and Demonstration goals, while Appendix B addresses the specific measures used to evaluate each of the 12 research hypotheses.

The core purpose of the evaluation is to determine the costs and effectiveness of the NHHPP PAP, when considered in its totality, and taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes. The evaluation will explore and explain the effectiveness of the Demonstration for each research hypothesis, including total costs in accordance with the evaluation design as approved by CMS. As shown in Appendix B, each research hypothesis includes one or more evaluation measures. Wherever feasible, each measure will be in a standardized form comparable to and compared against national values.

Included in the evaluation will be examinations of NHHPP PAP performance on a set of access and clinical quality measures against a comparable population in the New Hampshire Medicaid Care Management Program. These measures will be taken from the list of required data fields for the claims submitted by each QHP for each PAP recipient. The State will compare costs (i.e., total, administrative, and medical) under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. In this case, the evaluation will compare the costs of the PAP program to the estimated costs if that population would have remained in the Bridge program, which was created for Medicaid expansion.

The cost comparison will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses. The State will assess access and quality for the NHHPP PAP beneficiaries and Medicaid beneficiaries in managed care to ensure appropriate services are provided to the PAP beneficiaries. Moreover, to the extent possible, component contributions to changes in access and quality and their associated levels of investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.[4] Both cross-sectional and sequential cross-sectional analyses will be used, depending on the whether the measure is across one point in time or multiple points in time, along with the specific research hypothesis being addressed.

The operational details for the PAP evaluation are contained in the following four appendices:

- Appendix A – Evaluation Components
- Appendix B – Research Hypotheses, Groups, and Associated Methodologies
- Appendix C – Milestones and Timeline
- Appendix D – Rapid Cycle Assessment Measures

[4] To access and utilize administrative cost information, the non-encounter cost information will be generated by the State and provided to the evaluation contractor, as needed.

Before addressing the 12 research hypotheses and associated measures, the next section of the PAP evaluation plan defines the study and comparison groups, data sources, analytic methods, and limitations to the evaluation of the PAP Demonstration.

Study Population

The study population consists of all beneficiaries covered under Title XIX of the Social Security Act in the State of New Hampshire from 19 years through 64 years of age who are not medically frail, incarcerated, or enrolled in cost-effective employer sponsored insurance and who are enrolled in Medicaid managed care.[5] This study population will be divided into two groups to operationalize the evaluation—i.e., the study group and the comparison group.

Study Group

The study group is the NHHPP PAP group and consists of beneficiaries covered under Title XIX of the Social Security Act who are either:

1) Childless adults between the ages from 19 through 64 with incomes at or below 133 percent of the federal poverty level who are neither enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance or
2) Parents between the ages of 19 through 64 with incomes between 38 percent (for non-working parents) or 47 percent (for working parents) and 133 percent of the Federal Poverty Level and who are not enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance

The NHHPP PAP membership is estimated to contain approximately 45,000 beneficiaries.[6]

Comparison Groups

Two comparison groups are needed for this evaluation. The sequential cross-sectional comparison group (used in longitudinal analyses) consists of newly eligible members of the Bridge Program, most of whom will be eligible for the PAP program the following year. The Bridge Program is a transition program that enrolled Medicaid expansion beneficiaries into New Hampshire's Medicaid managed care program beginning in

[5] Coverage and delivery of benefits to eligible members are consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119.

[6] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf , Page 9 of 146. Last accessed on May 28, 2015.

August 2014. Assuming these beneficiaries remain eligible, Bridge Program members will be automatically enrolled in the PAP program in January 2016 leading to substantial overlap between the two populations. As such, the Bridge Program comparison group includes members enrolled in the Bridge Program beginning in August 2014 through December 31, 2015.

The non-PAP comparison group for all measures, except those derived through survey instruments,[7] consists of a statistically matched group of Title XIX beneficiaries in the State in parent/caretaker eligibility groups from 19 through 64 years of age who are not in the study group, not disabled, or incarcerated, and who are enrolled in a Managed Care Organization (MCO), updated at each measurement time.[8] The comparison group is estimated to contain between 12,000 and 15,000 beneficiaries, depending upon the number lost through the statistical matching process.[9] This group provides a baseline frame of reference for expected changes over time to assess the PAP program and its changes over time in subsequent years, if the PAP is continued. The start for this group's data should coincide with the start of the Bridge Program and its data.

Specifically for the cost-effectiveness analyses, the comparison group will consist of a statistically derived cohort of beneficiaries and their estimated costs if the Bridge Program were continued. The analysis will estimate what this population would have cost if the Bridge program continued past December 31, 2015, adjusting for items such as medical cost trend, demographic differences, acuity differences, and changes to targeted Bridge program provider reimbursement levels.

The evaluation of the Demonstration will be performed using rigorous actuarial and statistical methods to assess whether the beneficiaries in the NHHPP PAP are doing as well or better than in the Bridge program on the various measures in the evaluation. The population enrolled in the Bridge program will have very similar characteristics to the population enrolled in the PAP program, but the methodology will also use statistical matching techniques to ensure the populations used for comparison are as similar as possible. The analysis will compared the actual experience of the Bridge program population (trended and adjusted to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program. The methodology will be designed to determine the extent to which observed differences are statistically significant and meaningful to assess the research goals of the Demonstration.

[7] The evaluation contractor may use the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey or CAHPS-like survey for the intended data source. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[8] Statistical matching will be validated through a discriminant analysis with power set at approximately .8 for the comparison between groups on a set of criteria determined in coordination with subject matter experts.

[9] Email from Andrew Chalsma, Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services to Debra L. Chotkevys, Director, Professional Services, Health Services Advisory Group, Inc., on May 27, 2015.

Data Sources

New Hampshire is in the process of finalizing Memorandums of Understanding (MOU) with the QHPs for their participation in the PAP. While the MOUs are not yet signed, the Department and the QHPs have agreed on the terms that require the QHPs to provide encounter data to the state. The QHPs will submit data to the Department using the format and quality requirements of the State's Comprehensive Health Care Information System (CHIS), New Hampshire's All Payer Claims Database. Because the submission of data to the CHIS is a legal requirement to be a carrier in New Hampshire, the QHPs are already obligated to process and format the data according to the CHIS requirements. Existing CHIS data quality assurance processes will be employed to ensure the data are complete and of high quality. The QHPs will need to submit a separate duplicate feed for PAP members, because the CHIS data normally contain encrypted identifiers. The separate CHIS-like file the QHPs will provide to the Department will contain identifiers including member Medicaid ID which will allow linking the data to Medicaid membership and claims.

DHHS and its evaluation contractor will use multiple sources of data to assess the 12 research hypotheses. The data collected will include both administrative and survey-based data (e.g., CAHPS, CAHPS-like, telephonic information gathering). Administrative data sources include information extracted from DHHS's Medicaid Management Information System (MMIS), the State's Comprehensive Health Care Information System (CHIS), and the State's All-payer Hospital database. The three data sources are used to collect, manage, and maintain Medicaid recipient files (i.e., eligibility, enrollment, and demographics), fee-for-service (FFS) claims, and managed care encounter data. These data bases serve as central repositories for significant portions of the data DHHS will use to mine, collect, and query while addressing the 12 research hypotheses. DHHS and its evaluation vendor will work together with key data owners to ensure the appropriate data use agreements are in place to obtain the data. Data sharing Memorandums of Understandings (MOU) will be initiated with entities to allow access to and use of Medicaid claims and encounters, member demographics and eligibility/enrollment, and provider data.

Administrative Data

New Hampshire's Demonstration evaluation offers an opportunity to synthesize information from several data sources to determine the impact of the NHHPP PAP. The administrative data sources—i.e., CHIS, MMIS (including member, provider, and enrollment data), the All-payer Hospital databases—are necessary to address the 12 research hypothesis outlined in the evaluation design. Each measure (see Appendix B) associated with each research hypothesis lists the data source(s) used in addressing it. Three key fields that must be present to conduct the evaluation include the date of birth (for defining the study populations and some individual measures), a flag to identify whether a Medicaid recipient is enrolled in the PAP, and a flag to identify if the recipient is in a traditional Medicaid managed care.

Use of FFS claims and managed care encounters will be limited to final, paid status claims/ encounters. Interim transaction and voided records will be excluded from all evaluations, because these types of records introduce a level of uncertainty (from matching adjustments and third party liabilities to the index claims) that can impact reported rates.

CHIS

"The New Hampshire Comprehensive Health Care Information System (CHIS) was created by NH statute to make health care data 'available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.'"[10] The same legislation that created the CHIS also enacted statutes that mandated health insurance carriers to submit encrypted health care claims data and Health Employer Data and Information Set (HEDIS®[11]) data to the State. As a result, CHIS data will be useful in calculating several of the measures used in the Demonstration evaluation.

MMIS

Not all data required for the evaluation will be in the CHIS database. As such, access to Medicaid claims and encounters will be required to optimize the information available to calculate the various measures. In general, Medicaid encounters are received and processed by the State's fiscal agent on a weekly basis with a historical 'run-out' of three months. In addition to service utilization data, the NHHPP PAP evaluation will require access to supplemental Medicaid data contained in the State's MMIS—e.g., member demographics, eligibility/enrollment, and provider information.

New Hampshire Medicaid began processing managed care encounter data in July of 2015. New Hampshire is employing a three-fold strategy to ensure completeness and accuracy of the encounter data: 1) New Hampshire's Medicaid managed care contracts contain robust requirements for timeliness, completeness and accuracy with the possibility of liquidated damages if the standards are not met; 2) New Hampshire's encounter data processing solution pseudo adjudicates encounters through the State's MMIS applying many of the same quality edits employed for FFS claims; and 3) New Hampshire has availed itself of the optional EQRO activity of Encounter Data Validation (current EQRO contract includes activity and EQRO is currently implementing a EDI based solution for loading the data as part of validation). Because the processing of the data only began recently, NH does not yet have summary analysis on data quality. However, NH is confident that their strategies will produce valid and reliable data and is committed to that outcome.

[10] New Hampshire Comprehensive Health Care Information System. https://nhchis.com. Last accessed on May 26, 2015.
[11] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Member Demographics—Member data are used to assess member age, gender, and other demographic and economic information required for the calculation of specific measures. For example, member demographics are used to determine member's age in order to define the comparison group relative to the distribution of the population in the study group. Additionally, fields such as gender will be used for the prenatal and postpartum measures. Finally, key financial data will be used when assessing gaps in coverage.

Eligibility/Enrollment—The eligibility/enrollment file will also be used create the study and comparison groups, as well as the assessment of health insurance and enrollment gaps.

Provider—Provider data, such as office location and specialty, will be used to assess the availability of services for both study and comparison groups.

All-payer Hospital Data

All-payer Hospital Data will be used to generate baseline data on new enrollees to the NHHPP PAP. As newly enrolled members, data for this population will not be available in other State data sources since many of the NHHPP PAP beneficiaries will be new to Medicaid.

Consumer Surveys

CAHPS and/or CAHPS-like surveys will be used to assess satisfaction with provided health care services.[12] These instruments will include specific survey items designed to elicit information that address research hypotheses regarding members' continuity of health care coverage and health plan market diversity.

One option is for the State to work with New Hampshire's CAHPS vendor to seek approval from NCQA to supplement its annual CAHPS administration to include three evaluation-specific questions. These questions will be designed to capture elements of the waiver STCs that cannot be addressed through administrative data or currently collected survey items. These three items will address the following concepts:

1) Continuity in member health insurance coverage—research hypothesis 1 states that premium assistance beneficiaries will have equal or fewer gaps in health insurance coverage.
2) Continuous access to the same health plan—research hypothesis 2 states that premium assistance beneficiaries will have access to the same health plans and maintain continuous access to the same providers.

[12] Depending on the State's CAHPs vendor and survey logistics related to adding items to the annual CAHPS survey, DHHS may decide to administer a CAHP-like custom survey to maximize applicability to the study population and increase the likelihood of return.

3) Continuity in plan enrollment—research hypothesis 3 states that premium assistance beneficiaries will have equal or fewer gaps in plan enrollment leading to equal or greater continuity of care.

In choosing the potential responses for each of the three questions being proposed, the response categories will mimic other response categories used on the CAHPS form, such as the degree of respondent agreement with a statement or a Yes/No response. The final wording for each of the proposed items will be submitted to NCQA for review after collaboration with the State and its CAHPS vendor.

The CAHPS vendor is aware that the State is interested in comparing its Medicaid populations. For 2015, the CAHPS vendor has already prepared separate surveys for the NHHPP population and for the traditional Medicaid population. If the evaluation continues in successive years, the vendor will also separate the Medicaid population into three groups making the comparisons in this evaluation possible--i.e., the traditional managed care group, the NHHPP group, and the NHHPP PAP group.

An alternative option would be for the evaluation contractor to deploy an independent survey that is structured in a similar manner to CAHPS but could be administered in a more strategic and targeted manner than would normally be possible for CAHPS. This type of survey would capture the information required by each of the eight evaluation measures currently citing CAHPS as a potential data source.

Analytic Methods

The evaluation reporting will meet traditional standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation (e.g., for the evaluation design, data collection and analysis, and the interpretation and reporting of findings). The Demonstration evaluation will use the best available data, will use controls and adjustments where appropriate and available, and will report the limitations of data and the limitations' effects on interpreting the results. All research hypotheses and methods will incorporate results from sensitivity, specificity, and power analyses to ensure the validity of the evaluation findings. Lastly, the evaluation will discuss the generalizability of results in the context of the limitations.

As outlined earlier, the existence of the Bridge Program creates a unique comparison group for understanding various aspects of the Demonstration's research hypotheses. In order to ensure the appropriateness of comparisons, preliminary population profile reviews will be conducted on the Bridge and NHHPP PAP populations. These analyses will confirm key assumptions regarding the similarities and overlap in these populations on key demographic characteristics and serve as a foundation for future discriminant analyses and statistical matching. Furthermore, rates of enrollment (i.e., speed in reaching the eligible populations) will be assessed and compared for the Bridge Program and NHHPP PAP populations. As a result of the unique transition from Bridge Program to NHHPP PAP program, two distinct approaches to the analyses will be used

in order to maximize the retention of beneficiaries in each group over time. Specifically, the evaluation analyses will include the following methods.

1. **Cross-sectional Analysis:** These analyses examine results for selected measures for two different groups at the same point in time. For example, cross-sectional analyses will be used to evaluate NHHPP PAP members' access to certain services versus non-NHHPP PAP MCO members' access.
2. **Sequential, Cross-sectional Analysis:** These analyses will include both *single group* and *multiple group* evaluations of multiple measures over time. Single group evaluations involve pre- and post-testing of a population that is conceptually longitudinal but changes some percentage of its membership each year, such as the Medicaid population. Multiple group evaluations involve pre- and post-testing for all evaluation groups to create difference scores that are then compared across groups.

Both comparative methods will be used in the following NHHPP PAP evaluation. The specific choice of methods depends on the measure under discussion and the theoretical and empirical implications for policy-relevant and defensible results. For this reason, the specific comparative method is detailed within each of the measures used in the evaluation (See Appendix B and Appendix D). If the Demonstration is continued for an additional one or two years, the measures are also continued using the analogously extended groups (i.e., Bridge becomes NHHPP PAP and 'becomes' NHHPP PAP for three cycles of measurement).

The three main analytic methods used to determine whether the beneficiaries in the NHHPP PAP are doing as well or better than Medicaid beneficiaries in the traditional Medicaid managed care program on the various measures in the evaluation are the t-test, the z-test, and discriminant analysis. The t-test will be used for pre-post single group methods of assessment (e.g., sequential cross-sectional) as well as for cross-sectional comparisons of two groups at one point in time. A z-test will be used for comparative sequential cross-sectional designs where a difference-in-differences approach (i.e., absolute or relative) is applied, depending on the measures and scales used for their assessment. A discriminant analysis will also be used to ensure that Non-PAP comparison group is appropriately and statistically matched to the study population.

In situations where neither the t-test nor z-test is appropriate (e.g., a need to risk-adjust), a fourth method, multiple regression analysis, will be used to determine the size of group differences through the grouping variable in the model. This method has a long history of generating empirically robust results when the evaluation model is correctly specified. The evaluation contractor will utilize clinical subject matter experts (SMEs) when building multivariate models and identifying relevant control variables.

The cost-effectiveness portion of the evaluation examines costs in three ways: total and the medical and administrative components that, when summed, represent total healthcare costs. As a result, all costs (and credits) are required to fit into either the

medical or the administrative category. Both of the cost-effectiveness measures are reported in these three ways. There are three annual measures (i.e., 3-3, 7-1, and 7-2) and three rapid-cycle quarterly measures (i.e., CEC-1, CEC-2, and CEC-3) used assess the cost-effectiveness of the Demonstration. To do so, the costs (i.e., total and breakdown for medical and administrative) will be tracked for comparing actual NHHPP PAP costs to the estimated costs if the Bridge program were continued. After evaluating the available data, these comparisons may be modified or additional cost effectiveness comparisons may be developed if they are deemed to further the research goals of the Demonstration.

Finally, where appropriate, supplemental analyses will be conducted to further investigate and understand the impact of the NHHPP PAP program. These analyses may include plan-based comparative findings as well as the stratification of results by key demographic and/or programmatic characteristics. When possible, evaluation results will incorporate national or state-defined standards and/or benchmarks for comparison purposes. Together, the findings from these sub-group analyses will further inform the State regarding the impact of the NHHPP PAP program.

Process/Outcome Measures

When possible, process measures will be used since they do not require any form of risk adjustment beyond eligibility. The reason is related to the nature of process measures in that the 'processes' are required for anyone who meets the inclusion and exclusion criteria for the measure. Theoretically, a process measure should be able to reach 100 percent among the eligible populations.

Outcome measures often require some form of risk adjustment or stratification. Certain demographic characteristics must be stratified for CMS reporting, such as race, rather than used as a risk-adjustment variable in a multivariate model. For comparison purposes, a comparison group is formed from the non-PAP MCO Medicaid beneficiaries such that a discriminant analysis with policy-relevant predictor variables cannot distinguish group membership beyond randomness, with statistical power set to approximately .8 for the comparison.

Comparative Statistics

The t-tests (and z-tests where appropriate) will be used to assess whether any differences found between the study and comparison groups are statistically significant (i.e., unlikely to have occurred in the data through random chance alone). The traditionally accepted risk of error ($p \leq .05$) will be used for all comparisons. If risk adjustment is used, p-values will be generated through multiple regression analysis and assessed against the same critical p-value.

Limitations

The limitations surrounding this evaluation center on the lack of truly comparative data for the NHHPP PAP members for outcome variables in the first year of the Demonstration beyond the All-payer Hospital data. When a new and empirically different group is added to Medicaid, there is often no comparison group with data to assess potential programmatic differences between the new group and the effects of joining the ongoing Medicaid program, instead. As a result, assumptions on comparability are sometimes made that lack empirical evidence for support or that have somewhat inconsistent evidence of comparability.

Additionally, little or no data will exist in sufficient time for the New Hampshire legislature to decide whether it will continue the NHHPP PAP past its first year of operation. This situation will require the State legislature to make program decisions without the knowledge and support of the first annual evaluation of the program, or from the interim evaluation conducted after full implementation of the Demonstration.

Following its annual evaluation of the NHHPP PAP and subsequent synthesis of the results, DHHS and its evaluation vendor will prepare a report of the findings and how the results compare to the research hypotheses. Both the interim annual reports and the final summative evaluation report will be produced in alignment with STCs and the schedule of deliverables listed in Table 1 below. (See Appendix C for a detailed timeline.) Following approval to continue the NHHPP PAP in Year 2 and Year3 by the New Hampshire State Legislature, the schedule of deliverables will be updated to reflect additional reporting requirements.

Table 1—Schedule of Deliverables for the NHHPP PAP Waiver Evaluation

Deliverable	Date
NHHPP PAP Evaluation Design (STC #66)	
DHHS submits PAP Waiver Evaluation Methodology to CMS	6/4/2015
DHHS to post PAP Waiver Evaluation Methodology on the State's website for public comment	6/4/2015
DHHS to post final approved Evaluation Design on the State's website within 30 days of approval by CMS	On or before 10/15/2015
DHHS presentation to CMS on approved Evaluation Design (STC #73)	As Requested
Demonstration Year 1	
Quarterly: DHHS to report progress of Demonstration to CMS (STC #82)	30 days after the quarter
If Demonstration Continued, Interim Annual Evaluation Report (STC #70)	3/31/2017
If Demonstration Ended, Preliminary Summative Evaluation Report (STC #71)	6/29/2017
If Demonstration Ended, Final Summative Evaluation Report (STC #71)	12/31/17
DHHS presentation to CMS on Final Summative Evaluation Report (STC #73)	As Requested

Each evaluation report will present findings in a clear, accurate, concise, and timely manner. At minimum, all written reports will include the following six sections: Executive Summary, Demonstration Description, Study Design, Findings and Conclusions, Policy Implications, and Interactions with Other State Initiatives. Specifically, the reports will address the following:

1) The **Executive Summary** concisely states the goals for the Demonstration, the evaluation questions and hypotheses tested in the report, and updates on questions and hypotheses scheduled for future reports. In presenting the key findings, budget neutrality and cost-effectiveness will be placed in the context of policy-relevant implications and recommendations.

2) The **Demonstration Description** section focuses on programmatic goals and strategies, particularly related to budget neutrality and cost-effectiveness. The section succinctly traces the development of the program from the recognition of need to the present degree of implementation. This section will also include a discussion of the State's roll-out of the NHHPP PAP program along with its successes and challenges.

3) The **Study Design** section contains much of new information in the report. Its five sections include: evaluation design with the 12 research hypotheses and associated measures, along with the type of study design; impacted populations and stakeholders; data sources that include data collection field, documents, and collection agreements; analysis techniques with controls for differences in groups or with other State interventions, including sensitivity analyses when conducted; and limitations for the study.

4) The **Findings and Conclusions** section is a summary of the key findings and outcomes. The section focuses on cost-effectiveness, along with the successes, challenges, and lessons learned from the implementation of the Demonstration.

5) The **Policy Implications** section contains the policy-relevant and contextually appropriate interpretations of the conclusions. This section includes the existing and expected impact of the Demonstration within the health delivery system in the State in the context of the implications for State and federal health policy, including the potential for successful strategies to be replicated in other State Medicaid programs.

6) The **Interactions with Other State Initiatives** section contains a discussion of this Demonstration within an overall Medicaid context and consideration for the long-range planning efforts by the State. This discussion includes the interrelations between the Demonstration and other aspects of the State's Medicaid program, including interactions with other Medicaid waivers, the State Innovation Models (SIM) award, and other federal awards affecting service delivery, health outcomes, and the cost of care under Medicaid.

All reports, including the Evaluation Design, will be posted on the State Medicaid Website within 30 days of the approval of each document to ensure public access to evaluation documentation and to foster transparency. DHHS will notify CMS prior to publishing any results based on Demonstration evaluation for CMS' review and approval. The reports' appendices present more granular results and supplemental findings. The State will work with CMS to ensure the transmission of all required reports and documentation occurs within approved communication protocols.

Independent Entity

Based on State protocols, DHHS will follow established policies and procedures to acquire an independent entity or entities to conduct the NHHPP PAP Demonstration evaluation. The State will either undertake a competitive procurement for the evaluator or will contract with entities that have an existing contract relationship with the State. An assessment of potential vendors' experience, knowledge of State programs and populations, and resource requirements will determine selection of the final candidate, including steps to identify and/or mitigate any conflicts of interest.

Budget

Due to the complexity and resource requirements of the NHHPP PAP Demonstration, DHHS will need to conduct a competitive procurement to obtain the services of an independent entity to perform the services outlined in this evaluation design. As such, an estimated budget is currently unavailable and will be determined through the competitive bid process. Upon selection of an evaluation vendor, a final budget will be prepared in collaboration with the selected independent entity. Table 2 displays the proposed budget shell that will be used for submitting total costs for the Demonstration. Costs are broken out by staff, estimated hours, costs, and anticipated subcontractors. At this time, DHHS is working with its Actuarial vendor to secure their assistance in preparing all cost-related measures.

Table 2—Proposed Budget Template for NHHPP PAP

	Year X (January 2016-2017)		
Staff Title	*Loaded Rate*	*Hours*	*Total*
Executive Director, Research & Analysis			
Project Director, Research & Analysis			
Project Director			
Project Manager			
Project Support			
Analyst			
Database Developer			
Reports Team			
Subtotal Direct and Indirect Costs			
Subcontractor - Statistician			
Subcontractor –Survey Vendor			
Subcontractor – Actuarial Vendor			

Annual Total		

As noted earlier, the costs presented in Table 2 will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning analyses and report generation. A final budget will be submitted once a final evaluation contractor has been selected.

5. APPENDIX A: EVALUATION COMPONENTS

PAP Waiver Goal[1]	Hypothesis Being Addressed[13]	Dimension of Access and/or Quality[14]
1. Continuity of coverage - For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks	1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage	Comparisons of provider networks
	2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers	Provider experience
2. Plan Variety - The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts	3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs	Evidence of improved access and quality across the continuum of coverage and related health outcomes
	4. The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts	Comparisons of provider networks over time.
3. Cost-effective Coverage - The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs	5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	7. The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS	Comparisons of provider networks
4. Uniform provider access - The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire	8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	9. Premium assistance beneficiaries will have equal or better access to preventive care services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided	Consumer satisfaction and other indicators of consumer experience
	11. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes

[13] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf, Page 10 of 146. Last accessed on May 26, 2015.

[14] ibid, STC #69.1.a.

6. APPENDIX B: EVALUATION RESEARCH HYPOTHESES AND MEASURES

The 12 research hypotheses are grouped according to the four waiver goals delineated in Appendix A. The definitions presented below are generally quoted from Section II. Program Description and Objectives in the Special Terms and Conditions document.[15] Numbering of the individual research hypotheses from STC #69 is changed herein to correspond with the goals of the waiver shown in Appendix A.

Continuity of Coverage

Definition: For individuals whose incomes fluctuate, the NHHPP PAP Demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The State will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.

Hypothesis 1: ***Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage***

Gaps in insurance coverage decrease the potential for preventive care and, therefore, increase the potential for more expensive emergency and/or inpatient care. Due to the insurance premiums being paid by New Hampshire for eligible beneficiaries, any gaps in coverage should be for income level changes, moving out of State, aging out, death, incarceration, or other situation beyond the control of the State for ensuring continuous insurance coverage.

Measure 1-1	Continuity in Member Health Insurance Coverage
Definition:	The average number of gaps in insurance coverage
Technical Specifications:	The average number of gaps in insurance coverage per 100 members enrolled in PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[15] pa_termsandconditions.pdf

Measure 1-2	Continuity in Member Health Insurance Coverage
Definition:	The percentage of eligible members with gaps in insurance coverage
Technical Specifications:	The percentage of eligible members with gaps in insurance coverage, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 1-3	Patient Perspective on Continuity in Health Insurance Coverage
Definition:	Patient perspective on the continuity of health insurance coverage
Technical Specifications:	Eligible recipients will be surveyed to whether the members reported being without health insurance during the previous six months. "In the last six months, were you without health insurance at any time?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3[16]
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[16] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.

Hypothesis 2: ***Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers***

This two-part research hypothesis examines continuity of care within health plans and continuous access to providers associated with the member's health plan. For this research hypothesis, the providers are the groups of PCPs delivering care to the MCO's members. With the State paying for the beneficiaries' premiums, the intent is that members will see the same group of providers as least as commonly as the comparison group members.

Measure 2-1	Continuous Access to the Same Health Plan
Definition:	The percentage of eligible members with continuous access to the same health plan for the measurement year
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to the same health plan during the measurement period – one plan the entire time.
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 2-2	Patient Perspective on Continuity in Same Plan Coverage
Definition:	Patient perspective on continuous access to the same health care plan
Technical Specifications:	Eligible recipients will be surveyed to whether the members had continuous access to the same health care plan during the previous six months. "In the last six months, did you have to switch to a different health care plan?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 2-3	Patient Perspective on Continuous Access to Providers
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q6
Exclusion Criteria:	Subject to income level qualifications
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 2-4	Numbers of Medically Frail Self-Declarations
Definition:	The number of PAP members each year who self-declare as medically frail.
Technical Specifications:	The number of PAP members each year who self-declare as medically frail and leave the PAP population.
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	Annual, if the Demonstration is continued
Comparison Method(s):	None
National Benchmark:	None

Plan Variety

Definition: The NHHPP PAP Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the selection of plans for both Medicaid and Marketplace enrollees. The State will evaluate whether there is an increase in the number of available QHPs because of this potential for dual participation.

Hypothesis 3: ***Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs***

Beyond the continuity of insurance coverage previously addressed, this research hypothesis examines gaps in actual enrollment, the empirical continuity of care, and the administrative costs of care. If the NHHPP PAP functions as designed, actual enrollment should be at least as continuous as for the beneficiaries in the comparison group, their continuity of care should be at least as good due to improved access, and the overall administrative costs should decrease through knowledge of premium costs weighed against the costs in the comparison group. Three measures will, in combination, be used to assess this research hypothesis.

Measure 3-1	Continuity in Plan Enrollment
Definition:	The average number of gaps in enrollment from any Medicaid plan
Technical Specifications:	The average number of gaps in enrollment of any kind from any Medicaid MCO or PAP plan per 100 enrollee years, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State Eligibility and Enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-2	Continuity in Plan Enrollment
Definition:	Percentage of eligible members with continuous health plan access
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to any Medicaid MCO or PAP health plan during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-3	Patient Perspective on Continuity of Care
Definition:	The cornerstone of continuity of care is in knowing one's PCP. For this reason, this portion of the research hypothesis is defined through whether the beneficiary has a personal doctor. For respondents, this item is defined as the proportional choice for "A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?" for responses 'Yes' or 'No'.
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q10
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 3-4	Members' Administrative Cost (Total Costs and Medical Costs Captured in Research Hypotheses 7-1 and 7-2)
Definition:	Administrative per member per month (PMPM) cost
Technical Specifications:	Annual administrative costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Hypothesis 4: ***The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees***

The idea supporting this research hypothesis is that market forces will take note of the influx of covered beneficiaries from the NHHPP PAP and will compete for market

share. If the intended effect materializes, one benefit might be seamless transitions between the traditional marketplace and the NHHPP PAP. Beneficiaries might see an advantage to belonging to plans offering both types of coverage, which then might increase the total number of plans competing for market share and the potential of dual participation.

Measure 4-1	Medicaid Care Management Carriers Offering QHPs in the Marketplace
Definition:	Desk audit for the number of Medicaid Care Management carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option
Technical Specifications:	Count of the number of Medicaid Care Management carriers offering QHPs in the Marketplace for which dual participation could be an option
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None
Measure 4-2	**QHPs in the Marketplace Offering Medicaid MCO Plans**
Definition:	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter
Technical Specifications:	Count of the number of QHPs in the Marketplace offering Medicaid MCO Plans
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None

Cost-effective Coverage

Definition: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to traditional Medicaid managed care coverage. The State will evaluate whether QHP coverage is cost-effective, looking at the entire NHHPP PAP Demonstration period and trends that emerge as it proceeds.

Hypothesis 5: ***Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services***

'Non-emergent use' is interpreted to mean that the service could have been appropriately delivered at a lower level, such as an urgent care clinic or at a PCP's office. One of the intended functions of the NHHPP PAP is to treat beneficiaries in the

appropriate setting, which is often the PCP's office. The appropriate setting is frequently less expensive and provides more local access than is found with non-emergent use of emergency room services.

Measure 5-1	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Eligibility Group
Definition:	Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by eligibility group
Technical Specifications:	AMBCARE.09 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf[17]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 6: ***Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions***

'Potentially preventable' in operationalized as ambulatory sensitive conditions, suggesting that more timely PCP care could have prevented the admission, rather than the admission being at too high a level of service, distinguishing the research hypothesis from research hypothesis 5. For example, emergency room use and/or hospitalization for complications from the flu are potentially preventable with influenza and pneumococcal immunizations, as appropriate.

Measure 6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members
Definition:	Quarterly rate of inpatient hospital utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members
Technical Specifications:	HPP_INPASC.01 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test.

[17] NH Medicaid Care Management Quality Oversight Health Plan Reporting Specifications – V2.3

	2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 6-2	Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members
Definition:	Quarterly rate of emergency department utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members
Technical Specifications:	Analogous to HPP_INPASC.01, but in the Emergency Department setting
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 7: ***The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS***

This research hypothesis examines the relative costs in a comparative format between the more traditional Medicaid managed care program comprised of the comparison group and the new beneficiary program comprised of the study group. By knowing the premiums in advance, the State can make comparisons with the costs for non-premium assistance beneficiaries to ensure that the new beneficiaries in the NHHPP PAP will not cost New Hampshire more than if the State had enrolled the expansion group in the more traditional Medicaid managed care program comprising the comparison group.[18]

Measure 7-1	Total Costs by Group
Definition:	Total per member per month (PMPM) cost
Technical Specifications:	Annual total costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this

[18] Administrative costs are captured in research hypothesis 3.

	population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Measure 7-2	**Medical Costs by Group**
Definition:	Annual per member per month (PMPM) cost
Technical Specifications:	Annual medical costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Uniform Provider Access

Definition: The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the NHHPP PAP Demonstration to determine if it is comparable to the access afforded to the general Medicaid managed care population in New Hampshire.

Hypothesis 8: ***Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services***

One critical feature of the NHHPP PAP is the contracted QHPs' ability to deliver appropriate access to care through the availability of primary care and specialty physicians and associated services. The research hypothesis examines the extent to which the NHHPP PAP is successful in maintaining the access and services found in the traditional Medicaid managed care program.

Measure 8-1	Medication Management for People with Asthma (MMA)[19]
Definition:	The percentage of members 19–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period
Technical Specifications:	State-modified HEDIS specifications[20]
Exclusion Criteria:	Diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis, cystic fibrosis, acute respiratory failure, or members who have no asthma controller medications dispensed during the measurement year
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-2	Timeliness of Prenatal Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received prenatal care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.01 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

[19] The presented specifications are derived from the NCQA HEDIS 2015 Technical Specifications, Volume 2.
[20] HEDIS has some specifications that extend beyond the age range for the PAP program and are, therefore, State-modified to account for the age range difference.

Measure 8-3	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received postpartum care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.02 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-4	Patients' Perception of Ease of Getting Appointments with Specialists
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q18, CAHPS 5.0[21]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 8-5	Patients' Perception of Quick Access to Needed Care
Definition:	For respondents, a proportional choice for "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q4, CAHPS 5.0[22]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test.

[21] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.
[22] Ibid.

Measure 8-5	Patients' Perception of Quick Access to Needed Care
	2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Hypothesis 9: ***Premium assistance beneficiaries will have equal or better access to preventive care services***

Access to preventive care services is important for several reasons, as already seen through previous research hypotheses. Preventive services can help to maintain health and avoid more expensive emergency department use or hospitalization and are an important aspect of restraining the growth in the cost of providing health care. This research hypothesis evaluates access to preventive services.

Measure 9-1	Annual Access to (use of) Preventive/Ambulatory Health Services Adults by Age Group (i.e., 20-44, 45-64)
Definition:	The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group
Technical Specifications:	HEDIS_AAP - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid managed care national rates

Measure 9-2	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)
Definition:	The percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge
Technical Specifications:	HEDIS_FUH.01 - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-3	Annual Influenza Immunization, 19-64
Definition:	Flu vaccinations for adults ages 19 to 64: percentage of members 18 to 64 years of age who received an influenza vaccination between July 1 of the measurement year and the date on which the CAHPS 5.0 survey was completed
Technical Specifications:	NCQA
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-4:	Comprehensive Diabetes Care - Eye Exam
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed
Technical Specifications:	HEDIS_CDC.05 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-5	Comprehensive Diabetes Care - Medical Attention for Nephropathy
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who received medical attention for nephropathy
Technical Specifications:	HEDIS_CDC.06 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-6	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Definition:	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-7	Mental Health Utilization - 1
Definition:	Mental health inpatient discharges
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-8	Mental Health Utilization - 2
Definition:	Mental health inpatient average length of stay
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-9	Diabetes Monitoring for People With Diabetes and Schizophrenia
Definition:	The percentage of members 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.

National Benchmark:	HEDIS Medicaid Managed Care national rates

Hypothesis 10: ***Premium assistance beneficiaries will report equal or better satisfaction in the care provided***

Patient-centered health care is important for many reasons, not the least of which is the relationship between greater satisfaction and low costs of care. Patients tend to utilize preventive services and follow medical advice more often when they are satisfied with the care they receive. For that reason, this research hypothesis compares the satisfaction of the more traditional Medicaid managed care beneficiaries for their provided care with that of the NHHPP PAP beneficiaries.

Measure 10-1	Patients' Rating of Overall Health Care
Definition:	For respondents, a proportional choice for "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"
Technical Specifications:	CAHPS 5.0 specifications, Q8
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Measure 10-2	Patients' Rating the Health Plan
Definition:	For respondents, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"
Technical Specifications:	CAHPS 5.0 specifications, Q26
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Hypothesis 11: ***Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits***

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are important to maintain health, catch illness early, and prevent disease when possible. The medically recommended schedule for these services continues until the beneficiary's

21st birthday. This research hypothesis examines the extent to which premium assistance beneficiaries 19 and 20 years of age received these services compared with the comparison group.

Measure 11-1	EPSDT Screening
Definition:	Total eligible beneficiaries who received at least one initial or periodic Screen
Technical Specifications:	EPSDT.06 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 12: ***Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT)***

Non-emergency transportation services support timely access to care at the appropriate level of care, which helps to reduce cost, as discussed in previous research hypotheses. This research hypothesis seeks to ensure that premium assistance members maintain appropriate access to non-emergency transportation services.

Measure 12-1	NEMT Request Authorization Approval Rate by Mode of Transportation
Definition:	The percentage of NEMT requests authorized, of those requested during the measure data period, by mode of transportation (i.e., contracted transportation provider - non-wheelchair van, volunteer driver, member, public transportation, wheelchair van, other), for the eligible population
Technical Specifications:	NH specifications for HPP_NEMT.06 (including A-F)[23]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

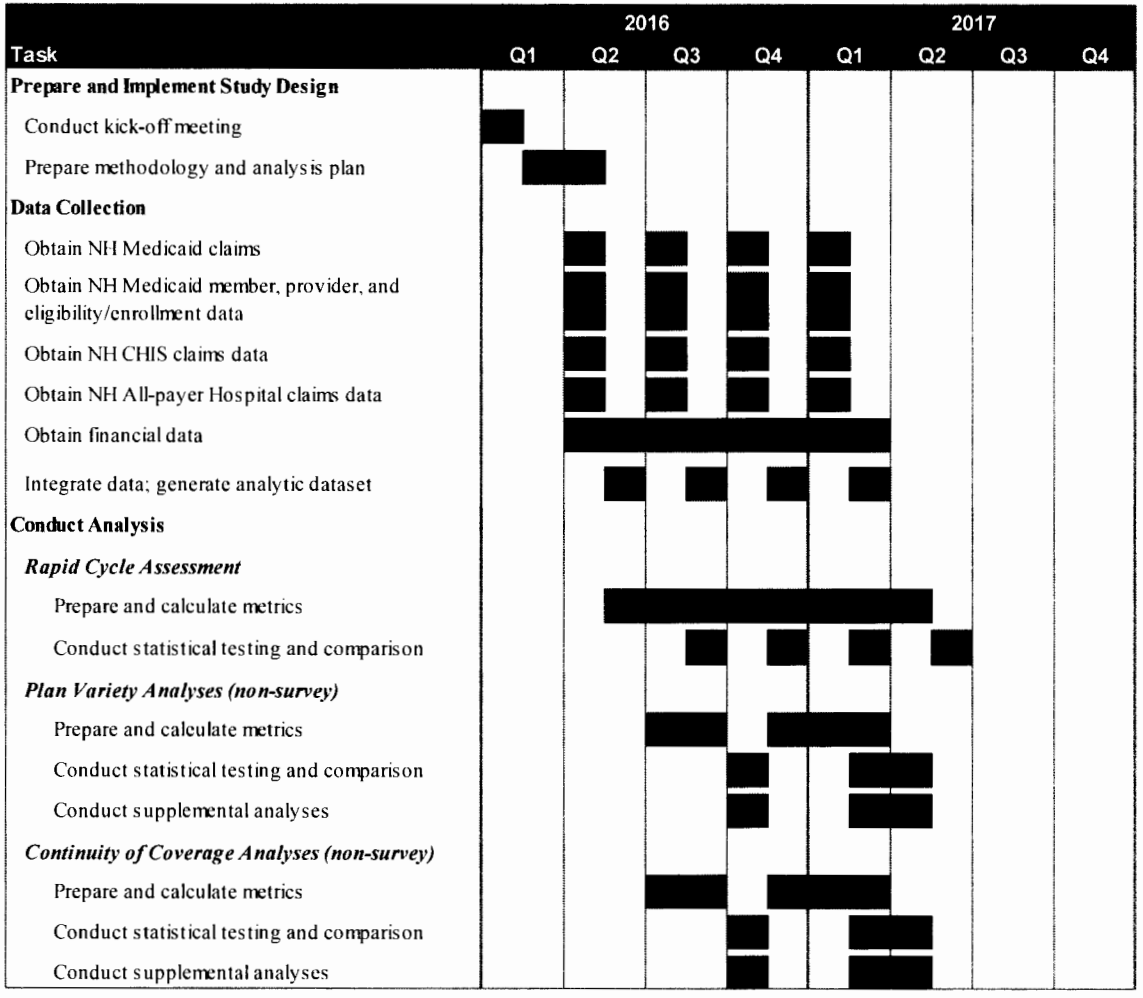
[23] New Hampshire Medicaid Quality Information System (MQIS), Specifications, Non-Emergent Transportation - NH Health Protection Program, Version 1.0, Published March 31, 2015.

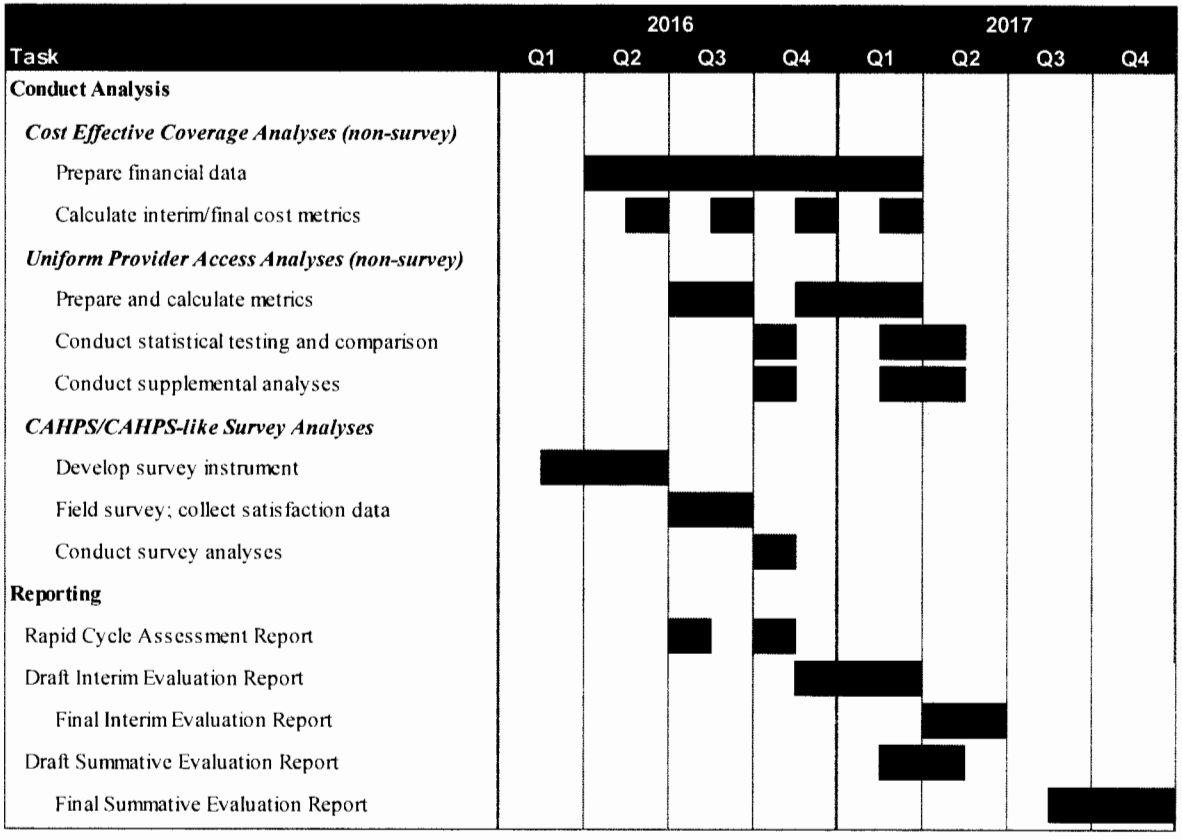
7. Appendix C: Evaluation Timeline

The following project timeline has been prepared for the Demonstration evaluation outlined in the preceding sections. This timeline should be considered preliminary and subject to change based upon approval of the Evaluation Design and implementation of the NHHPP PAP. A final detailed timeline will be developed upon selection of the Independent Entity tasked with conducting the evaluation.

Figure C- 1 outlines the proposed timeline and tasks for conducting the NHHPP PAP evaluation.

Figure C-1—NHHPP PAP Evaluation Project Timeline




2016
2017
Task
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Conduct Analysis
Cost Effective Coverage Analyses (non-survey)
Prepare financial data
Calculate interim/final cost metrics
Uniform Provider Access Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses
CAHPS/CAHPS-like Survey Analyses
Develop survey instrument
Field survey; collect satisfaction data
Conduct survey analyses
Reporting
Rapid Cycle Assessment Report
Draft Interim Evaluation Report
Final Interim Evaluation Report
Draft Summative Evaluation Report
Final Summative Evaluation Report

Continuity of Coverage (COC)

From a policy perspective in public health, continuity of coverage (COC) begins at the onset of available coverage (i.e., January 1, 2016, for NHHPP PAP members), rather than once coverage has been secured at a potentially later date. By definition, therefore, the 45,000 New Hampshire residents who are eligible for NHHPP PAP coverage before January 1, 2016,[24] and have NHHPP PAP coverage on January 1, 2016, have started continuity of coverage on time and do not have a *de facto* gap at the start of their available coverage.

Measure COC-1	Cumulative Initiation of Continuity in Member Health Insurance Coverage
Definition:	The cumulative number of NHHPP PAP beneficiaries with initiated coverage
Technical Specifications:	The total (i.e., sum) of the number of NHHPP PAP beneficiaries per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Measure COC-2	Proportional Initiation of Continuity in Member Health Insurance Coverage
Definition:	The proportion of the expected population of NHHPP PAP beneficiaries who have initiated coverage
Technical Specifications:	The ratio of the total (i.e., sum) of the number of NHHPP PAP beneficiaries to the 45,000 eligible people per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Plan Variety (PV)

One intended outcome of the NHHPP PAP is to motivate private insurers to create a dual participation in the Medicaid Care Management program and the Marketplace.

[24] New Hampshire Health Protection Program, Premium Assistance, Section 1115, Research and Demonstration Waiver, Final Application, November 7, 2014, Section 1, page 2

This dual participation would afford Medicaid beneficiaries with seamless coverage during times of transition, either across eligibility groups within Medicaid or from Medicaid to the Marketplace. From a rapid cycle perspective, the policy relevant outcome would be an increase in dual participation insurers.

Measure PV-1	Dual Participation Providers
Definition:	The number of dual participation providers
Technical Specifications:	The quarterly number of dual participation providers from the implementation of the potential for dual participation on November 1, 2015 through April 30, 2016 and quarterly thereafter
Data Source(s):	Administrative review
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Cost-effective Coverage (CEC)

One of the intended consequences of the premium assistance approach is to increase QHP enrollment and, therefore, result in greater economies of scale and competition among QHPs, lowering PMPM costs for Medicaid coverage.

Measure CEC-1	Total PMPM Total Cost - Quarterly
Definition:	Total per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly total costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-2	Medical PMPM Total Cost - Quarterly
Definition:	Medical per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly medical costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and

	reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-3	Administrative PMPM Total Cost - Quarterly
Definition:	Administrative per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly administrative costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Uniform Provider Access (UPA)

One of the requirements for the NHHPP PAP is that it should provide equal or better access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration. One performance measure that has the potential not only to be available to rapid fire assessment, but could also touch on all three settings for uniform provider assess (i.e., primary, specialty, and behavioral health care services), is postpartum care. Regardless of how long the beneficiary has been enrolled in the NHHPP PAP, postpartum care is a valid measure of uniform provider access.

Measure UPA-1	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between each quarter who received timely and appropriate postpartum care
Technical Specifications:	HEDIS_PPC.02 – modified from NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf to be reported quarterly
Data Source(s):	All-payer Hospital, CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Exhibit A-3
Analytical Methods

1. ANALYTIC METHODS

1.1. Once the populations are matched and metrics are calculated, a series of tests and analyses will follow to determine the impact of the NHHPP PAP program on access, quality, and cost. The statistical test or method applied to the evaluation of each measure will depend on the measure construct and underlying data used for measure calculation. In general, one or more of the following methods will be used for each measure in the evaluation:

1.1.1. **T-test or paired t-test** – The selection of the t-test or paired t-test will depend upon the degree of independence of members across evaluation periods. In other words, if a large percentage of the members are in both the baseline and evaluation period(s), a paired t-test may be performed in lieu of the standard t-test.

1.1.2. **Z-test or McNemar's test** – Similar to the scenario presented above, the choice of tests depends upon the degree of independence across evaluation periods. McNemar's test would be employed in lieu of a z-test if a large percentage of the members are in both the baseline and evaluation period(s).

1.1.3. **Difference-in-Differences (DiD)** – The two sets of tests noted above will indicate whether there is a significant change in measures rates/outcomes across time periods but do not indicated magnitude of impact or change. DiD, in addition to detecting significant changes across time periods, will provide information on the magnitude or impact of PAP on measure rates and outcomes.

1.2. Table 7 presents an overview of the proposed evaluation methods by measure type. Most measures will be subject to multiple tests. As noted previously, Table 8 provides a measure-by- measure presentation of analytic methods.

Table 7 – Proposed Evaluation Methods

Proposed Evaluation Methods			
Analytic Method	Measure Type		
	Administrative (Claims)	Survey	Other
Propensity Score Matching	X		
Hypothesis Testing (e.g., t-test,	X	X	
Difference-in-Difference	X	X	
Panel Format/Longitudinal			X

2. HYPOTHESIS TESTING

2.1. As presented and discussed above, hypothesis testing will be conducted to determine if there are significant changes in measure rates and outcomes between the baseline and evaluation period(s). Depending on the data source and type of measure one or more of the following four hypothesis tests will be conducted:

2.1.1. Independent t-test

2.1.2. Paired t-test

2.1.3. Z-test

2.1.4. McNemar's test

2.2. While the above tests provide insight into whether the change for each measure between the baseline periods and evaluation period(s) is significant, it does not provide insight into the magnitude of impact and change over time. In order to determine the degree of the PAP's impact, HSAG also will utilize DiD, which is discussed in detail in the next section.

3. DIFFERENCE-IN-DIFFERENCES ANALYSIS

3.1. Once the populations are matched and metrics are calculated, a DiD analysis will compare the rates/outcomes for the two populations during the baseline period (CY 2015) and the first interim evaluation period, and subsequently the final evaluation period(s). The DiD analysis will allow for expected costs and rates for the treatment group (i.e., Bridge/PAP population) to be calculated by taking into account expected changes in costs and rates without the PAP program. This will be completed by subtracting the average change in the control group from the average change in the treatment group,8 thus removing biases from the evaluation period(s) comparisons due to permanent differences between the two groups. In other words, any cost or rate changes caused by factors external to the PAP program would apply to both groups equally, and the DiD methodology will remove the potential bias, the result of which will leave a clearer picture of the actual effect of the program. The generic DiD model is:

$$y = \beta_0 + \beta_1 dB + \delta_0 d2 + \delta_1 d2 * dB + u$$

3.2. Where y is the outcome of interest and $d2$ is a dummy variable for the remeasurement timeperiod. The dummy variable dB identifies potential differences between the control and the intervention groups prior to the intervention. The time period dummy variable, $d2$, captures factors that would have changed in the absence of the intervention. The coefficient of interest, δ_1, multiplies the interaction term, $d2 * dB$, which is the same as the dummy variable equal to one for those observations in the treatment group in the remeasurement period. The final DiD estimate is:

$$\delta_1 = (\bar{y}_{B,2} - \bar{y}_{B,1}) - (\bar{y}_{A,2} - \bar{y}_{A,1})$$

Contractor Initials: MeP

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3.3. The estimate will provide the expected costs and rates without the intervention (i.e., expectedadjustment factor). If the δ_1 coefficient is significantly different from zero, then it is reasonable to conclude that the outcome differed between the treatment and control group, after the PAP program went into effect. For this analysis, a statistically significant difference will be represented by a p-value of 0.05 or less, indicating the probability of the results occurring by chance is less than 5 percent. If a demographic or disease covariate remains unbalanced after the matching process, that covariate will be included in the DiD regression model as a control variable. This will reduce any remaining bias in the program effect coefficient associated with the unbalanced covariate. Balance for each covariate will be evaluated by comparing the distributions between the control group and treatment group using statistical tests. If the test results in a statistically significant difference (i.e., a p-value of 0.05 or less), the covariate will be included in the final DiD regression model as a control.

3.4. Table 8 provides detail for each measure that will be included in the evaluation. The following explains each column:

3.4.1. **Measure ID**—The measure ID as provided in the CMS approved evaluation plan.

3.4.2. **Measure Description**—The name/description of the measure as provided in the CMS approved evaluation plan.

3.4.3. **Interim Evaluation**—An assessment of the ability to calculate and present the measure for the interim evaluation. Some measures have a response of a "qualified" yes. Detail and possible mitigation strategies are provided for the "qualified" yes responses.

3.4.4. **Summative Evaluation(s)**—A similar assessment to the interim evaluation is performed for all the measures used for the final evaluation.

3.4.5. **Analytic and Evaluation Methods**—The methods employed to determine the impact of the NHPP PAP for each measure. For example, measure 1-1 will be evaluated by performing propensity score matching to yield comparable control and treatment groups. After completion of PS matching, either a t-test or paired t-test (depending on the degree of independence of members across evaluation periods) will be performed, in addition to a Difference-in-Difference analysis.

Table 8 – Measure Evaluation Methods

Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
1-1	Continuity in Member Health Insurance Coverage—	Yes	Yes	PS matching, t-test or paired t-test, and DiD
1-2	Continuity in Member Health Insurance Coverage—	Yes	Yes	PS matching, z-test or McNemars test, and DiD
1-3	Patient Perspective on Continuity in Health Insurance Coverage	Yes—only results from the CAHPS survey administration in 2017 can be presented since this measure/question was not included in 2015 administration.	Yes - a comparison between CAHPS 2017 and 2018 administration can be evaluated	No PS matching for survey measures, z-test or McNemars test, and DiD
2-1	Continuous Access to the Same Health Plan	Yes	Yes	PS matching, z-test or McNemars test, and DiD
2-2	Patient Perspective on Continuity in Same Plan Coverage	Yes—only results from the CAHPS survey administration in 2017 can be presented since this measure/ question was not included in 2015 administration.	Yes - a comparison between CAHPS 2017 and 2018 administration can be performed	No PS matching for survey measures, z-test or McNemars test, and DiD

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Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
2-3	Patient Perspective on Continuous Access to Providers	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, and DiD
2-4	Number of Medically Frail Self-Declarations	Yes	Yes	Longitudinal counts
3-1	Continuity in Plan Enrollment— Average Number of Gaps in	Yes	Yes	PS matching, t-test or paired t-test, and DiD
3-2	Continuity in Plan Enrollment— Percentage of Eligible Members with Continuous Health Plan Access	Yes	Yes	PS matching, z-test or McNemars test, and DiD
3-3	Patient Perspective on Continuity of Care	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, and DiD
3-4	Members' Administrative Cost (Total and Medical Costs Captured in 7-1 and 7-2)	Yes	Yes	PS matching, t-test or paired t-test, and DiD
4-1	Medicaid Care Management Carriers Offering QHPs in the Marketplace	Yes	Yes	Panel Format/Longitudinal counts
4-2	QHPs in the Marketplace Offering Medicaid MCO Plans	Yes	Yes	Panel Format/Longitudinal counts

Contractor Initials: MAP

Date: 12-22-16

Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
5-1	Ambulatory Care: ED Visits Potentially Treatable in Primary Care by Eligibility Group	Yes	Yes	PS matching, t-test or paired t-test, and DiD
6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	Yes	Yes	PS matching, t-test or paired t-test, and DiD
6-2	Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	Yes	Yes	PS matching, t-test or paired t-test, and DiD
7-1	Total Costs by Group	Yes	Yes	PS matching, t-test or paired t-test, and DiD
7-2	Medical Costs by Group	Yes	Yes	PS matching, t-test or paired t-test, and DiD
8-1	Medication Management for People with Asthma	Yes	Yes	PS matching, z-test or McNemars test, and DiD
8-2	Timeliness of Prenatal Care	Yes	Yes	PS matching, z-test or McNemars test, and DiD
8-3	Postpartum Care	Yes	Yes	PS matching, z-test or McNemars test, and DiD

Contractor Initials: MSD

Date: 12/22/16

Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
8-4	Patients' Perception of Ease of Getting Appointments with Specialists	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, or t- test or paired t-test, and DiD
8-5	Patients' Perception of Quick Access to Needed Care	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, or t- test or paired t-test, and DiD
9-1	Annual Access to Preventative/ Ambulatory Heath Services	Yes	Yes	PS matching, z-test or McNemars test, and DiD
9-2	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	Yes	Yes	PS matching, z-test or McNemars test, and DiD
9-3	Annual Influenza Immunization, 19—64	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, and DiD
9-4	Comprehensive Diabetes Care—Eye Exam	Yes—The baseline period may have to be modified to account for the fact that there is not adequate experience of care for a full measurement year.	Yes	PS matching, z-test or McNemars test, and DiD

Contractor Initials: MGD

Date: 12-22-16

Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
9-5	Comprehensive Diabetes Care—Medical Attention for Nephropathy	Yes—The baseline period may have to be modified to account for the fact that there is not adequate experience of care for a full measurement year.	Yes	PS matching, z-test or McNemars test, and DiD
9-6	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Yes—though sufficient experience of care/enrollment might limit the ability to calculate this measure for the base year	Yes	PS matching, z-test or McNemars test, and DiD
9-7	Mental Health Utilization—1	Yes	Yes	PS matching, t-test or paired t-test, and DiD
9-8	Mental Health Utilization—2	Yes	Yes	PS matching, t-test or paired t-test, and DiD

Contractor Initials: MSD

Date: 12/22/16

Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
9-9	Diabetes Monitoring for People With Diabetes and Schizophrenia	Yes—The measurement period may have to be modified to account for the fact that there is not adequate experience of care for a full measurement year.	Yes	PS matching, z-test or McNemars test, and DiD
10-1	Patients' Rating of Overall Health Care	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, or t- test or paired t-test, and DiD
10-2	Patients' Rating of Health Plan	Yes	Yes	No PS matching for survey measures, z-test or McNemars test, or t- test or paired t-test, and DiD
11-1	EPSDT Screening	Yes	Yes	PS matching, t-test or paired t-test, and DiD
12-1	NEMT Request Authorization Approval Rate by	Yes	Yes	PS matching, t-test or paired t-test, and DiD

Measure ID	Measure Description	Interim Evaluation	Summative Evaluation(s)	Analytic and Evaluation Methods
COC-1	The cumulative number of NHHPP PAP beneficiaries with initiated coverage	Yes	Yes	Panel Format/Longitudinal counts
COC-2	The proportion of the expected population of the NHHPP PAP beneficiaries who have initiated coverage	Yes	Yes	Panel Format
PV-1	The number of dual participation providers	Yes	Yes	Panel Format/ Longitudinal counts
CEC-1	Total PMPM cost, reported quarterly	Yes	Yes	PS matching, t-test or paired t-test, and DiD
CEC-2	Medical PMPM cost, reported quarterly	Yes	Yes	PS matching, t-test or paired t-test, and DiD
CEC-3	Administrative PMPM cost, reported quarterly	Yes	Yes	PS matching, t-test or paired t-test, and DiD
UPA-1	Postpartum Care	Yes	Yes	PS matching, z-test or McNemars test, and DiD

Contractor Initials: MED

Date: 12/22/16

Exhibit A - 4 Reporting Timeframes

	CMS Special Terms & Conditions (STC) #	Outline Due to DHHS from Contractor	Due to DHHS from Contractor	Due to CMS from DHHS
Quarterly Evaluation Reports	80		1st Report – 30 days prior to due date. Ongoing – 15 days prior to due date.	30 days after the quarter
CAHPS Medicaid Adult Survey Results Report	N/A	N/A	June 30th	N/A
Rapid Cycle Reports	82	60 days prior to CMS deadline	30 days prior to CMS deadline	TBD
Interim Evaluation Report	70	10/1/2017	1/1/2018	3/31/2018
Summative Evaluation Report	71	1/1/2019	3/31/2019	6/29/2019
Final Summative Evaluation Report	72		9/30/2019	12/31/2019

Contractor Initials: MED

Date: 12/22/16

Exhibit B

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed Form P-37, General Provisions, Block 1.8, Price Limitation for services provided as specified in Exhibit A, Scope of Services.
2. This contract is funded with general, other, and federal funds. Department access to supporting funding for this project is dependent upon the criteria set forth in the Catalog of Federal Domestic Assistance (CFDA) (https://www.cfda.gov) #93.778, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Programs.
3. The Contractor shall use and apply all contract funds for authorized direct and indirect costs to provide services in Exhibit A, Scope of Services, in accordance with Exhibit B-1, Budget.
4. Payment for services provided in accordance with Exhibit A, Scope of Services, shall be made as follows:
   - 4.1. Payments shall be made on cost reimbursement and fee-for-service basis only, for allowable costs, expenses and fees in accordance with Exhibits B-1, Budget.
   - 4.2. Allowable costs and expenses shall include those expenses detailed in Exhibit B-1, Budget.
   - 4.3. The Contractor shall submit monthly invoices using invoice forms provided by the Department.
   - 4.4. The Contractor shall submit supporting documentation that support evidence of actual expenditures, in accordance with Exhibit B-1, Budget for the previous month by the tenth (10th) working of the current month.
   - 4.5. Supporting documentation in Section 4.4, above, shall include a report of staff hours worked on the project for the month invoiced, as detailed by:
     - 4.5.1. Staff name.
     - 4.5.2. Title.
     - 4.5.3. Hours worked on the project.
5. The Contractor shall submit invoices for services outlined in Exhibit A, Scope of Services in accordance with budget line items in Exhibit B-1, Budget and Exhibit B-2, Budgeted Hours, by e-mail, on Department approved invoices to:

   Medicaid Quality Administrator
   Office of Quality Assurance and Improvement
   NH Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301
   Email: patrick.mcgowan@dhhs.nh.gov

Exhibit B

6. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this Agreement may be withheld, in whole or in part, in the event of noncompliance with any State or Federal law, rule or regulation applicable to the services provided, or if the said services have not been completed in accordance with the terms and conditions of this Agreement.
7. Notwithstanding Form P-37, General Provisions, Paragraph 18, Amendment, an amendment limited to the adjustment of amounts between budget line items within the price limitation can be made by written agreement of both parties without further approval of the Governor and Executive Council.

Exhibit B-1 Budgets

Health Services Advisory Group, Inc. New Hampshire Department of Health and Human Services Premium Assistance Program Evaluation Plan Implementation RFP-2016-OQAI-01-PREMI Budgeted Cost by State Fiscal Year				
	January 1, 2017 - June 30, 2017	**July 1, 2017 - June 30, 2018**	**July 1, 2018 - June 30, 2019**	**July 1, 2019 - December 31, 2019**
Salaries/Wages	$ 72,258.00	$ 150,253.00	$ 158,649.00	$ 80,654.00
Fringe Benefits	$ 28,324.00	$ 58,897.00	$ 62,188.00	$ 31,615.00
Total Personnel Cost	*$ 100,582.00*	*$ 209,150.00*	*$ 220,837.00*	*$ 112,269.00*
Other Direct Costs				
Subcontractor - DataStat	$ 10,547.00	$ 18,985.00	$ 8,438.00	$0
Subcontractor - Milliman	$ 63,637.00	$ 128,737.00	$ 131,699.00	$ 66,598.00
Travel	$ 1,120.00	$ 2,062.00	$ 1,884.00	$ 942.00
Total Other Direct Cost	*$ 75,304.00*	*$ 149,784.00*	*$ 142,021.00*	*$ 67,540.00*
Total Direct Costs	$ 175,886.00	$ 358,934.00	$ 362,858.00	$ 179,809.00
Indirect Costs	$ 82,551.00	$ 170,563.00	$ 177,593.00	$ 89,583.00
Total Project Cost	**$ 258,437.00**	**$ 529,497.00**	**$ 540,451.00**	**$ 269,392.00**

Contractor Initials: MSP
Date: 12-22-16

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** 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 the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. The Division reserves the right to renew the Contract for up to one (1) additional year, subject to the continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

Contractor Initials MEP

Date 12-22-16

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

Date

Name: Mary Ellen Dalton, PhD, MBA, RN
Title:Chief Executive Officer

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor Name:

12-22-16
Date

Name: Mary Ellen Dalton, PhD, MBA, RN
Title: Chief Executive Officer

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

12-22-16
Date

Mary Ellen Dalton
Name: Mary Ellen Dalton, PhD, MBA, RN
Title: Chief Executive Officer

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

12-22-16
Date

Name: Mary Ellen Dalton, PhD, MBA, RN
Title: Chief Executive Officer

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

12-22-16
Date

Name: Mary Ellen Dalton, PhD, MBA, RN
Title: Chief Executive Officer

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 & Human Services	Health Services Advisory Group, Inc
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Deborah H. Fournier	Mary Ellen Dalton, PhD, MBA, RN
Name of Authorized Representative	Name of Authorized Representative
Medicaid Director	Chief Executive Officer
Title of Authorized Representative	Title of Authorized Representative
1-5-17	12/22/16
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

12/22/16
Date

Name: Mary Ellen Dalton, PhD, MBA, RN
Title: Chief Executive Officer

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 14443260

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   x NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that HEALTH SERVICES ADVISORY GROUP, INC. is a Arizona Profit Corporation registered to do business in New Hampshire as HSAG OF AZ on April 16, 2012. 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: **669367**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 20th day of December A.D. 2016.

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

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

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

2. The following is a true copy of the resolution duly adopted at a meeting of the Board of Directors of

the Agency duly held on 11/29/2016:
(Date)

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

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

3. The forgoing resolutions have not been amended or revoked, and remain in full force and effect as of

the 22 day of December, 2016.
(Date Contract Signed)

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

of the Agency.

Joellen Tenison
(Signature of the Elected Officer)

STATE OF ARIZONA

County of Maricopa

The forgoing instrument was acknowledged before me this 3rd day of January 2017.

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

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

(Notary Public/Justice of the Peace)

Commission Expires: June 24, 2017

HEALSER-02 SLOGAN

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/20/2016

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

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

PRODUCER License # 0C36861 Phoenix-Alliant Insurance Services, Inc. 2415 E Camelback Rd Ste 420 Phoenix, AZ 85016	CONTACT NAME: Diana M Klase PHONE (A/C, No, Ext): (602) 707-1900 FAX (A/C, No): (480) 333-6973 E-MAIL ADDRESS: DKlase@alliant.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Hartford Fire Insurance Company — 19682
INSURED Health Services Holdings, Inc. | Health Services Advisory Group, Inc. 3133 East Camelback Rd., Ste 100 Phoenix, AZ 85016	INSURER B :
	INSURER C :
	INSURER D :
	INSURER E :
	INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	X COMMERCIAL GENERAL LIABILITY			59UUNZM6078	07/01/2016	07/01/2017	EACH OCCURRENCE	$	1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	300,000
							MED EXP (Any one person)	$	5,000
							PERSONAL & ADV INJURY	$	1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$	2,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$	2,000,000
	OTHER:						STOP GAP	$	1,000,000
A	AUTOMOBILE LIABILITY			59UUNZM6078	07/01/2016	07/01/2017	COMBINED SINGLE LIMIT (Ea accident)	$	1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$	
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$	
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$	
								$	
A	X UMBRELLA LIAB X OCCUR			59RHUZM4623	07/01/2016	07/01/2017	EACH OCCURRENCE	$	10,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$	10,000,000
	DED X RETENTION $ 10,000							$	
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			59WEZJ2839	07/01/2016	07/01/2017	X PER STATUTE / OTH-ER		
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N/A						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)

30 Day Notice of Cancellation endorsement (except 10 Days for non-payment) applies to General Liability if required by contract; such notice does not apply if not required.

CERTIFICATE HOLDER

Department of Health & Human Services
Attn: Denise Sherburne
Contracts & Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NOTICE OF CANCELLATION TO CERTIFICATE HOLDER(S)

This policy is subject to the following additional Conditions:

A. If this policy is cancelled by the Company, other than for nonpayment of premium, notice of such cancellation will be provided at least thirty (30) days in advance of the cancellation effective date to the certificate holder(s) with mailing addresses on file with the agent of record or the Company.

B. If this policy is cancelled by the Company for nonpayment of premium, or by the insured, notice of such cancellation will be provided within (10) days of the cancellation effective date to the certificate holder(s) with mailing addresses on file with the agent of record or the Company.

If notice is mailed, proof of mailing to the last known mailing address of the certificate holder(s) on file with the agent of record or the Company will be sufficient proof of notice.

Any notification rights provided by this endorsement apply only to active certificate holder(s) who were issued a certificate of insurance applicable to this policy's term.

Failure to provide such notice to the certificate holder(s) will not amend or extend the date the cancellation becomes effective, nor will it negate cancellation of the policy. Failure to send notice shall impose no liability of any kind upon the Company or its agents or representatives.