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

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Late A

Nicholas A. Toumpas
Commissioner

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Mary Ann Cooney
Associate Commissioner

APR 23 2014

April 21, 2014

H-3

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

SOLE SOURCE

50% General funds
50% Federal funds

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Human Services to enter into a **sole source** agreement with MAXIMUS Health Services, Inc., 1891 Metro Center Drive, Reston, VA (Vendor# 175787-R001) for the operation of a Temporary Enrollment and Eligibility Call Center supporting Medicaid enrollment inquiries and processing applications under the New Hampshire Health Protection Act in an amount not to exceed \$500,000 effective date of Governor and Executive Council approval, through June 30, 2015.

Funds to support this request are anticipated to be available in the following account in State Fiscal Year 2014 and 2015, with authority to adjust amounts between the state fiscal years, within the price limitation and amend the related terms of the contract without further approval from Governor and Executive Council:

05-00095-047-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: OFC OF MEDICAID & BUS PLCY, OFF. OF MEDICAID & BUS. POLICY, MEDICAID CARE MANAGEMENT

SFY	Class/Account	Class Title	Activity Number	Current Modified Budget
2014	102-500731	Contracts for Program Services	47000900	\$250,000
2015	102-500731	Contracts for Program Services	47000900	\$250,000
			Total	\$500,000

EXPLANATION

The purpose of this Request is to enter into a **sole source** agreement with the Contractor to support the enrollment process, provide choice counseling, and assist callers with inquiries regarding

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and the Honorable Council

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New Hampshire's Medicaid programs including but not limited to: Eligibility, Enrollment Options including Fee for Service, Medicaid Care Management (MCM), the New Hampshire Health Protection Program (the NH mandatory HIPP Program and the voluntary Bridge to Marketplace and Premium Assistance Program), and the Federally Facilitated Marketplace (FFM)- specific programs under the New Hampshire Health Protection Act. Expansion of Medicaid eligibility is subject to the prior approval by the Centers for Medicare and Medicaid Services (CMS) of all state plan amendments and/or waivers required for the implementation of the expansion of Medicaid eligibility. This contract is subject to obtaining such approvals. Further, this contract is a sole source agreement due to the need for the Department to have this function in place and available to our clients at the start of the NH Health Protection Program.

It is estimated approximately 50,000 newly Medicaid eligible clients will apply for the Medicaid program. Eligible clients will need to receive information and education about the various components of the New Hampshire Health Protection Program, such as the mandatory Health Insurance Premium Payment (HIPP), the Voluntary Bridge to the Marketplace, and the Premium Assistance Payment program. Each eligible client not qualifying for HIPP or if employer based insurance is deemed not cost effective, will need to enroll in one of three Alternative Benefit Plans offered under NH Medicaid Care Management. Because of the large number of Medicaid clients that will be enrolled initially, the Department requires a vendor to temporarily operate a call center to:

- Provide information to clients about the Medicaid application process.
- Provide information to clients about the enrollment process
- Provide information to clients about the Health Insurance Premium Payment program (HIPP), the Voluntary Bridge to the Marketplace program and the Premium Assistance Payment program.
- Provide support to clients not eligible for HIPP in making a choice of health plan or choosing a health plan, and respond to questions regarding the differences between Medicaid Fee-for-Service and Care Management; and
- Process enrollment into one of the three Managed Care Organizations, using the State's software.

This contract is based on a cost per minute rate of \$0.57, where the vendor will only bill for time spent on live calls handled by the Call Center. The number of clients who will seek Call Center assistance, the volume of calls and the duration of calls can only be estimated. By contracting for a cost per minute rate the Department is at less risk than agreeing to a fixed price contract, which would expose the Department to financial loss if the Call Center were underutilized.

Should Governor and Executive Council not approve this contract, the start date for the Medicaid Expansion enrollment, will be delayed.

The Office of Human Services will evaluate this contract and the vendor's performance. Primarily, evaluation of the vendor's performance will be based on the following performance measures:

- Weekly Call Blockage Rate;
- Weekly Call Abandoned Call Rate;
- Weekly Average Speed of Answer;
- Weekly Longest Delay;
- Weekly Call Resolution Rate;

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- Weekly First Call Resolution Rate;
- Weekly Transfer Rate to Medicaid Client Services;
- Weekly Average Call Time;
- Customer Satisfaction; and
- Weekly Direct Staff Rate. Defined as the weekly percentage of staff that are assigned to only answer calls for this contract.

Source of Funds: 50% Federal Department of Health and Human Services, Center for Medicare and Medicaid Services; 50% General Funds.

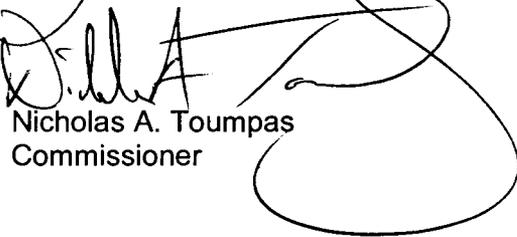
Area Served: Statewide.

Respectfully submitted,



Mary Ann Cooney
Associate Commissioner

Approved By:



Nicholas A. Toumpas
Commissioner

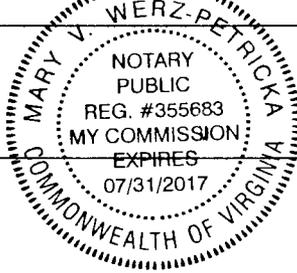
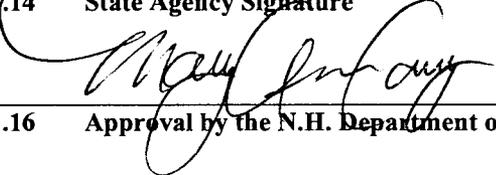
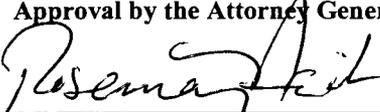
Subject: Temporary Call Center

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 and Human Services Office of Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301	
1.3 Contractor Name Maximus Health Services, Inc.		1.4 Contractor Address 1891 Metro Center drive Reston, VA 20190	
1.5 Contractor Phone Number (703) 251-8254	1.6 Account Number 10-047-79480000-102 500731	1.7 Completion Date June 30, 2015	1.8 Price Limitation \$500,000.00
1.9 Contracting Officer for State Agency Eric D. Borrin		1.10 State Agency Telephone Number (603) 271-9558	
1.11 Contractor Signature 		1.12 Name and Title of Contractor Signatory Adam Polatnick Vice President Assistant General Counsel	
1.13 Acknowledgement: State of <u>VA</u> , County of <u>FAIRFAX</u> On <u>4/18/14</u> , 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  [Seal]			
1.13.2 Name and Title of Notary or Justice of the Peace <u>MARY V. WERZ - PETRIKKA</u> <u>NOTARY PUBLIC</u>			
1.14 State Agency Signature 		1.15 Name and Title of State Agency Signatory <u>MARY Ann Cooney</u> <u>Associate Commissioner</u>	
1.16 Approval by the N.H. Department of Administration, Division of Personnel (if applicable) By: _____ Director, On: _____			
1.17 Approval by the Attorney General (Form, Substance and Execution) By:  On: <u>4-22-14</u>			
1.18 Approval by the Governor and Executive Council By:  DEPUTY SECRETARY OF STATE APR 23 2014			

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

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

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

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

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

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

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.

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

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

9. DATA/ACCESS/CONFIDENTIALITY/PRESERVATION.

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

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

Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

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

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

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

14. INSURANCE.

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

certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than ten (10) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A ("Workers' Compensation").

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

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

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

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

19. CONSTRUCTION OF AGREEMENT AND TERMS.

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

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

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

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

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

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



Exhibit A

Scope of Services

1. Provisions Applicable to All Services

The Contractor hereafter agrees:

- A. That, to the extent future legislative action by the NH General Court or Federal or State court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Contract so as to achieve compliance therewith, in which event the price limitations for such Service(s) shall be renegotiated;
- B. To comply with all applicable requirements of Appendix E- CMS Checklist For Enrollment Broker Contract Approval dated July 11, 2003.
- C. Order of Precedence: In the event of conflict or ambiguity among any of the text of the Contract Documents, the following Order of Precedence shall govern:
 - 1. The State of New Hampshire terms and conditions, Form P-37 and Exhibits A-J;
 - 2. Appendix E- CMS Checklist For Enrollment Broker Contract Approval dated July 11, 2003 which is hereafter incorporated by reference;
 - 3. RFP#12- DHHS-CM-02 which is hereafter incorporated by reference; and
 - 4. The MAXIMUS Health Services, Inc Proposal, dated June 22, 2012 which is hereafter incorporated by reference;
- D. The Contractor is independent from any Managed Care Entity (MCE) and health care provider that provides coverage in New Hampshire where the Contractor will be conducting enrollment activities.
- E. No person who is an owner, employee, consultant or has a contract with the Contractor either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program, debarred by any Federal agency, or subject to civil money penalty.
- F. The Contractor will provide choice counseling and enrollment activities that do not promote enrollment discrimination (consistent with SSA 1903(m)(2)(A)(v)



Exhibit A

- 42 CFR 438.6 (d)(l), (3) and (4) SMM 2090.4) on the basis of health status or the need for health services or on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origins.
- G. The Contractor will comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1973, and the Americans with Disabilities Act.
- H. The Contractor shall provide all services outlined in the documents referenced in 1.B. above, along with all other services outlined within this Exhibit;
- I. Program Overview: The contractor will act as a call center during the enrollment periods. The contractor shall maintain all call center functions currently in operation and provide all other services outlined with this Exhibit on or before May 1, 2014. The State shall provide for sufficient notice of any change in start date. The Department will make efforts to provide reasonable notice to the contractor;
- J. This Contract and the work to be performed here under is subject to the prior enactment of legislation authorizing NH Healthcare expansion programs.
- K. This Contract and the work to be performed here under as well as all state plan amendments and/or waivers required for the implementation of NH Healthcare expansion program eligibility are subject to the prior approval of the Centers for Medicare and Medicaid Services (CMS).
- L. The Department shall inform the Contractor when call volume has been decreased, as determined by the Department, to end the call center services, with 30 day advance notice.
- 2. Roles and Responsibilities** – The following shall not be interpreted as a comprehensive list, but to operate the call center, in general the:
- A. Responsibilities of Contractor –



Exhibit A

The Contractor shall function as an Enrollment Broker and will be responsible for the activities necessary or required to fulfill its obligations under this Contract to support an incoming and outgoing call center for telephone enrollment inquiries and processing, which shall include, but are not limited to:

1. Location;
2. Staffing;
3. All Equipment (phones, computers, etc.);
4. Systems other than New HEIGHTS to meet the requirements of the contract, including all reporting requirements;
5. Assist callers with inquiries regarding New Hampshire's Medicaid programs including but not limited to: Eligibility, Enrollment Options including Fee for Service, Medicaid Care Management (MCM), the New Hampshire Health Protection Program (the NH mandatory HIPP Program and the voluntary Bridge to Marketplace Premium Assistance Program), and the Federally Facilitated Marketplace (FFM).

a. The assistance shall include but not be limited to provision of the following as directed by the Department.

- i. education
- ii. information
- iii. enrollment activities: preliminary screening for eligibility, preliminary screening for non-plan services, assisting with applications and assisting with accessing and entering data with the appropriate NH DHHS systems.
- iv. transferring clients to appropriate NH DHHS offices, MCM Health Plans, or other resources
- v. assistance will also include the capability for outbound calls to clients, potential clients, Health Plans and others as indicated
- vi. additional services as directed by the Department



Exhibit A

6. Provide choice counseling, including providing information to enrollees about the enrollment process, provide support to clients in making a choice of health plan or choosing a health plan, and respond to questions regarding the differences between Eligibility, Enrollment Options including Fee for Service, Medicaid Care Management (MCM), the New Hampshire Health Protection Program (the NH mandatory HIPP Program and the voluntary Bridge to Marketplace Premium Assistance Program), and the Federally Facilitated Marketplace (FFM).
7. Provide enrollment services including processing enrollment, changes, disenrollment's into one of the three Managed Care Programs, using the State's software; or into one of the other Healthcare options.
8. Outreach and Education, as determined by the Department, subject to review and prior approval of the Department of call scripts, education materials or any other documentation required for this function.
9. Use materials developed by the department in Exhibit A:2-B in the prevalent non-English languages of New Hampshire as identified in RFP RFP#12- DHHS-CM-02 and:
 - a. make oral interpretation services available free of charge to each potential enrollee and enrollee and;
 - i. must notify its enrollees that oral interpretation is available for any language,
 - ii. that written information is available in prevalent languages and,
 - iii. how to access the interpretation services and written information

B. Responsibilities of the Department –

The Department shall continue to be responsible for:

1. Providing the contractor with:



Exhibit A

- i. Access to the New HEIGHTS enrollment software module through a Citrix Environment (including licenses for Citrix);
 - ii. Training based on the contractor's approved training planning;
 - iii. The call center toll-free number;
 - iv. All enrollment notices and information and instructional materials are available upon request and easily understood by enrollees and potential enrollees.
 - v. Written materials that address special needs in the appropriate alternative formats.
 - vi. Information for enrollees and potential enrollees with information relative to the enrollment process, enrollee rights, including: plan election, open enrollment and associated timeframes, enrollee status, PCP selection and Health Plan Comparison
2. Approval of all call scripts
 3. Approval of all Outreach and Education activities not undertaken directly by the Department;
 4. Eligibility determination/exemption and exclusions processing;
 5. Dual eligibility enrollment processing;
 6. MCO Selection and Opt-out for web-based enrollments, U.S. mail based enrollment, auto-assignment enrollment, and administrative enrollment;
 7. Transfers between MCOs, including "for cause" and "without cause" change requests;
 8. Enrollment related interfaces;
 9. Enrollment data reconciliation; and
 10. Provider network data base directory, which may be utilized via the Managed Care Organization's Websites and other Healthcare program websites;
- 3. Program Goal and Objectives**



Exhibit A

- A. **Goal:** Ongoing operation of a temporary call center as it relates to NH Healthcare expansion programs with implementation of all other aspects of this Exhibit on or before **May 1, 2014**;
- B. The Contractor's achievement of this goal shall be based on the measured progress of the following objectives by the implementation date set for all other aspects of this Exhibit:
 - 1. Program Operation Specifications;
 - 2. Staffing Specifications;
 - 3. Technical Telephone System Specifications; and
 - 4. Technical Software System Specifications;

4. Program Operations

- A. Objective #1 Program Operational Specifications:
 - 1. The call center shall be maintained and operated within the 48 contiguous states to support the required functions of this contract.
 - 2. The call center shall be accessible through a statewide toll-free number that is provided by, and exclusively owned by the Department;
 - 3. Customer service representatives shall answer calls Monday through Friday 8:30 a.m. to 7:00 p.m. Eastern Standard Time. The Department reserves the right to require Call Center operations for four (4) consecutive hours on Saturdays. Start and end times for Saturday hours shall be determined by the Department. The call center shall be closed on all State of New Hampshire employee holidays, as published at <http://admin.state.nh.us/hr/> except that the center will be open on Veteran's Day;
 - 4. During non-business hours, the call center shall have a system capable of accepting, recording, or providing instruction to incoming callers;
 - 5. In the absence of the declaration of a weather emergency by the state of New Hampshire or the Call Center location/s, the call center shall provide staff during regularly scheduled business hours;



Exhibit A

6. At all times the call center shall have the capability to accommodate speech and hearing-impaired clients at no cost to the individuals;
 7. At all times the call center shall have the capability to make available oral interpretation services for all Limited-English Proficient individuals via the State of NH language and TTY lines. These services will be at no cost to the individuals;
 8. The contractor shall have a comprehensive plan to handle call volume that exceeds staff capacity. This plan shall include the capacity to roll calls over to other phone centers within one hour of the increase in call volume;
 9. Call center staff shall verify a caller's identity using at least two points of verification (name, date of birth, Social Security number, address, case number, etc.) in the New HEIGHTS system;
 10. The Contractor shall collaborate with the Department and other contractors designated by the Department to create protocol for managing all calls received by the call center. The Department shall have final approval of all protocol established for this contract;
 11. The contractor shall develop telephone scripts, approved by the Department that will be used by the staff of the center;
 12. The contractor shall establish a call center Customer Satisfaction survey for clients to provide feedback on the service they receive from the call center; and
 13. The contractor shall permit the Department to monitor live calls;
- B. Objective #2 Staffing Specifications:
1. Provide qualified staff to operate the call center; and
 2. Dedicate a single point of contact that is continuously accessible to the Department;
- C. Objective #3 Technical Telephone System Specifications: Telephone system, which shall be provided by the contractor shall:



Exhibit A

1. Be capable of transferring calls to the Department's Voice Over Internet Protocol (VOIP) telephone system;
2. Capable of inbound and outbound calls;
3. Provide for a reliable transfer mechanism for calls received by the contractor's call center that have unique circumstances or situations and that will need to be passed to the Medicaid Client Services. This group is supported by a Cisco Unified Communications System running Call Manager version 8.5 and UCCX version 8.5;
4. Calls shall be handled by customer service representatives.
5. The call center shall have the ability to route calls to specific queues, such as an automatic call distribution system. The message system used during regular business hours shall:
 - i. Advise caller of their estimated wait time;
 - ii. Allow callers to leave a voicemail;
 - iii. Provide information about the Department's Healthcare Programs, webpage;
 - vii. Provide information to clients about the enrollment process, provide support to clients in making a choice of health plan or choosing a health plan, and respond to questions regarding the differences between Medicaid Fee-for-Service, Care Management and Healthcare expansion options; and
 - viii. Any other message(s) deemed necessary by the State;
6. The call center shall track call statistics necessary to provide the Performance Reports specified in this agreement; and
7. The telephone system shall have the ability to allow during high call volume callers to leave a message and their call will be returned within one business day;

D. Objective #4 Technical Software System Specifications:

1. The contractor shall use the Department's New HEIGHTS eligibility system to perform the processing enrollment functions of this contract;



Exhibit A

2. New HEIGHTS shall be accessed by users in remote locations through a Citrix environment. The Citrix environment provides full connectivity to the application, through the internet, without the need of a fat client on the local desktop. The user will access the Citrix Access Gateway securely using 128bit encryption via SSL/https;
3. Thin client requirements are 64-bit or 32-bit editions of the following operating systems: Windows 7, Windows Vista, Windows XP Professional (Service Pack 2 or later for 32-bit edition), Windows XP embedded, Windows Server 2003, and Windows 2000 Professional (latest Service Pack);
4. The contractor's information technology system approach will ensure, at a minimum, the following:
 - i. Secure internet access to provide efficient communication for Contractor staff to operate New HEIGHT for the number of staff working on the system;
 - ii. Internet browser with 128-bit encryption Internet Explorer 6.0, Mozilla Firefox 4, (Google Chrome is not supported);
 - iii. Standard PC architecture, as required for the operating system. At a minimum:
 - a. 1.5 GHz processor or faster;
 - b. 1 GB RAM or greater;
 - c. Hard drive with 500 MB or more free space; and
 - d. Video card capable of 1024 x 600 resolution and 32-bit color or more;
 - iv. The Citrix Receiver Client shall be installed on each user's PC to the first log in. The file is available for download at:http://www.citrix.com/lang/English/lp/lp_2309126.asp?ntref=DLpro mo1a;



Exhibit A

v. The contractor shall update or modify all software and technology systems to ensure compatibility with Department resources as needed, and

5. User accounts shall be person specific and will be activated by the State. Each user shall be required to sign the Department's computer Use Agreement. Identification of each user and completed Computer use Agreements shall be received by the State a minimum of two weeks prior to system use;

5. Program Management

1. Following protocol defined in Section 4.A.10. which shall include but not be limited to:

- i. The primary function of providing clients with objective information and processing the enrollment of the client in their available and selected Health Plan; and
- ii. Transferring complicated cases to Client Services; and
- iii. Referring misdirected calls.

6. Performance Measures:

A. Excellent Customer Service.

To be documented by the following performance measures; to be delineated by type of program. :

- a. Medicaid Managed Care Program (MCM);
- b. Health Insurance Premium Payment (HIPPP);
- c. Federally Facilitated Marketplace (FFM)
- d. Other categories as determined by the Department

1. Accessibility:

- i. Blockage Rate – Defined as the weekly percentage of total calls that receive a busy signal. Calls going directly to voicemail are not considered a blocked call; and
- ii. Abandoned Call Rate – Defined as the weekly percentage of total calls that are abandoned by the client or contractor;



Exhibit A

2. Speed of Service:

- i. Average Speed of Answer – Defined as the percentage of weekly live calls that are answered within 180 seconds; and
- ii. Longest Delay – Defined as the longest wait time that any caller experienced during the week;

B. Quality Information. As documented by the following performance measures:

- i. Call Resolution Rate – Defined as the percentage of total calls that are resolved. A call is considered resolved when at the end of the call the client has been:

- Provided information about the enrollment process based on established protocol; and
- All members of the case required to select an MCO have their enrollments processed in New HEIGHTS;

- ii. First Call Resolution Rate – Defined as the percentage of total calls resolved in a single contact; and

iii. Transfer Rate to Client Services

– Defined as the weekly percentage of total calls transferred to Client Services. This is determined by the percentage of all calls received by the contractor that are then transferred to Client Services;

C. Efficiency in Meeting Customer’s Needs. As documented by the following performance measures:

- i. Average Call Time – Defined as the weekly average phone time spent on each call; and
- ii. Customer Satisfaction Ratio – The weekly percentage of customers from a sample that are satisfied with the service of the call center;

D. Dedicating Staff Directly to this Contract: As documented by the following performance measure:

- i. Direct Staff Rate – Defined as the weekly percentage of staff that are assigned to only answer calls for this contract; and



Exhibit A

E. Performance Weekly Minimums: The Contractor shall complete the minimum weekly goals for each performance measure. Successful performance in this contract shall be evaluated based on the contractor meeting the proposed goals for each performance measure;

Performance Measures	
Customer Service – Accessibility	Minimum Goal
Blockage Rate (Percentage)	0%
Abandoned Call Rate (Percentage)	5%
Customer Service – Speed of Service	Minimum Goal
Average Speed of Answer within 180 Seconds (Percentage)	90%
Longest Delay (Minutes)	12
Quality Information – Resolution	Minimum Goal
Call Resolution Rate (Percentage)	90%
First Call Resolution Rate (Percentage)	70%
Transfer Rate to Medicaid CS (Percentage)	5%
Efficiency – Contact Handling	Minimum Goal
Average Call Time (Minutes)	7
Customer Satisfaction Ratio (Percentage)	95%
Direct Resources	Minimum Goal
Direct Staff Rate (Percentage)	95%

7. Contract Deliverables and Reports:

A. Within 7 days of the approval of the contract the contractor will provide a preliminary implementation plan to be approved by the Department. The plan should provide enough detail for the Department to understand the Contractor’s approach to assuring the call center, outreach and education for all elements of Exhibit A will be in operation on or before May 1, 2014, which shall include but not be limited to all necessary program and system testing;



Exhibit A

- B. Within 15 days of the approval of the contract, the contractor shall provide a preliminary training plan to be approved by the Department;
- C. Within 30 days of the approval of the contract, the contractor shall provide an acceptable disaster recovery plan in place in the event the call center is disabled, which shall be approved by the Department;
- D. Within 30 days of the approval of the contract, the contractor shall provide a work plan for how the call center will operate in the event that New HEIGHTS is not accessible through the Citrix Environment. The plan shall be approved by the Department;

8. Program Reporting

- A. The contractor shall provide weekly and monthly reports detailing the status of the performance measures described in Section 6, above. This shall include but not be limited to:
 - 1. Quantitative data on the weekly measures; and
 - 2. Qualitative data on any weekly measure that is not in compliance with the minimum requirement, which shall include but not be limited to: an explanation as well as a plan to bring the measure into compliance;
- B. The contractor shall provide weekly reports that detail by hour the status of all items contained in Section 1, Item C, Section 2, Item A, #5 and Section 6, in a format agreeable to the Department. The contractor shall report in the same manner on the following metrics:
 - 1. Calls received, delineated by type of program referenced in the call. :
 - a. Medicaid Managed Care Program (MCM);
 - b. Health Insurance Premium Payment (HIPPP);
 - c. Federally Facilitated Marketplace (FFM)
 - d. Other categories as determined by the Department
 - 2. Enrollments both inquiries and transactions processed, delineated by type of Medicaid program referenced in the call
 - a. Medicaid Managed Care Program (MCM);
 - b. Health Insurance Premium Payment (HIPPP);



Exhibit A

- c. Federally Facilitated Marketplace (FFM)
- d. Other categories as determined by the Department
- 3. Calls answered;
- 4. Calls transferred to other site as specified in protocol;
- 5. Calls sent to the selected contractor's overflow site, when primary site is at maximum capacity;
- 6. Calls abandoned;
- 7. Average wait time; and
- 8. Maximum wait time; and
- 9. Call back time;
- C. Reports and details regarding Customer Satisfaction, about the contractor's call center; and
- D. Other ad hoc reports as requested by the Department;

9. New Hampshire Technology General Provisions

A. Intellectual Property

Upon successful completion and/or termination of the implementation of the Project, the State of New Hampshire shall own and hold all, title, and rights for the New HEIGHTS software. In no event shall the contractor use its general knowledge, skills, experience, and any other ideas, concepts, know-how, and techniques that are acquired or used in the course of its performance under this Agreement in the New HEIGHTS software.

- 1. State's Data – All rights, title and interest in State Data shall remain with the State; and
- 2. Survival – This Contract Agreement Section 9-A: *Intellectual Property* shall survive the termination of the Contract.

B. Use of State's Information, Confidentiality

In performing its obligations under the contract, the Contractor may gain access to information of the State, including State Confidential Information.

"State Confidential Information" shall include, but not be limited to,

information exempted from public disclosure under New Hampshire RSA



Exhibit A

Chapter 91-A: *Access to Public Records and Meetings* (see e.g. RSA Chapter 91-A: 5 *Exemptions*). The Contractor shall not use the State Confidential Information developed or obtained during the performance of, or acquired, or developed by reason of the Contract, except as directly connected to and necessary for the Contractor's performance under the Contract;

1. State Confidential Information-

Contractor shall maintain the confidentiality of and protect from unauthorized use, disclosure, publication and reproduction (collectively "release"), all State Confidential Information that becomes available to the Contractor in connection with its performance under the contract, regardless of its form.

Subject to applicable federal or State laws and regulations, Confidential Information shall not include information which: (i) shall have otherwise become publicly available other than as a result of disclosure by the receiving party in breach hereof; (ii) was disclosed to the receiving party on a non-confidential basis from a source other than the disclosing party, which the receiving party believes is not prohibited from disclosing such information as a result of an obligation in favor of the disclosing party; (iii) is developed by the receiving party independently of, or was known by the receiving party prior to, any disclosure of such information made by the disclosing party; or (iv) is disclosed with the written consent of the disclosing party. A receiving party also may disclose Confidential Information to the extent required by an order of a court of competent jurisdiction.

Any disclosure of the State Confidential Information shall require the prior written approval of the State. Contractor shall immediately notify the State if any request, subpoena or other legal process is served upon the Contractor regarding the State Confidential Information, and the Contractor

**New Hampshire Department of Health and Human Services Contract for:
Enrollment Broker to support Medicaid Care Management and NH
Healthcare expansion**



Exhibit A

shall cooperate with the State in any effort the State takes to contest the request, subpoena or other legal process, at no additional cost to the State. In the event of the unauthorized release of State Confidential Information, the Contractor shall immediately notify the State, and the State may immediately be entitled to pursue any remedy at law and in equity, including, but not limited to, injunctive relief;

2. Contractor Confidential Information

Insofar as the Contractor seeks to maintain the confidentiality of its confidential or proprietary information, the Contractor must clearly identify in writing all information it claims to be confidential or proprietary. Notwithstanding the foregoing, the State acknowledges that the Contractor considers the Software and Documentation to be Confidential Information. Contractor acknowledges that the State is subject to State and federal laws governing disclosure of information including, but not limited to, RSA Chapter 91-A. The State shall maintain the confidentiality of the identified Confidential Information insofar as it is consistent with applicable State and federal laws or regulations, including but not limited to, RSA Chapter 91-A. In the event the State receives a request for the information identified by the Contractor as confidential, the State shall notify the Contractor and specify the date the State will be releasing the requested information. At the request of the State, the Contractor shall cooperate and assist the State with the collection and Review of the Contractor's information, at no additional expense to the State. Any effort to prohibit or enjoin the release of the information shall be the Contractor's sole responsibility and at the Contractor's sole expense. If the Contractor fails to obtain a court order enjoining the disclosure, the State shall release the information on the date specified in the State's notice to the Contractor, without any liability to the State; and

AP
Date 1/27



Exhibit A

3. Survival – This Contract Agreement Section 9-B, Use of State’s Information, Confidentiality, shall survive termination or conclusion of the Contract;

C. State Owned Documents and Data:

Contractor shall provide the State access to all documents, State Data, materials, reports, and other work in progress relating to the Contract (“State Owned Documents”). Upon expiration or termination of the Contract with the State, Contractor shall turn over all State-owned documents, materials, reports, and work in progress relating to the Contract to the State; and

D. Data Breach – If any State Data is breached as a result of the contractor’s system, the contractor shall be fully liable for all costs associated with that breach. The Contractor will notify the Administrator of Client Services and then collaborate with the Department on notifying all necessary parties about the breach.

10. Definitions

A. For the purpose of this contract Enrollee shall mean a Medicaid recipient who is currently enrolled in an MCO as contracted by the state in a given managed care program.

B. For the purpose of this contract Potential enrollee shall mean a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO as contracted by the state.

11. Provision for Contract Extension

A. The Department reserves the right to extend this contract by mutual agreement of both parties and approval of the Governor and Executive Council for up to four additional years.

EXHIBIT A-1

Assurances and citations required by CMS- Crosswalk for State of New Hampshire enrollment broker contract

Specific Items to meet the obligations of Regulations at 42 CFR 438.810 that specify State expenditures will be available for the use of enrollment brokers are eligible for FFP only if the initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS. The following are Contractor and Department assurances per the CMS requirements:

Legal Cite	Subject
SSA 1903(b)(4)(A) 42 CFR 438.810(a)	<u>Independence.</u> The contractor shall be independent from any health care vendor, managed care organization under contract with DHHS and health care provider that provides coverage in the state of NH. See Exhibit A:1- C
SSA 1903(b)(4)(B) 42 CFR 438.810(b)	<u>Freedom from conflict of interest.</u> The contractor shall not be affiliated with any person who is an owner, employee, consultant, or has a contract with the broker and neither has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program, debarred by any Federal agency, or subject to civil money penalty. Therefore the contractor shall not have: Exhibit A:1- E <ul style="list-style-type: none"> • Any direct or indirect financial interest in any entity or health care provider • Been excluded from participation under title XVIII or XIX of the Act; • Been debarred by any Federal agency; or • Been, or is now, subject to civil money penalties under the Act.

EXHIBIT A-1

Legal Cite	Subject
SSA 1932(d)(3) 42 CFR 438.58(a) and (b)	<u>Conflict of interest safeguards.</u> The State shall have in place conflict of interest safeguards for officers and employees of the State and local entity, with responsibilities relating to the default enrollment process and who have responsibilities relating to the MCO (managed care) contracts. NH Revised Statutes Annotated and NH Division of Personnel Rules and Regulations.
SSA SSA 1903(m)(2)(A)(v) 42 CFR 438.6 (d)(1), (3) and (4) SMM 2090.4	<u>Enrollment discrimination prohibited.</u> The contractor shall provide that choice counseling and enrollment activities do not promote enrollment discrimination for any potential enrollee or for any managed care entity or health provider as per Exhibit A: 1-F
42 CFR 438.6(f)(1)	<u>Compliance with contracting rules.</u> The contractor shall comply with all Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act as per Exhibit A: 1-G and Exhibit G
42 CFR 438.810(a) 45 CFR 74.43 and 74.44 SMM 2080.6 SMM 2080.3 SMM 2080.5 SMM 2080.4 SMM 2080.10 SMM 2080.11	<u>Enrollment Broker Contract Functions</u> The contractor shall: as noted in Exhibit A:2-A
42 CFR 438.10(a)	<u>Terminology.</u> <u>Enrollee</u> means a Medicaid recipient who is currently enrolled in an MCO as contracted by the state in a given managed care program. <u>Potential enrollee</u> means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO as contracted by the state: as noted in Exhibit A:10

EXHIBIT A-1

Legal Cite	Subject
SSA 1932(a)(5)(A) 42 CFR 438.10(d)(1)(i) 42 CFR. 438.10(b)(1) SMD letter 02/20/98	<p>Information - Format requirements. The Department shall develop all enrollment notices, and informational and instructional materials that are easily understood and in a language and format for any potential enrollee; various languages; adapted for visually impaired an the deaf and hard of hearing. Exhibit A: 2- B</p>
42 CFR 438.10(c)(3) 42 CFR 438.10(c)(5)(i) 42 CFR 438.10(c)(4)	<p>Information - Language requirements. The contractor shall use materials developed by the department as above in the prevalent non-English languages in its particular service area, as specified by the State in the contract. The contractor must make oral interpretation services available free of charge to each potential enrollee and enrollee and must notify its enrollees:</p> <ul style="list-style-type: none"> • that oral interpretation is available for any language, • that written information is available in prevalent languages and • how to access the interpretation services and written information. Exhibit A: 2-A
42 CFR 438.10(d) (1)(ii) and (d)(2)	<p>Information - Alternative formats. The Department shall make Written material available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. Exhibit A 2-B</p>



Exhibit B

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, of Form P-37 for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. Payment for said services shall be made as follows:
 - 2.1 The Contractor will submit an invoice by the tenth working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement.
 - 2.2 For incoming calls, the Contractor shall only bill the State at a cost of \$0.57 per minute for time the Contractor is speaking to a live person.
 - 2.3 For outgoing calls, the Contractor shall only bill the State at a cost of \$0.57 per minute for the time the Contractor is speaking to a live person.
 - 2.4 Training costs shall be reimbursed at a rate of \$184.55 per trainee, per day up to 12 days per trainee.
 - 2.4.1 \$38,700 of the amount listed in the Price Limitation, block 1.8, of Form P-37 is reserved for reimbursement of training costs in SFY 2014.
 - 2.4.2 \$10,000 of the amount listed in the Price Limitation, block 1.8, of Form P-37 is reserved for reimbursement of training costs in SFY 2015.
 - 2.4.3 Reimbursement for each trainee is capped at 12 days per individual. Provision of training beyond this reimbursement limitation is at the sole expense of the Contractor.
 - 2.4.4 Payment for training reimbursement is capped at \$48,700 for the contract period. Provision of training beyond this reimbursement limitation is at the sole expense of the Contractor.
 - 2.5 Requests for payment must be signed by an authorized representative of the Contractor.
 - 2.6 Payments may be withheld pending receipt of required reports as defined in Exhibit A.
 - 2.7 A final payment request shall be submitted no later than sixty days after the Contract ends. Failure to submit the invoice by this date could result in non-payment.
 - 2.8 Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this Contract 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.
 - 2.9 Invoices must be submitted to:

Financial Manager Client Services
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301



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 fundors 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 fundors, 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. **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:

- 16.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
- 16.2. 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
- 16.3. Monitor the subcontractor's performance on an ongoing basis
- 16.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
- 16.5. 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. Notwithstanding paragraph 18 of the Form P-37, General Provisions, an amendment limited to the transfer of funds within the budget and within the price limitation can be made by written agreement of both parties and may be made without obtaining approval from the Governor and Executive Council.

4. Subparagraph 14.1.1 of the General Provisions of this contract is deleted and the following subparagraph is added:
 - 14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than \$1,000,000 per occurrence with additional general aggregate coverage of not less than \$1,000,000; and

AP
Date NAE



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: MAXIMUS HEALTH SERVICES, INC

4/18/14
Date

[Signature]
Name:
Title:



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: MARBLE HEALTH SERVICES, INC

4/18/14
Date

AP
Name: **Adam Polatnick**
Title: **Vice President
Assistant General Counsel**



**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: MAXIMUS HEALTH SERVICES, INC.

APB

4/18/14
Date

Name: _____
Title:

**Adam Polatnick
Vice President
Assistant General Counsel**



CERTIFICATION REGARDING
THE AMERICANS WITH DISABILITIES ACT COMPLIANCE

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

1. By signing and submitting this proposal (contract) the Contractor agrees to make reasonable efforts to comply with all applicable provisions of the Americans with Disabilities Act of 1990.

Contractor Name: MAXIMUS HEALTH SERVICES, INC.

4/18/14
Date

[Signature]

Name:

Title:

Adam Polatnick
Vice President
Assistant General Counsel



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: Maximus Health Services, Inc

4/18/14
Date

AP
Name: **Adam Polatnick**
Title: **Vice President
Assistant General Counsel**



HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

Definitions

1. "Breach" shall have the same meaning as the term "Breach" in Title XXX, Subtitle D. Sec. 13400.
2. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
3. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
4. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.
5. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.
6. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.
7. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, Title XIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.
8. "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.
9. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).
10. "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.
11. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
12. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.501.
13. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.
14. "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.
15. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreasonable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.
16. 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.



Use and Disclosure of Protected Health Information

1. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, the Business Associate shall not, and shall ensure that its directors, officers, employees and agents, do not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. Business Associate may use or disclose PHI:
 - 2.1. For the proper management and administration of the Business Associate;
 - 2.2. As required by law, pursuant to the terms set forth in paragraph d. below; or
 - 2.3. For data aggregation purposes for the health care operations of Covered Entity.
3. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402 of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
4. 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.
5. 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.

Obligations and Activities of Business Associate

1. Business Associate shall report to the designated Privacy Officer of Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement, including any security incident involving Covered Entity data, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402.
2. The Business Associate shall comply with all sections of the Privacy and Security Rule as set forth in, the HITECH Act, Subtitle D, Part 1, Sec. 13401 and Sec. 13404.
3. 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.
4. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section (3)b and (3)k herein. The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard provision #13 of this Agreement for the purpose of use and disclosure of protected health information.
5. 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.



6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.

Obligations of Covered Entity

1. 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.
2. 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.
3. 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.

Termination for Cause

In addition to standard provision #10 of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.



Miscellaneous

1. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, and the HITECH Act as amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.
2. 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.
3. 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.
4. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule and the HITECH Act.
5. 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.
6. 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 k, the defense and indemnification provisions of section 3 d and standard contract provision #13, shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Contractor Name: MAXIMUS HEALTH SERVICES, INC

4/18/14
Date

[Signature]
Name: Adam Polatnick
Title: Vice President
Assistant General Counsel

State Agency Name:
NH DHHS

4/21/14
Date

[Signature]
Name: MARY ANN COONEY
Title: Associate Commissioner



**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: MARIMUS HEALTH SERVICES, INC

4/18/14
Date

[Signature]
Name:
Title: **Adam Polatnick
Vice President
Assistant General Counsel**



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: 07-840-2994
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?

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: _____

APPENDIX A

CMS CHECKLIST FOR ENROLLMENT BROKER CONTRACT APPROVAL

(7/11/03)

State: _____
Contract Period: _____
Contractor: _____

Type of Program:
___ 1915(a)(1)(A) voluntary
___ State Plan Amendment
___ 1915(b) waiver
___ 1115 waiver
___ Other

Type of Review:
___ Initial
___ Renewal
___ Amendment

Type of Contract:
___ Contract
___ Interagency Agreement

Reviewer: _____ Date: _____

The checklist is divided into five parts:

Part 1 - all required enrollment broker contract functions.

Part 2 - information requirements for information provided to enrollees and potential enrollees on behalf of the State.

Part 3 - required if the State mandates its enrollment broker to perform choice counseling.

Part 4 - required if the State mandates its enrollment broker to perform enrollment activities.

Part 5 - required if the State delegates these optional activities to the enrollment broker.

The contract must contain either Part 3 or Part 4 or both because an enrollment broker is required by the regulation to be an individual or entity that performs choice counseling or enrollment activities, or both.

Enrollment Broker Introduction

Regulations at 42 CFR 438.810 specify that State expenditures for the use of enrollment brokers are eligible for FFP only if the initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS. The CMS Enrollment Broker Contract Checklist is intended for use by regional office staff in evaluating state managed care enrollment broker (EB) contracts operating under the new Balanced Budget Act (BBA). The checklist contains statutory references and contract requirements collected from the Code of Federal Regulations (CFR), the State Medicaid Manual (SMM), State Medicaid Director (SMD) letters, and the Social Security Act (SSA) which contain provisions enacted by the BBA of 1997. The cites are arranged in order of precedence, with the statutory cite being primary.

Each reviewer will need to evaluate the Enrollment Broker contract being reviewed to determine the activities for which the State is contracting. Enrollment broker is defined in the regulation to mean an individual or entity that performs choice counseling or enrollment activities, or both. However, other parts of the regulation refer to the State or its contracted representative performing specified tasks. To the extent those tasks specified in the BBA regulations, are required of the Enrollment Broker acting as the State's contracted representative, the Regional Office will want to ensure that the contract meets Federal requirements. As a note of caution though, the reviewer should review the contract within the broader context of the State's managed care program and note that different States may perform the tasks directly and not require all tasks of all Enrollment Brokers contractors.

For the purposes of this evaluation process, a contract is a legally binding document between the State and the contractor that defines the contractor's responsibilities. Depending on the State, the contract may be a standalone document, or it may incorporate the RFP, and/or the contractor's proposal, and/or State rule or statute by reference. If required contract language is found in other documents, it should be cross-referenced in the contract.

Instructions for Using the Checklist:

Evaluators should review the contract language and compare it to the "Subject" column in the table to determine whether the required language is contained in the contract. The column "Where Found" is provided for the evaluator's use in noting where the required language is found in the contract or other document. If the language is present and fulfills

APPENDIX A

the requirement, evaluators should place a check in the "Met" column. If the language is absent, evaluators should leave the column blank or indicate "No". If the requirement is not applicable to the entity or review you are doing, indicate "N/A". Resolution of issues concerning absent or incomplete requirements is left up to the discretion of the evaluation team. *Note: Because the statements referred to in this checklist are federal requirements, it is not sufficient to have generic contract language saying the contractor must comply with all federal statutes and regulations. Shaded rows indicate the item is not required in the contract itself but must be in a document that is legally binding on the entity, (e.g. state statute, state regulation). Items that are not shaded must be in the contract itself. Contracts must comply with all procurement requirements in 45 CFR Part 74.*

Column Explanations:

"Optional or Requirement" This column helps the reader determine if the item is a requirement of all enrollment broker contracts, an information requirement, a choice counseling or enrollment activity, a State policy option, or an optional State delegated activity.

"Legal Cite" If there is a statutory cite which further clarifies the requirement, it is the one given. Other cites (regulation, State Medicaid Manual, State Medicaid Director letters) are listed below the statutory reference so that an evaluator may refer to other resources for further clarification of the requirement.

"Where Found" This column has been provided for the evaluator to fill in the contract section and page number (or other citation) indicating where documentation that the requirement has been met was found.

"Met" "[blank]" or "No" means requirement is not met.
 A checkmark means the requirement is met.
 "N/A" means the requirement is not applicable.

Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
Part 1 - Requirements						
AF.1.01	Requirement	SSA 1903(b)(4)(A) 42 CFR 438.810(a)	<p>Independence. The contract must state that the enrollment broker is independent from any MCE and health care provider that provides coverage in the same state in which the enrollment broker is conducting enrollment activities. State expenditures for the use of enrollment brokers are eligible for FFP only if the broker and its subcontractors are independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services.</p> <p>A broker or subcontractor is not considered "independent" if it—</p> <ul style="list-style-type: none"> • Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State; • Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or • Owns or controls an MCO, PIHP, PAHP, PCCM or other health care provider in the State. 			
AF.1.02	Requirement	SSA 1903(b)(4)(B) 42 CFR 438.810(b)	<p>Freedom from conflict of interest. The contract must state that no person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program, debarred by any Federal agency, or subject to civil money penalty. State expenditures for the use of enrollment brokers are eligible for FFP only if</p>			

Contractor Initials *AP*

Date *7/18/14*

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
AF.1.03	Requirement	SSA 1932(d)(3) 42 CFR 438.58(a) and (b)	<p>the broker and its subcontractors are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them—</p> <ul style="list-style-type: none"> • Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services; • Has been excluded from participation under title XVIII or XIX of the Act; • Has been debarred by any Federal agency; or • Has been, or is now, subject to civil money penalties under the Act. <p>Conflict of interest safeguards. The contract must specify conflict of interest safeguards for officers and employees of the State and local entity, with responsibilities relating to the default enrollment process. As a condition for contracting with MCOs, PIHPs, or PAHPs, a State must have in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or the default enrollment process specified in § 438.50(f) for States with 1932 SPA programs. These safeguards must be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).</p>			
AF.1.04	Requirement	SSA SSA 1903(m)(2)(A)(v) 42 CFR 438.6 (d)(1), (3) and (4) SMM 2090.4	<p>Enrollment discrimination prohibited. The contract must provide that choice counseling and enrollment activities do not promote enrollment discrimination consistent with the regulation requirements:</p> <ul style="list-style-type: none"> • MCO, PIHP, PAHP, or PCCMs must accept individuals in the order in which they apply without restriction, (unless authorized by the Regional Administrator), up to the limits set under their contract. • The contract must specify that the enrollment broker will not discriminate against individuals eligible to be covered under contract on the basis of health status or need for health services. • The Enrollment Broker will not allow the MCO, PIHP, PAHP or PCCM entity to discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin. <p>Compliance with contracting rules. The contract must comply with all Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.</p>			See Subpart C, 438.100(a)(2)
AF.1.05	Requirement	42 CFR 438.6(f)(1)	<p>Enrollment Broker Contract Functions. The contract is precise regarding specific</p>			
AF.1.06	Requirement	42 CFR 438.810(a)				

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
	nt	45 CFR 74.43 and 74.44 SMM 2080.6 SMM 2080.3 SMM 2080.5 SMM 2080.4 SMM 2080.10 SMM 2080.11	<p>functions of the contractor and the scope of those functions.</p> <ul style="list-style-type: none"> • A clear and accurate description of the technical requirements for the material, product, or service to be procured. • Contracts must be in writing. • The Contract identifies the population covered by the Contract. • The contract should be precise regarding ambiguous areas such as nonperformance, payment, and other sensitive issues where the possibility of dispute exists. • Specify the contract period, procedures and criteria for extending the contract period. • Specify renegotiations procedures and criteria as follows: <ul style="list-style-type: none"> • For good cause, only at the end of the contract period; and • For modification(s) during the contract period, if circumstances warrant, at the discretion of the state. Grounds for renegotiating the contract are defined in detail <p>The contract must specify the functions of the enrollment broker, including:</p> <p>Enrollment broker: means an individual or entity that performs choice counseling or enrollment activities, or both.</p> <p>Enrollment services: means choice counseling, or enrollment activities, or both.</p> <p>Choice counseling: means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider.</p> <p>Enrollment activities: means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person.</p>			
AF.1.07	Requirement nt	42 CFR 438.10(a)	<p><u>Terminology.</u></p> <p><u>Enrollee</u> means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.</p> <p><u>Potential enrollee</u> means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.</p>			
Part 2 - Information						
AF.2.01	Requirement nt - Information	SSA 1932(a)(5)(A) 42 CFR 438.10(d)(1)(i) 42 CFR. 438.10(b)(1) SMD letter 02/20/98	<p><u>Information - Format requirements.</u> The contract specifies that all enrollment notices, and informational and instructional materials are available upon request and prepared in a way that is easily understood by enrollees and potential enrollees. Written material must use easily understood language and format</p>			
AF.2.02	Requirement nt - Information	42 CFR 438.10(c)(3) 42 CFR 438.10(c)(5)(i)	<p><u>Information - Language requirements.</u> The Enrollment Broker must make its written information available in the prevalent non-English languages in its particular service area, as specified by the State in the contract. The Enrollment Broker must make oral</p>			

Contractor Initials AP

Date 7/18/04

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
	n	42 CFR 438.10(c)(4)	<p>interpretation services available free of charge to each potential enrollee and enrollee. The Enrollment Broker must notify its enrollees:</p> <ul style="list-style-type: none"> • that oral interpretation is available for any language, • that written information is available in prevalent languages and • how to access the interpretation services and written information. 			
AF.2.03	Requirement - Information	42 CFR 438.10(d)(1)(ii) and (d)(2)	<p><u>Information - Alternative formats.</u> Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.</p>			
AF.2.04	Information - State Delegation Option	SSA 1932(a)(5)(D) 42 CFR 438.10(e)&(f) SMM 2088.8 SMM 2092.9	<p><u>Information - Potential Enrollees and Enrollees non-covered services.</u> If the State delegates this function to the enrollment broker, the contract must ensure that each managed care enrollee is informed of any services available under the State plan and not covered by the capitated or FFS contractor. The enrollment broker shall make available to potential enrollees and new enrollees, information in a written and prominent manner of any benefits to which the enrollee may be entitled but which are not made available to the enrollee by the entity. Such information shall include information on where and how such enrollee may access benefits not made available to the enrollee through the MCE.</p>			
AF.2.05	Information - State Delegation Option	42 CFR 438.10(e)(1) and (e)(2) 42 CFR 438.102(c)	<p><u>Information - Potential Enrollees.</u> If the State delegates this function to the enrollment broker, the contract must provide the information of this section to each potential enrollee as follows:</p> <ul style="list-style-type: none"> • At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program. • Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHP, or PCCMs. <p>The information for potential enrollees must include the following:</p> <ul style="list-style-type: none"> • General information about— <ul style="list-style-type: none"> ➢ The basic features of managed care; ➢ Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and ➢ MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care; • Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request: <ul style="list-style-type: none"> ➢ Benefits covered. ➢ Cost sharing, if any. ➢ Service area. 			

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
AF.2.06	Information - State Delegation Option	42 CFR 422.208 42 CFR 422.210 42 CFR 431.230 42 CFR 438.10(f) 42 CFR 438.10(f)(2) 42 CFR 438.10(f)(3) 42 CFR 438.10(f)(6) SMD Letter 1/21/98 42 CFR 438.10(f)(6)(iv) 42 CFR 438.10(g)(1) 42 CFR 438.10(h) 42 CFR 438.102(c) 42 CFR 438.400 through 42 CFR 438.424 42 CFR 438.6(h) 42 CFR 438.6(h) 42 CFR 438.6(i)(1) 42 CFR 438.6(i)(2) 42 CFR 489.102(a) SMM 2900 SMM 2902.2	<p>➤ Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.</p> <p>➤ Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.</p> <p><u>Information - Enrollees.</u> If the State delegates this function to the enrollment broker, the contract must provide the information of this section to each enrollee as follows:</p> <ul style="list-style-type: none"> • notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period. • notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenroll enrollment for cause. • notify all enrollees of their right to request and obtain the information listed in paragraph 1 of this section and, if applicable, paragraph 2 and 3 of this section, at least once a year. • furnish to each of its enrollees the information specified in paragraph 1 of this section and, if applicable, paragraph 2 and 3 of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment. • give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraph 1 of this section and, if applicable, paragraph 2 and 3 of this section, at least 30 days before the intended effective date of the change. • furnish to each of its enrollees the information specified in paragraph 1 and, if applicable, paragraphs 2 and 3, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment. <p>Paragraph 1: The information in 42 CFR 438.10(f)(6) for MCO, PIHP, PAHP and PCCM includes:</p> <ul style="list-style-type: none"> • Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this 			

Contractor Initials AR
 Date 4/18/14

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
			<p>includes, at a minimum, information on primary care physicians, specialists, and hospitals.</p> <ul style="list-style-type: none"> • Any restrictions on the enrollee's freedom of choice among network providers. • Enrollee rights and protections, as specified in § 438.100. • Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in § 438.10(g)(1), and for PAHP enrollees, the information specified in § 438.10(h). • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements. • The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. • The extent to which, and how, after-hours and emergency coverage are provided, including: <ul style="list-style-type: none"> ➢ What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in § 438.114(a). ➢ The fact that prior authorization is not required for emergency services. ➢ The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent. ➢ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract. ➢ The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care. • The poststabilization care services rules set forth at § 422.113(c) of this chapter. • Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. • Cost sharing, if any. • How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service. <p>Paragraph 2: Information to MCO or PIHP enrollees (42 CFR 438.10 (g))</p> <ul style="list-style-type: none"> • Grievance, appeal and fair hearing procedures and timeframes, as provided in 438.400 through 438.424, in a State -developed or State-approved description that 			

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
			<p>must include the following:</p> <ul style="list-style-type: none"> • For State fair hearing: <ul style="list-style-type: none"> ➢ The right to hearing; ➢ The method for obtaining a hearing; and ➢ The rules that govern representation at the hearing. • The right to file grievances and appeals. • The requirements and timeframes for filing a grievance or appeal • The availability of assistance in the filing process • The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone. • The fact that, when requested by the enrollee-- <ul style="list-style-type: none"> ➢ Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and ➢ The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee. • Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service. • Advance Directives, as set forth in 438.6(i)(1). • Additional information that is available upon request, including the following: <ul style="list-style-type: none"> ➢ Information on the structure and operation of the MCO or PIHP. ➢ Physician incentive plans as set forth in 438.6(h) of this chapter. <p>Paragraph 3 - Information to PAHP enrollees (42 CFR 438.10 (h))</p> <ul style="list-style-type: none"> • The right to a State fair hearing, which includes the following: <ul style="list-style-type: none"> ➢ The right to a hearing ➢ The method of obtaining a hearing ➢ The rules that govern representation • Advance directives, as in 438.6(i)(2) to the extent that the PAHP includes any of the providers listed in 489.102(a). <p>Upon request physician incentive plans as in 438.6(h).</p> <p><u>Information - Informing Enrollees of Rights.</u> The State must ensure that each managed care enrollee is guaranteed the rights of this section. The State, its representative or the contracting entity must inform the enrollees of their rights.</p> <p>If the State delegates this function to the enrollment broker, the contract must specify the functions for which the Enrollment Broker is responsible. An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to —</p> <ul style="list-style-type: none"> • Receive information in accordance with § 438.10. 			
AF.2.07	Information - State Delegation Option	42. CFR 438.10(f)(3) 42 CFR 438.100(b)(2)(ii) 42 CFR 438.100(c)				

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
			<ul style="list-style-type: none"> Be treated with respect and with due consideration for his or her dignity and privacy. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(f)(6)(xii).) Participate in decisions regarding his or her health care, including the right to refuse treatment. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR part 164. An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§ 438.206 through 438.210. Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP or PCCM and its providers or the State agency treat the enrollee. 			
Part 3 - Choice Counseling						
AF.3.01	Choice Counseling Requirement	42 CFR 438.10(b)(2)	<p><u>Choice Counseling - Mechanism.</u> If the State delegates this function to the enrollment broker, the State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program. The State must specify the functions that the Enrollment Broker is responsible for to help enrollees and potential enrollees understand the State's managed care program.</p>			
Part 4 - Enrollment Activities						
AF.4.01	Enrollment Activities Requirement	42 CFR 434.6(a)(3) SMM 2080.7	<p><u>Enrollment - Process.</u> The contract specifies enrollment and reenrollment procedures for the covered population, including a description of marketing approach, the period of enrollment, reasons for involuntary cancellation of enrollment (such as pre-existing conditions and maximum use of services), refusal to enroll, and the period of open enrollment, if limited.</p> <p><u>Enrollment - Voluntary unless 1932 SPA or a waiver program.</u> Contracts with Enrollment Brokers must provide that the MCO, PIHP, PAHP or PCCM enrollment is voluntary, except in the case of mandatory enrollment under an approved 1932 SPA or a waiver program.</p> <p><u>Enrollment - Automatic reenrollment.</u> If the State plan so specifies, the contract must provide for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. If the State chooses to limit</p>			
AF.4.02	Enrollment Activities Requirement	42 CFR 438.6 (d)(2)				
AF.4.03	Enrollment Activities - State	42 CFR 438.56(c)(2)(iii) 42 CFR 438.56(g)				

Contractor Initials AP
Date 4/18/14

APPENDIX A

Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
AF.4.05	Enrollment Activity Requirement - 1932 SPA Programs only	SMM 2090.5 SSA 1932(a)(2) 42 CFR 438.50(d)	<p>disenrollment, a recipient may request disenrollment upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.</p> <p><u>Enrollment Activities - Limitations on enrollment 1932 SPA States.</u> If the Enrollment Broker is conducting enrollment activities including default enrollment for a State with a 1932 SPA, the contract provides for exclusion of special populations from mandatory enrollment. The default algorithm to be used should be reviewed to ensure that, in implementing the State plan managed care option, the EB will not require the following groups to enroll in an MCO or PCCM:</p> <ul style="list-style-type: none"> • Recipients who are also eligible for Medicare. • Indians who are members of Federally recognized tribes, except when the MCO or PCCM is— <ul style="list-style-type: none"> ➢ The Indian Health Service; or ➢ An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service. • Children under 19 years of age who are— <ul style="list-style-type: none"> ➢ Eligible for SSI under title XVI; ➢ Eligible under section 1902(e)(3) of the Act; ➢ In foster care or other out-of-home placement; ➢ Receiving foster care or adoption assistance; or ➢ Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs. 			
AF.4.06	Enrollment Activity Requirement - 1932 SPA Programs only	42 CFR 438.50(e)	<p><u>Enrollment Activity - Priority for enrollment in 1932 SPA</u> If the Enrollment Broker is conducting enrollment activities, existing members MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity to accept all those seeking enrollment under the program.</p>			
AF.4.07	Enrollment Activity Requirement - 1932 SPA Programs	42 CFR 438.50(f)	<p><u>Enrollment Activity - Enrollment by default in 1932 SPA.</u> If the Enrollment Broker is conducting enrollment activities,</p> <ul style="list-style-type: none"> • For recipients who do not choose an MCO or PCCM during their enrollment period, the State must have a default enrollment process for assigning those recipients to contracting MCOs and PCCMs. • The process must seek to preserve existing provider-recipient relationships and 			

APPENDIX A

Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
AF.4.08	Enrollment Activity - 1932 SPA Programs only	42 CFR 438.10(i)	<p>relationships with providers that have traditionally served Medicaid recipients. If that is not possible, the State must distribute the recipients equitably among qualified MCOs and PCCMs available to enroll them, excluding those that are subject to the intermediate sanction described in § 438.702(a)(4).</p> <ul style="list-style-type: none"> An "existing provider-recipient relationship" is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population. <p>Information - Comparison information for 1932 SPA. If the State plan provides for mandatory enrollment under a 1932 SPA AND the State delegates this function to the enrollment broker, the contract must provide required information on MCOs and PCCMs in a comparative, chart-like format, either directly or through the MCO or PCCM.</p> <p><i>Required comparative, chart-like information.</i> The following must be provided for each contracting MCO or PCCM in the potential enrollee and enrollee's service area in a comparative, chart-like format:</p> <ul style="list-style-type: none"> The MCO's or PCCM's service area. The benefits covered under the contract. Any cost sharing imposed by the MCO or PCCM. To the extent available, quality and performance indicators, including enrollee satisfaction. <p><i>When the information must be furnished.</i> The information must be furnished:</p> <ul style="list-style-type: none"> For potential enrollees - <ul style="list-style-type: none"> at the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program. Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHPs, or PCCMs. For enrollees, annually and upon request. 			
AF.4.09	Enrollment Activity - State Policy Option	42 CFR 438.6(m) SMM 2090.2	<p>Choice of health professional. If the Enrollment Broker is assisting with the selection of PCPs, the contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate. The contract specifies that each enrolled beneficiary can choose his health professional in the HMO, PIHP or the PAHP to the extent possible and appropriate. This language is required only if the enrollment broker bears some responsibility for selection of the primary care provider.</p>			
AF.4.10	Enrollment	42 CFR 438.52(d)	<p>Enrollment Activity - Limitations on changes between primary care providers. If the</p>			

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Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
	Activity - State Optional Policy	42 CFR 438.56(c) Regulation Correction 10/25/02 SMD letter 01/14/98	Enrollment Broker is conducting enrollment activities, and enrolling individuals directly with primary care providers for an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of section 438.52 (i.e., rural area exception to choice allowing a single contracting entity), any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitation on disenrollment under 438.56(c) (i.e., annual open enrollment).			
AF.4.11	Enrollment Activity	42 CFR 438.56(d)(3)(i) and (ii)	<p><u>Disenrollment - Functions.</u> The State should specify who is responsible for taking action on a recipient's request for disenrollment. If the entity or Enrollment Broker is responsible, the Enrollment Broker functions should be explained in the contract. If the entity may either approve a request for disenrollment or refer the request to the State, the Enrollment Broker's role should be explained.</p> <p>If the Enrollment Broker is responsible for processing disenrollment requests, the contract should outline acceptable procedures and reasons for granting or not granting a disenrollment request. For a request received directly from the recipient, or one referred by the MCO, PIHP, PAHP, or PCCM, the State agency (or its Enrollment Broker) must take action to approve or disapprove the request based on the following:</p> <ul style="list-style-type: none"> • Reasons cited in the request. • Information provided by the MCO, PIHP, PAHP, or PCCM at the agency's request. <p>Any of the reasons specified in paragraph (d)(2) of this section.</p>			
AF.4.12	Enrollment Activity - State Policy Option	42 CFR 438.56(d)(5)(ii) and (iii) 42 CFR 438.56(e)(1)	<p><u>Disenrollment - Use of entity's grievance procedures.</u> If the state requires the enrollee to seek redress through the MCO, PIHP, PAHP, or PCCM grievance system, the grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 438.56(e)(1). If, as a result of the grievance process, the MCO, PIHP, PAHP, or PCCM approves the disenrollment, the State agency (or its Enrollment Broker) is not required to make a determination.</p>			
AF.4.13	Enrollment Activity	SSA 1932(a)(4)(A) 42 CFR 438.56(c)(2)(ii) SMD letter 01/21/98 SMM 2090.3	<p><u>Disenrollment - Annual Open Enrollment Period.</u> If the State chooses to limit disenrollment, the contract must provide that a recipient may request disenrollment without cause at least once every 12 months thereafter. In addition, during the open enrollment period, the HMO or PHP must accept individuals who are eligible to be covered under the contract: (i) In the order in which they apply; (ii) Without restriction, unless authorized by the Regional Administrator; and (iii) Up to the limits set under the MCE contract.</p>			
AF.4.14	Enrollment Activity	SSA 1932(e)(2)(C) 42 CFR 438.56(c)(iv) 42 CFR 438.702(a)(3)	<p><u>Disenrollment - During intermediate sanctions.</u> If the State chooses to limit disenrollment, the contract must provide that a recipient may request disenrollment when the State imposes the intermediate sanction specified in 438.702(a)(3).</p>			See Sanctions Subpart I. 438.702(a)(3)

APPENDIX A

Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
		SMD letter 02/20/98				
AF.4.15	Enrollment Activity	42 CFR 438.56(d)(1)(i) and (ii)	<p><u>Disenrollment - Requests.</u> The recipient (or his or her representative) must submit an oral or written request to the State agency (or its agent). If the State permits MCOs, PIHP, PAHPs or PCCMs to process disenrollment requests, then the recipient would submit the oral or written request to the entity.</p> <p><u>Disenrollment - Cause.</u> The following are cause for disenrollment:</p> <ul style="list-style-type: none"> • The enrollee moves out of the MCO's, PIHP's, PAHP's or PCCM's service area. • The plan does not, because of moral or religious objections, cover the service the enrollee seeks. • The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. • Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs. 			
AF.4.16	Enrollment Activity	42 CFR 438.56(d)(2)	<p><u>Disenrollment - Timeframes.</u> Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO, PIHP, PAHP, or PCCM files the request. If the MCO, PIHP, PAHP, or PCCM or the State agency (whichever is responsible) fails to make the determination within these timeframes, the disenrollment is considered approved.</p>			
AF.4.17	Enrollment Activity	42 CFR 438.56(e)(1) and (2) 42 CFR 438.56(d)(4) SMM 2090.6 SMM 2090.11				
AF.4.18	Enrollment Activity	42 CFR 438.56(f)	<p><u>Disenrollment - Denial notice and appeals.</u> A State that restricts disenrollment under this section must take the following actions:</p> <ul style="list-style-type: none"> • Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. • Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. 			
AF.4.19	Enrollment Activities	SSA 1903(m)(2)(A)(v) SSA 1932(a)(4)(A) and (B) 42 CFR 456(c) 42 CFR 438.56(c)(1) 42 CFR 438.56(b)(1), (2), and (3) SMD Letter 1/21/98	<p><u>Disenrollment - Reasons for Disenrollment.</u> If the Enrollment Broker is conducting enrollment activities including disenrollment, the contract must specify:</p> <ul style="list-style-type: none"> • the reasons for disenrollment the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee. <p>If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a recipient may request disenrollment as follows:</p> <ul style="list-style-type: none"> • For cause, at any time. • Without cause, at the following times: <ul style="list-style-type: none"> ➤ During the 90 days following the date of the recipient's initial enrollment with 			

Contractor Initials AP
Date 4/18/04

APPENDIX A

Item #	Optional or Requirement	Legal Cite	Subject	Where found	Met	Comments
Part 5 - State Delegated Activities						
AF.5.01	State Delegation Option	SMD letter 01/21/98 SMM 2090.6 thru 9 SMM 2090.4 SMM 2090.12 SMM 2090.12 SMM 2088.3 SMM 2080.7	<p>the MCO, PIHP, PAHP, or PCCM, or the date the State sends the recipient notice of the enrollment, whichever is later.</p> <ul style="list-style-type: none"> ➤ At least once every 12 months thereafter. ➤ Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity. • When the State imposes the intermediate sanction specified in § 438.702(a)(3). The enrollment broker may not allow an MCO, PIHP, PAHP or PCCM may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees 			
AF.5.02	State Delegation Option	42 CFR 438.208(c)(2)	<p><u>Enrollees with special health care needs assessment.</u> If the State delegates this function to the enrollment broker, the contract must require that the entity implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. At State discretion, exceptions may exist for MCOs that serve dually eligible enrollees.</p> <p><u>Language.</u> If the State delegates this function to the enrollment broker, the contract must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.</p>			
AF.5.03	State Delegation Option	42 CFR 438.10(c)(1) 438.204(b)(2)	<p><u>Race, ethnicity, and primary language identification.</u> If the State delegates this function to the enrollment broker, the contract must identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.</p>			

Contractor Initials AR
Date 7/18/19

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 Maximus Health Services, Inc. a(n) Indiana corporation, is authorized to transact business in New Hampshire and qualified on January 23, 2009. I further certify that all fees and annual reports required by the Secretary of State's office have been received.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 3rd day of April, A.D. 2014

A handwritten signature in cursive script, appearing to read "William M. Gardner".

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Bruce Caswell, do hereby certify that:

(Name of Board Member; cannot be contract signatory)

1. I am a Member of the Board of Directors of MAXIMUS Health Services, Inc.; and
2. That Adam C. Polatnick, Vice President and Assistant General Counsel is hereby authorized on behalf of this Organization to enter into the contract titled Temporary Call Center with the State of New Hampshire and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he may deem necessary, desirable or appropriate.

That authorization has not been amended or revoked, and remain in full force and effect as of the 18th day of April, 2014

(Date Contract Signed or after the date it was signed)

Bruce L. Caswell

(Signature of Board Member)

STATE OF Virginia

County of Fairfax

The forgoing instrument was acknowledged before me this 18th day of April, 2014.

by Bruce L. Caswell.

(Name of Board Member)

Gail Leslie Buchanan

(Notary Public/Justice of the Peace)

(NOTARY SEAL)

Commission Expires:

4/30/2015





CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
04/02/2014

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 MARSH USA INC. SUITE 400 1255 23RD STREET, N.W. WASHINGTON, DC 20037 Attn: DC.CertRequestSiebel@marsh.com 500625-XS-UMB-13-14	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS:		FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE		
INSURED MAXIMUS, INC. 1891 METRO CENTER DRIVE RESTON, VA 20190-5287	INSURER A: Hartford Fire Insurance Co	NAIC # 19682	
	INSURER B: Twin City Fire Insurance Co	29459	
	INSURER C: N/A	N/A	
	INSURER D: Trumbull Insurance Company	27120	
	INSURER E:		
	INSURER F:		

COVERAGES **CERTIFICATE NUMBER:** CLE-003831339-07 **REVISION NUMBER:** 9

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			42UENZW3578	05/01/2013	05/01/2014	EACH OCCURRENCE	\$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 1,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person)	\$ 10,000
	GEN'L AGGREGATE LIMIT APPLIES PER:							PERSONAL & ADV INJURY
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						GENERAL AGGREGATE	\$ 2,000,000
							PRODUCTS - COMP/OP AGG	\$ 2,000,000
								\$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> ALL OWNED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS						PROPERTY DAMAGE (Per accident)	\$
								\$
	UMBRELLA LIAB						EACH OCCURRENCE	\$
	<input type="checkbox"/> OCCUR						AGGREGATE	\$
	EXCESS LIAB							\$
	<input type="checkbox"/> CLAIMS-MADE							\$
	DED							\$
	RETENTION \$							\$
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			42 WN MG3740 (AOS)	05/01/2013	05/01/2014	<input checked="" type="checkbox"/> WC STATU-TORY LIMITS	OTHER
B	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			42 WBR MG3741 (WI)	05/01/2013	05/01/2014	E.L. EACH ACCIDENT	\$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	\$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	\$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
RE: THE NEW HAMPSHIRE TEMPORARY ENROLLMENT CALL CENTER - DOLT NO. 2012-158

SEE ADDITIONAL PAGE.

CERTIFICATE HOLDER NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES ATTN: ERIC D. BORRIN CONTRACTS AND PROCUREMENT UNIT 129 PLEASANT STREET- BROWN BUILDING CONCORD, NH 03301	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Manashi Mukherjee
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ADDITIONAL REMARKS SCHEDULE

AGENCY MARSH USA INC.		NAMED INSURED MAXIMUS, INC. 1891 METRO CENTER DRIVE RESTON, VA 20190-5287	
POLICY NUMBER		EFFECTIVE DATE:	
CARRIER	NAIC CODE		

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

NOTICE OF CANCELLATION TO CERTIFICATE HOLDER(S) - GENERAL LIABILITY AND / OR AUTOMOBILE LIABILITY: THIS POLICY IS SUBJECT TO THE FOLLOWING ADDITIONAL CONDITIONS: A. IF THIS POLICY IS CANCELLED BY THE CARRIER, 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 CARRIER. B. IF THIS POLICY IS CANCELLED BY THE CARRIER 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 CARRIER. 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 CARRIER WILL BE SUFFICIENT PROOF OF NOTICE. ANY NOTIFICATION OF 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 CARRIER OR ITS AGENTS AND REPRESENTATIVES.

WITH REGARDS TO WORKERS' COMPENSATION: IF THIS POLICY IS CANCELLED BY THE CARRIER, OTHER THAN FOR NON-PAYMENT OF PREMIUM, NOTICE OF SUCH CANCELLATION WILL BE PROVIDED TO THE CERTIFICATE HOLDER(S) WITH MAILING ADDRESSES ON FILE WITH THE AGENT OF RECORD. SUCH NOTICE WILL BE PROVIDED WITHIN 30 DAYS OF THE CARRIER'S RECEIPT OF CERTIFICATE HOLDER(S) INFORMATION FROM THE AGENT OF RECORD. IF NOTICE IS MAILED, PROOF OF MAILING ADDRESS OF THE CERTIFICATE HOLDER(S) ON FILE WITH THE AGENT OF RECORD 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 CARRIER OR ITS AGENTS OR REPRESENTATIVES.