



Appendix C

Medicaid Care Management Services Model Contract

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1 INTRODUCTION

1.1 Purpose

1.1.1 This Medicaid Care Management Contract (the “Agreement”) is a comprehensive full risk prepaid capitated contract that sets forth the terms and conditions for the Managed Care Organization’s (MCO’s) participation in the New Hampshire (NH) Medicaid Care Management (MCM) program.

1.2 Term

1.2.1 Contractual obligations, including readiness review, will become effective on the date the Governor and Executive Council approve the executed MCM Contract or health maintenance organization (HMO) licensure in the State of New Hampshire or whichever is later. The Program Start Date shall begin on July 1, 2019, and the Contract term will continue through June 30, 2024. The MCO’s participation in the MCM program is contingent upon the MCO’s successful completion of the contract readiness review period, as determined by DHHS. The MCO is solely responsible for the cost of all work during the readiness review and undertakes the work at its sole risk. If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, July 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Contract.

2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 **Adults with Special Health Care Needs**

2.1.1.1 “Adults with Special Health Care Needs” means Members who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age. This includes, but is not limited to Members with: Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); a Severe Mental Illness (SMI), Serious Emotional Disturbance (SED), Intellectual and/or Developmental Disability (I/DD), Substance Use Disorder diagnosis; or chronic pain.

2.1.2 **Advance Directive**

2.1.2.1 “Advance Directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of NH, relating to the provision of health care when a Member is incapacitated. [42 CFR 489.100]

2.1.3 **Affordable Care Act**

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2.1.3.1 “Affordable Care Act” means the Patient Protection and Affordable Act, P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted on March 30, 2010.

2.1.4 Agreement

“Agreement” means this entire written Agreement (the MCM Contract) between DHHS and the MCO, including its exhibits.

2.1.5 American Society of Addiction Medicine (ASAM) Criteria

2.1.5.1 “American Society of Addiction Medicine (ASAM) Criteria” means a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.¹

2.1.6 Americans with Disabilities Act (ADA)

2.1.6.1 “Americans with Disabilities Act (ADA)” means a civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.²

2.1.7 Appeal Process

2.1.7.1 “Appeal Process” means the procedure for handling, processing, collecting and tracking Member requests for a review of an adverse benefit determination which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.8 ASAM Level of Care

2.1.8.1 “ASAM Level of Care” means a standard nomenclature for describing the continuum of recovery-oriented addiction services. With the continuum, clinicians are able to conduct multidimensional assessments that explore individual risks and needs, and recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs.³

2.1.9 Assertive Community Treatment (ACT)

2.1.9.1 “Assertive Community Treatment (ACT)” means the evidence-based practice of delivering comprehensive and effective services to

¹ The American Society of Addiction Medicine, “What is the ASAM Criteria,” available at <https://www.asam.org/resources/the-asam-criteria/about>

² The Americans with Disability Act National Network, “What is the Americans with Disabilities Act,” available at <https://adata.org/learn-about-ada>

³ Continuum, “What are the ASAM Levels of Care,” available at <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>

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Members with SMI by a multidisciplinary team primarily in their homes, communities, and other natural environments.

2.1.10 Auxiliary Aids

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

2.1.11 Behavioral Health Services

2.1.11.1 "Behavioral Health Services" means mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.12 Behavioral Health Crisis Treatment Center (BHCTC)

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

2.1.13 Bright Futures

2.1.13.1 "Bright Futures" means a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.14 Capitation Payment

2.1.14.1 "Capitation Payment" means the monthly payment by DHHS to the MCO for each Member enrolled in the MCO's plan for which the MCO provides Covered Services under this Agreement. Capitation payments are made only for Medicaid-eligible Members and retained by the MCO for those Members. DHHS makes the payment regardless of whether the Member receives services during the period covered by the payment. [42 CFR 438.2]

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2.1.15 Care Coordination

2.1.15.1 "Care Coordination" means the interaction with established local community-based providers of care, including Local Care Management entities, to address the physical, behavioral health and psychosocial needs of Members.

2.1.16 Care Management

2.1.16.1 "Care Management" means direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.17 Care Manager

2.1.17.1 "Care Manager" means a qualified and trained individual who is hired directly by the MCO, a provider in the MCO's network (a "Participating Provider"), or a provider for a Local Care Management entity with which the MCO contracts who is primarily responsible for providing Care Coordination and Care Management services as defined by this Agreement.

2.1.18 Case Management

2.1.18.1 "Case Management" means services that assist Members in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

2.1.19 Centers for Medicare & Medicaid Services (CMS)

2.1.19.1 "Centers for Medicare & Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare programs.

2.1.20 Children with Special Health Care Needs

2.1.20.1 "Children with Special Health Care Needs" means Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.21 Children's Health Insurance Program (CHIP)

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2.1.21.1 “Children’s Health Insurance Program (CHIP)” means a program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.22 Choices for Independence (CFI)

2.1.22.1 “Choices for Independence (CFI)” means the Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities. The CFI waiver is also known as HCBS for the Elderly and Chronically Ill (HCBS-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and Covered Services are identified in He-E 801.⁴

2.1.23 Chronic Condition

2.1.23.1 “Chronic Condition” means a physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.24 Clean Claim

2.1.24.1 “Clean Claim” means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

2.1.25 Cold Call Marketing

2.1.25.1 “Cold Call Marketing” means any unsolicited personal contact by the MCO or its designee, with a potential Member or a Member with another contracted MCO for the purposes of Marketing. [42 CFR 438.104(a)]

2.1.26 Community Mental Health Services

2.1.26.1 “Community Mental Health Services” means mental health services provided by a Community Mental Health Program (“CMH Program”) or Community Mental Health Provider (“CMH Provider”) to eligible Members as defined under He-M 426.

2.1.27 Community Mental Health Program (“CMH Program”)

2.1.27.1 “Community Mental Health Program (“CMH Program”)", synonymous with Community Mental Health Center, means a program established and administered by the State, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency,

⁴ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-e.html

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medical or psychiatric screening and evaluation, Case Management, and psychotherapy services, [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.28 Community Mental Health Provider (“CMH Provider”)

2.1.28.1 “Community Mental Health Provider (“CMH Provider”)” means a Medicaid Provider of Community Mental Health Services that has been previously approved by the DHHS Commissioner to provide specific mental health services pursuant to He-M 426 [He-M 426.02: (g)]. The distinction between a CMH Program and a CMH Provider is that a CMH Provider offers a more limited range of services.

2.1.29 Comprehensive Assessment

2.1.29.1 “Comprehensive Assessment” means a person-centered assessment to help identify a Member’s health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.30 Confidential Information

2.1.30.1 “Confidential Information” means information that is exempt from disclosure to the public or other unauthorized persons under State or federal law. Confidential Information includes, but is not limited to, personal information (PI).

2.1.31 Consumer Assessment of Health Care Providers and Systems (CAHPS®)

2.1.31.1 “Consumer Assessment of Health Care Providers and Systems (CAHPS®)” means a family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of health care.

2.1.32 Continuity of Care

2.1.32.1 “Continuity of Care” means the provision of continuous care for chronic or acute medical conditions through Member transitions between: facilities and home; facilities; Providers; service areas; managed care contractors; Marketplace, Medicaid fee-for-service (FFS) or private insurance and managed care arrangements. Continuity of Care occurs in a manner that prevents unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.33 Continuous Quality Improvement (CQI)

2.1.33.1 “Continuous Quality Improvement (CQI)” means the systematic process of identifying, describing, and analyzing strengths and

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problems and then testing, implementing, learning from, and revising solutions.

2.1.34 Copayment

2.1.34.1 “Copayment” means a monetary amount that a Member pays directly to a Provider at the time a covered service is rendered.

2.1.35 Corrective Action Plan (CAP)

2.1.35.1 “Corrective Action Plan (CAP)” means a plan that the MCO completes to identify and respond to any issues and/or errors in instances where it fails to comply with DHHS requirements.

2.1.36 Covered Services

2.1.36.1 “Covered Services” means health care services as defined by DHHS and State and federal regulation and includes Medicaid State Plan services specified in this Agreement, In Lieu of Services, any Value-Added Services agreed to by the MCO in the Agreement, and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.37 Designated Local Care Management Entities

2.1.37.1 “Designated Local Care Management Entities” means Integrated Delivery Networks (IDNs) that have been certified as Designated Local Care Management Entities by DHHS; Health Homes, if DHHS elects to implement Health Homes under the Medicaid State Plan Amendment authority; and other contracted entities capable of performing Local Care Management for a designated cohort of Members, as determined by DHHS.

2.1.38 Dual-Eligible Members

2.1.38.1 “Dual-Eligible Members” means Members who are eligible for both Medicare and Medicaid.

2.1.39 Emergency Medical Condition

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

2.1.40 Emergency Services

2.1.40.1 “Emergency Services” means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish the

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services needed to evaluate or stabilize an Emergency Medical Condition. [42 CFR 438.114(a)]

2.1.41 Equal Access

2.1.41.1 "Equal Access" means Members have the same access to Providers and services.

2.1.42 Evidence-Based Supported Employment (EBSE)

2.1.42.1 "Evidence-Based Supported Employment (EBSE)" means the provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by Dartmouth Medical School to promote successful competitive employment in the community.

2.1.43 Exclusion Lists

2.1.43.1 "Exclusion Lists" means HHS Office of the Inspector General's (OIG) List of Excluded Individuals/Entities; the System of Award Management; the Social Security Administration Death Master File; the list maintained by the Office of Foreign Assets Controls; and to the extent applicable, National Plan and Provider Enumeration System (NPPES).

2.1.44 External Quality Review (EQR)

2.1.44.1 "External Quality Review (EQR)" means the analysis and evaluation described in 42 CFR 438.350 by an External Quality Review Organization (EQRO) detailed in 42 CFR 438.42 of aggregated information on quality, timeliness, and access Covered Services that the MCO or its Subcontractors furnish to Medicaid recipients.

2.1.45 Family Planning Services

2.1.45.1 "Family Planning Services" means services available to Members without the need for a referral or Prior Authorization that include: consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases; distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases; provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the state in which services are provided; referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine. Members may access these services by Participating and Non-Participating Providers.

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2.1.46 Federally Qualified Health Centers (FQHCs)

2.1.46.1 “Federally Qualified Health Center (FQHC)” means a public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

2.1.47 Granite Advantage Members

2.1.47.1 “Granite Advantage Members” means Members who are covered under the NH Granite Advantage waiver, which includes individuals in the Medicaid new adult eligibility group, covered under Title XIX of the Social Security Act who are adults, aged nineteen (19) up to and including sixty-four (64) years, with incomes up to and including one hundred and thirty-eight percent (138%) of the federal poverty level (FPL) who are not pregnant, not eligible for Medicare nor enrolled in NH’s Health Insurance Premium Payment (HIPP) program.

2.1.48 Grievance Process

2.1.48.1 “Grievance Process” means the procedure for addressing Member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.49 Home and Community Based Services (HCBS)

2.1.49.1 “Home and Community Based Services (HCBS)” means the waiver of Sections 1902(a)(10) and 1915(c) of the Social Security Act, which allows the federal Medicaid funding of LTSS in non-institutional settings for Members who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility (ICF). This includes services provided under the HCBS-CFI waiver program, Developmental Disabilities (HCBS-DD) waiver program, Acquired Brain Disorders (HCBS-ABD) waiver program, and In Home Supports (HCBS-I) waiver program.

2.1.50 Hospital-Acquired Conditions and Provider Preventable Conditions

2.1.50.1 “Hospital-Acquired Conditions and Provider Preventable Conditions” means a condition that meets the following criteria: Is identified in the Medicaid State Plan; has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Member; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a Member, surgical or other invasive procedure

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performed on the wrong body part, or surgical or other invasive procedure performed on the wrong Member.

2.1.51 In Lieu Of Services

2.1.51.1 An "In Lieu Of Service" means an alternative service or setting that DHHS has approved as medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan. A Member cannot be required by the MCO to use the alternative service or setting. Any In Lieu Of service must be authorized by DHHS, either via DHHS's issuance prospective identification of approved In Lieu of Services or through an agreement reached between DHHS and the MCO. The utilization and actual cost of In Lieu Of Services will be taken into account in developing the component of the capitation rates that represents the Medicaid State Plan Covered Services, unless a statute or regulation explicitly requires otherwise.

2.1.52 Incomplete Claim

2.1.52.1 "Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.

2.1.53 Indian Health Care Provider (IHCP)

2.1.53.1 "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

2.1.54 Integrated Care

2.1.54.1 "Integrated Care" means the systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.⁵

2.1.55 Integrated Delivery Network (IDN)

2.1.55.1 "Integrated Delivery Network" means a regionally-based network of physical and behavioral health providers and/or social service organizations that participate in the NH Building Capacity for Transformation Section 1115 Waiver or are otherwise determined by DHHS to be an Integrated Delivery Network.

2.1.56 Limited English Proficiency (LEP)

2.1.56.1 "Limited English Proficiency (LEP)" means a Member's primary language is not English and the Member may have limited ability to read, write, speak or understand English.

⁵ SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?", available at: <https://www.integration.samhsa.gov/about-us/what-is-integrated-care>

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2.1.57 Local Care Management

2.1.57.1 "Local Care Management" means the MCO engages in real-time, high-touch, in-person Care Management and consistent follow-up with Providers and Members to assure that selected Members are making progress with their care plans.

2.1.58 Long Term Services and Supports (LTSS)

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

2.1.59 Managed Care Information System (MCIS)

2.1.59.1 "Managed Care Information System (MCIS)" means a comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides information on areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR 438.242(a)]; collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an encounter data system [42 CFR 438.242(b)(2)]; is capable of meeting the requirements listed throughout this Agreement; and is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

2.1.60 Marketing

2.1.60.1 "Marketing" means any communication from the MCO to a potential Member, or Member who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the Member to enroll with the MCO or to either not enroll, or disenroll from another DHHS contracted MCO. [42 CFR 438.104(a)]

2.1.61 Marketing Materials

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

2.1.62 Managed Care Organization (MCO)

2.1.62.1 "Managed Care Organization (MCO)" means an entity that has a certificate of authority of certificate of registration from the NH Insurance Department (NHID) that contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible Members under the MCM program.

2.1.63 MCO Alternative Payment Model (APM) Implementation Plan

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2.1.63.1 “MCO Alternative Payment Model (APM) Implementation Plan” means the MCO’s plan for meeting the APM requirements described in this Agreement. The MCO APM Implementation Plan must be reviewed and approved by DHHS.

2.1.64 MCO Data Certification

2.1.64.1 “MCO Data Certification” means data submitted to DHHS and certified by one (1) of the following: the MCO’s Chief Executive Officer (CEO); the MCO’s Chief Financial Officer (CFO); or an individual who has delegated authority to sign for, and who reports directly to, the MCO’s CEO or CFO.

2.1.65 MCO Formulary

2.1.65.1 “MCO Formulary” means the list of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the DHHS-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.66 MCO Quality Assessment and Performance Improvement (QAPI) Program

2.1.66.1 “MCO Quality Assessment and Performance Improvement (QAPI) Program” means an ongoing and comprehensive program for the services the MCO furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program. [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]

2.1.67 MCO Utilization Management Program

2.1.67.1 “MCO Utilization Management Program” means a program developed, operated, and maintained by the MCO that meets the criteria contained in this Agreement related to Utilization Management. The MCO Utilization Management Program must include defined structures, policies, and procedures for Utilization Management.

2.1.68 Medicaid Director

2.1.68.1 “Medicaid Director” means the State Medicaid Director of NH DHHS.

2.1.69 Medicaid Management Information System (MMIS)

2.1.69.1 “Medicaid Management Information System (MMIS)” as defined by the CMS.gov glossary is: a CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, Surveillance and Utilization Review Subsystem (SURS), Management and Administrative Reporting System (MARS), and potentially encounter processing.

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2.1.70 Medical Loss Ratio (MLR)

2.1.70.1 “Medical Loss Ratio (MLR)” means the proportion of premium revenues spent on clinical services and quality improvement, calculated in compliance with the terms of this Agreement and with all federal standards, including 42 CFR 438.8.

2.1.71 Medically Necessary

2.1.71.1 Per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members under twenty-one (21) years of age, “Medically Necessary” means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.71.2 For Members twenty-one (21) years of age and older, “Medically Necessary” means services that a licensed Provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

2.1.71.2.1 Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the Member’s illness, injury, disease, or its symptoms;

2.1.71.2.2 Not primarily for the convenience of the Member or the Member’s family, caregiver, or health care Provider;

2.1.71.2.3 No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the Member’s illness, injury, disease, or its symptoms; and

2.1.71.2.4 Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].⁶

2.1.72 Medication Assisted Treatment (MAT)

2.1.72.1 “Medication Assisted Treatment (MAT)” means the use of medications in combination with counseling and behavioral therapies for the treatment of Substance Use Disorder.⁷

2.1.73 Member

⁶ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

⁷ SAHMSA-HRSA Center for Integrated Health Solutions, “Medication Assisted Treatment,” available at <https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>

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2.1.73.1 “Member” means an individual who is enrolled in managed care through an MCO having an Agreement with DHHS. [42 CFR 438.10(a)]

2.1.74 Member Advisory Board

2.1.74.1 “Member Advisory Board” means a group of Members that represents the Member population, established and facilitated by the MCO. The Member Advisory Board must adhere to the requirements set forth in this Agreement.

2.1.75 Member Encounter Data (Encounter Data)

2.1.75.1 “Member Encounter Data (“Encounter Data”)” means the information relating to the receipt of any item(s) or service(s) by a Member under this Agreement between DHHS and an MCO that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

2.1.76 Member Handbook

2.1.76.1 “Member Handbook” means a handbook based upon the model Member Handbook developed by DHHS and published by the MCO that enables the Member to understand how to effectively use the MCM program in accordance with this Agreement and 42 CFR 438.10(g).

2.1.77 National Committee for Quality Assurance (NCQA)

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

2.1.78 NCQA Health Plan Accreditation

2.1.78.1 “NCQA Health Plan Accreditation” means MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.79 Neonatal Abstinence Syndrome (NAS)

2.1.79.1 “Neonatal Abstinence Syndrome (NAS)” means a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.⁸

2.1.80 Non-Emergency Medical Transportation (NEMT)

2.1.80.1 “Non-Emergency Medical Transportation (NEMT)” means transportation services arranged by the MCO and provided free of charge to Members who are unable to pay for the cost of transportation to Provider offices and facilities for Medically Necessary care and services

⁸ CMCS Informational Bulletin, “Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants,” Centers for Medicare and Medicaid Services, June 11, 2018, available at <https://www.medicare.gov/federal-policy-guidance/downloads/cib060818.pdf>

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covered by the Medicaid State Plan, regardless of whether those Medically Necessary services are covered by the MCO.

2.1.81 Non-Participating Provider

2.1.81.1 "Non-Participating Provider" means a person, health care Provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with the MCO to participate in the MCO's Provider network, but provides health care services to Members under appropriate scenarios (e.g., a referral approved by the MCO).

2.1.82 Non-Symptomatic Office Visits

2.1.82.1 "Non-Symptomatic Office Visits" means preventive care office visits available from the Member's Primary Care Provider (PCP) or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

2.1.83 Non-Urgent, Symptomatic Office Visits

2.1.83.1 "Non-Urgent, Symptomatic Office Visits" means routine care office visits available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention, but that require monitoring.

2.1.84 Ongoing Special Condition

2.1.84.1 "Ongoing Special Condition" means, in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.85 Overpayments

2.1.85.1 "Overpayments" means any amount received to which the Provider or person is not entitled. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.

2.1.86 Participating Provider

2.1.86.1 "Participating Provider" means a person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and

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licensure, and who is under a written contract with the MCO to provide services to Members under the terms of this Agreement.

2.1.87 Peer Recovery Program

2.1.87.1 "Peer Recovery Program" means a program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or another accrediting body approved by DHHS, is under contract with DHHS's contracted facilitating organization, or is under contract with DHHS's Bureau of Drug and Alcohol Services to provide Peer Recovery Support Services (PRSS).

2.1.88 Performance Improvement Project (PIP)

2.1.88.1 "Performance Improvement Project (PIP)" means an initiative included in the QAPI program that focuses on clinical and non-clinical areas. A PIP shall be developed in consultation with the EQRO. [42 CFR 438.330(b)(1); 42 CFR 438.330(d)(1); 42 CFR 438.330(a)(2)].

2.1.89 Physician Group

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

2.1.90 Physician Incentive Plan

2.1.90.1 "Physician Incentive Plan" means any compensation arrangement between the MCO and Providers that apply to federal regulations found at 42 CFR 422.208 and 42 CFR 422.210, as applicable to Medicaid managed care on the basis of 42 CFR 438.3(i).

2.1.91 Post-Stabilization Services

2.1.91.1 "Post-Stabilization Services" means contracted services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition. [42 CFR 438.114; 422.113]

2.1.92 Practice Guidelines

2.1.92.1 "Practice Guidelines" means evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines must be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field, must consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

2.1.93 Prescription Drug Monitoring Program (PDMP)

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2.1.93.1 “Prescription Drug Monitoring Program (PDMP)” means the program operated by the NH Office of Professional Licensure and Certification that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in NH.

2.1.94 Primary Care Provider (PCP)

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

2.1.95 Prior Authorization

2.1.95.1 “Prior Authorization” means the process by which DHHS, the MCO, or another MCO participating in the MCM program, whichever is applicable, authorizes, in advance, the delivery of Covered Services based on factors, including but not limited to medical necessity, cost-effectiveness, and compliance with this Agreement.

2.1.96 Priority Population

2.1.96.1 “Priority Population” means a population that is most likely to have Care Management needs and be able to benefit from Care Management. The following groups are considered Priority Populations under this Agreement: Adults and Children with Special Health Care Needs; Members receiving services under HCBS waivers; Members identified as those with rising risk; individuals with high unmet resource needs; mothers of babies born with NAS and their infants; pregnant women with Substance Use Disorder; intravenous drug users; individuals that have been in the ED for an overdose event in the last twelve (12) months; and other Priority Populations as determined by the MCO and/or DHHS.

2.1.97 Program Start Date

2.1.97.1 “Program Start Date” means the date when the MCO is responsible for coverage of services to its Members in the MCM program, contingent upon contract approval by the Governor and Executive Council and DHHS’s determination of successful completion of the readiness review period.

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2.1.98 Provider

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

2.1.99 Provider Directory

2.1.99.1 "Provider Directory" means information on the MCO's Participating Providers for each of the Provider types covered under this Agreement, available in electronic form and paper form upon request to the Member in accordance with 42 CFR 438.10 and the terms of this Agreement.

2.1.100 Psychiatric Boarding

2.1.100.1 "Psychiatric Boarding" means a Member's continued physical presence in an emergency room or another temporary location after either completion of an Involuntary Emergency Admission (IEA) application, revocation of a conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility by a Court.

2.1.101 Qualified Bilingual/Multilingual Staff

2.1.101.1 "Qualified Bilingual/Multilingual Staff" means an employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that he or she is proficient in speaking and understanding spoken English and at least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

2.1.102 Qualified Interpreter for a Member with a Disability

2.1.102.1 "Qualified Interpreter for a Member with a Disability" means an interpreter who, via a remote interpreting service or an on-site appearance, adheres to generally accepted interpreter ethics principles, including Member confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

2.1.103 Qualified Interpreter for a Member with LEP

2.1.103.1 "Qualified Interpreter for a Member with LEP" means an interpreter who, via a remote interpreting service or an on-site appearance adheres to generally accepted interpreter ethics principles, including Member confidentiality; has demonstrated proficiency in speaking and understanding spoken English and at least one (1) other

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spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

2.1.104 Qualified Translator

2.1.104.1 “Qualified Translator” means a translator who adheres to generally accepted translator ethics principles, including Member confidentiality; has demonstrated proficiency in writing and understanding written English and at least one (1) other written non-English language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. [45 CFR 92.4, 92.201(d)-(e)]

2.1.105 Qualifying APM

2.1.105.1 “Qualifying APM” means an APM approved by DHHS as consistent with the standards specified in this Agreement and in any subsequent DHHS guidance, including the DHHS Medicaid APM Strategy.

2.1.106 Recovery

2.1.106.1 “Recovery” means a process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.⁹

2.1.107 Referral Provider

2.1.107.1 “Referral Provider” means a Provider, who is not the Member’s PCP, to whom a Member is referred for Covered Services.

2.1.108 Risk Scoring and Stratification

2.1.108.1 “Risk Scoring and Stratification” means the methodology to identify Members who are part of a Priority Population for Care Management and who should receive a Comprehensive Assessment. The MCO must provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level including details regarding the algorithm and data sources used to identify eligible Member for Care Management.

2.1.109 Rural Health Clinic (RHC)

2.1.109.1 “Rural Health Clinic (RHC)” means a clinic located in an area designated by DHHS as rural, located in a federally designated medically

⁹ SAMHSA, “Recovery and Recovery Support,” available at: <https://www.samhsa.gov/recovery>

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underserved area, or has an insufficient number of physicians, which meets the requirements under 42 CFR 491.

2.1.110 Second Opinion

2.1.110.1 "Second Opinion" means the opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the MCO has allowed the Member to consult, at no cost to the Member. [42 CFR 438.206(b)(3)]

2.1.111 Subcontract

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

2.1.112 Subcontractor

2.1.112.1 "Subcontractor" means a person or entity that is delegated by the MCO to perform an administrative function or service on behalf of the MCO that directly or indirectly relates to the performance of all or a portion of the duties or obligations under this Agreement. A Subcontractor does not include a Participating Provider.

2.1.113 Substance Use Disorder

2.1.113.1 "Substance Use Disorder" means a cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in HE-W 513.02.¹⁰

2.1.114 Substance Use Disorder Provider

2.1.114.1 "Substance Use Disorder Provider" means all Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.¹¹

2.1.115 Term

2.1.115.1 "Term" means the duration of this Agreement.

2.1.116 Third Party Liability (TPL)

2.1.116.1 "Third Party Liability (TPL)" means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required

¹⁰ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

¹¹ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid State Plan.

2.1.117 Transitional Care Management

2.1.117.1 "Transitional Care Management" means the responsibility of the MCO to manage transitions of care for all Members moving from one (1) clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.118 Transitional Health Care

2.1.118.1 "Transitional Health Care" means care that is available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

2.1.119 Transitional Home Care

2.1.119.1 "Transitional Home Care" means care that is available with a home care nurse, a licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or specialty care Provider or as part of the discharge plan.

2.1.120 Trauma Informed Care

2.1.120.1 "Trauma Informed Care" means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for Recovery; recognizes the signs and symptoms of trauma in Members, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.¹²

2.1.121 Urgent, Symptomatic Office Visits

2.1.121.1 "Urgent, Symptomatic Office Visits" means office visits, available from the Member's PCP or another Provider within forty-eight (48) hours, for the presentation of medical signs or symptoms that require

¹² SAMHSA, "Trauma Informed Approach and Trauma-Specific Interventions," available at: <https://www.samhsa.gov/nctic/trauma-interventions>

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immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

2.1.122 Utilization Management

2.1.122.1 "Utilization Management" means the criteria of evaluating the necessity, appropriateness, and efficiency of Covered Services against established guidelines and procedures.

2.1.123 Value-Added Services

2.1.123.1 "Value-Added Services" means services not included in the Medicaid State Plan that the MCO elects to purchase and provide to Members at the MCO's discretion and expense to improve health and reduce costs. Value-Added Services are not included in capitation rate calculations.

2.1.124 Willing Provider

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

2.2 Acronym List

- 2.2.1** AAP means American Academy of Pediatrics.
- 2.2.2** ABD means Acquired Brain Disorder.
- 2.2.3** ACT means Assertive Community Treatment.
- 2.2.4** ADA means Americans with Disabilities Act.
- 2.2.5** ADL means Activities of Daily Living.
- 2.2.6** ADT means Admission, Discharge and Transfer.
- 2.2.7** AIDS means Acquired Immune Deficiency Syndrome.
- 2.2.8** ANSA means Adult Needs and Strengths Assessment.
- 2.2.9** APM means Alternative Payment Model.
- 2.2.10** ARNP means Advanced Registered Nurse Practitioner.
- 2.2.11** ASAM means American Society of Addiction Medicine.
- 2.2.12** ASC means Accredited Standards Committee.
- 2.2.13** ASFRA means Assisted Suicide Funding Restriction Act.
- 2.2.14** ASL means American Sign Language.
- 2.2.15** BCPP means Breast and Cervical Cancer Program.
- 2.2.16** BHCTC means Behavioral Health Crisis Treatment Center.

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- 2.2.17** CAHPS means Consumer Assessment of Healthcare Providers and Systems.
- 2.2.18** CANS means Child and Adolescent Needs and Strengths Assessment.
- 2.2.19** CAP means Corrective Action Plan.
- 2.2.20** CAPRSS means Council on Accreditation of Peer Recovery Support Services.
- 2.2.21** CARC means Claim Adjustment Reason Code.
- 2.2.22** CDT means Code on Dental Procedures and Nomenclature.
- 2.2.23** CEO means Chief Executive Officer.
- 2.2.24** CFI means Choices for Independence.
- 2.2.25** CFO means Chief Financial Officer.
- 2.2.26** CHIP means Children's Health Insurance Program.
- 2.2.27** CHIS means Comprehensive Health Care Information System.
- 2.2.28** CMH means Community Mental Health.
- 2.2.29** CMO means Chief Medical Officer.
- 2.2.30** CMR means Comprehensive Medication Review.
- 2.2.31** CMS means Centers for Medicare & Medicaid Services.
- 2.2.32** COB means Coordination of Benefits.
- 2.2.33** COBA means Coordination of Benefits Agreement.
- 2.2.34** CPT means Current Procedural Terminology.
- 2.2.35** CQI means Continuous Quality Improvement.
- 2.2.36** DBT means Dialectical Behavioral Therapy.
- 2.2.37** DCYF means New Hampshire Division for Children, Youth and Families.
- 2.2.38** DD means Developmental Disability.
- 2.2.39** DHHS means New Hampshire Department of Health and Human Services.
- 2.2.40** DME means Durable Medical Equipment.
- 2.2.41** DOD/DOB means Change in contract ***Date of Birth.
- 2.2.42** DOJ means (New Hampshire or United States) Department of Justice.
- 2.2.43** DRA means Deficit Reduction Act.
- 2.2.44** DSM means Diagnostic and Statistical Manual of Mental Disorders.

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- 2.2.45** DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.
- 2.2.46** DUR means Drug Utilization Review.
- 2.2.47** EBSE means Evidence-Based Supported Employment.
- 2.2.48** ECI means Elderly and Chronically Ill.
- 2.2.49** ED means Emergency Department.
- 2.2.50** EDI means Electronic Data Interchange.
- 2.2.51** EFT means Electronic Funds Transfer.
- 2.2.52** EOB means Explanation of Benefits.
- 2.2.53** EPSDT means Early and Periodic Screening, Diagnostic and Treatment.
- 2.2.54** EQR means External Quality Review.
- 2.2.55** EQRO means External Quality Review Organization.
- 2.2.56** ERISA means Employees Retirement Income Security Act of 1974.
- 2.2.57** EST means Eastern Standard Time.
- 2.2.58** ETL means Extract, Transformation and Load.
- 2.2.59** FAR means Federal Acquisition Regulation.
- 2.2.60** FCA means False Claims Act.
- 2.2.61** FDA means Food and Drug Administration for the United States Department of Health and Human Services.
- 2.2.62** FFATA means Federal Funding Accountability & Transparency Act.
- 2.2.63** FFS means Fee-for-Service.
- 2.2.64** FPL means Federal Poverty Level.
- 2.2.65** FQHC means Federally Qualified Health Center.
- 2.2.66** HCBS means Home and Community Based Services.
- 2.2.67** HCBS-I means Home and Community Based Services In Home Supports.
- 2.2.68** HCPCS means Health Care Common Procedure Coding System.
- 2.2.69** HHS means United States Department of Health and Human Services.
- 2.2.70** HIPAA means Health Insurance Portability and Accountability Act.
- 2.2.71** HIPP means Health Insurance Premium Payment.

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- 2.2.72** HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.
- 2.2.73** HIV means Human Immunodeficiency Virus.
- 2.2.74** HMO means health maintenance organization.
- 2.2.75** HRSA means Health Resources and Services Administration for the United States Department of Health and Human Services.
- 2.2.76** I/T/U means Indian Tribe, Tribal Organization, or Urban Indian Organization.
- 2.2.77** IADL means Instrumental Activities of Daily Living.
- 2.2.78** IBNR means Incurred But Not Reported.
- 2.2.79** ICF means Intermediate Care Facility.
- 2.2.80** ID means Intellectual Disabilities.
- 2.2.81** IDN means Integrated Delivery Network.
- 2.2.82** IEA means Involuntary Emergency Admission.
- 2.2.83** IHCP means Indian Health Care Provider.
- 2.2.84** HIS means Indian Health Service.
- 2.2.85** IMD means Institution for Mental Disease.
- 2.2.86** IVR means Interactive Voice Response.
- 2.2.87** LEP means Limited English Proficiency.
- 2.2.88** LTSS means Long-Term Services and Supports.
- 2.2.89** MACRA means Medicare Access and CHIP Reauthorization Act of 2015.
- 2.2.90** MAT means Medication Assisted Treatment.
- 2.2.91** MCIS means Managed Care Information System.
- 2.2.92** MCM means Medicaid Care Management.
- 2.2.93** MCO means Managed Care Organization.
- 2.2.94** MED means Morphine Equivalent Dosing.
- 2.2.95** MFCU means New Hampshire Medicaid Fraud Control Unit.
- 2.2.96** MLADCs means Masters Licensed Alcohol and Drug Counselors.
- 2.2.97** MLR means Medical Loss Ratio.
- 2.2.98** MMIS means Medicaid Management Information System.
- 2.2.99** NAS means Neonatal Abstinence Syndrome.

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- 2.2.100** NCPDP means National Council for Prescription Drug Programs.
- 2.2.101** NCQA means National Committee for Quality Assurance.
- 2.2.102** NEMT means Non-Emergency Medical Transportation.
- 2.2.103** NH means New Hampshire.
- 2.2.104** NHID means New Hampshire Insurance Department.
- 2.2.105** NPI means National Provider Identifier.
- 2.2.106** NPES means National Plan and Provider Enumeration System.
- 2.2.107** OB/GYN means Obstetrics/Gynecology or Obstetricians/Gynecologists.
- 2.2.108** OIG means Office of the Inspector General for the United States Department of Health and Human Services.
- 2.2.109** OTP means Opioid Treatment Program.
- 2.2.110** PBM means Pharmacy Benefits Manager.
- 2.2.111** PCA means Personal Care Attendant.
- 2.2.112** PCP means Primary Care Provider.
- 2.2.113** PDL means Preferred Drug List.
- 2.2.114** PDMP means Prescription Drug Monitoring Program.
- 2.2.115** PHI means Protected Health Information.
- 2.2.116** PI means Personal Information.
- 2.2.117** PIP means Performance Improvement Project.
- 2.2.118** POS means Point of Service.
- 2.2.119** PRSS means Peer Recovery Support Services.
- 2.2.120** QAPI means Quality Assessment and Performance Improvement.
- 2.2.121** QOS means Quality of Service.
- 2.2.122** RARC means Reason and Remark Codes.
- 2.2.123** RFP means Request for Proposal.
- 2.2.124** RHC means Rural Health Clinic.
- 2.2.125** SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.
- 2.2.126** SBIRT means Screening, Brief Intervention, and Referral to Treatment.
- 2.2.127** SED means Serious Emotional Disturbance.

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- 2.2.128** SHIP means State's Health Insurance Assistance Program.
- 2.2.129** SIU means Special Investigations Unit.
- 2.2.130** SMART means Specific, Measurable, Attainable, Realistic, and Time Relevant.
- 2.2.131** SMDL means State Medicaid Director Letter.
- 2.2.132** SMI means Severe Mental Illness.
- 2.2.133** SNF means Skilled Nursing Facility.
- 2.2.134** SPMI means Severe or Persistent Mental Illness.
- 2.2.135** SSADMF means Social Security Administration Death Master File.
- 2.2.136** SSAE means Statement on Standards for Attestation Engagements.
- 2.2.137** SSI means Supplemental Security Income.
- 2.2.138** SSN means Social Security Number.
- 2.2.139** TAP means Technical Assistance Publication.
- 2.2.140** TDD means Telecommunication Device for Deaf Persons.
- 2.2.141** TPL means Third Party Liability.
- 2.2.142** TTY means Teletypewriter.
- 2.2.143** UAT means User Acceptance Testing.
- 2.2.144** UDS means Urine Drug Screenings.
- 2.2.145** VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO. The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 Representation and Warranties

3.1.2.1 The MCO represents and warrants that it will fulfill all obligations under this Agreement and meet the specifications as described in the Agreement during the Term, including any subsequently negotiated, and mutually agreed upon, specifications.

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3.1.2.2 The MCO acknowledges that, in being awarded this Agreement, DHHS has relied upon all representations and warrants made by the MCO in its response to the DHHS Request for Proposal (RFP), including any addenda, with respect to delivery of Medicaid managed care services.

3.1.2.3 The MCO represents and warrants that it shall comply with all of the material submitted to, and approved by DHHS as part of its readiness review. Any material changes to such approved materials or newly developed materials require prior written approval by DHHS before implementation.

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

3.1.2.5 This Agreement shall be signed and dated by all parties, and approved by Governor and Council.

3.1.3 Program Management Plan

3.1.3.1 The MCO shall develop and submit a Program Management Plan for DHHS's review and approval. The MCO shall provide the initial Program Management Plan to DHHS for review and approval at the beginning of the readiness assessment period; in future years, any modifications to the Program Management Plan must be presented for prior approval to DHHS at least sixty (60) calendar days prior to the coverage year. The Program Management Plan shall:

3.1.3.1.1 Elaborate on the general concepts outlined in the MCO's Proposal and the section headings of the Agreement;

3.1.3.1.2 Describe how the MCO will operate in NH by outlining management processes such as workflow, overall systems as detailed in the section headings of Agreement, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to Member and Provider experiences;

3.1.3.1.3 Describe how the MCO will ensure timely notification to DHHS regarding:

3.1.3.1.3.1. Expected or unexpected interruptions or changes that impact MCO policy, practice, operations, Members or Providers,

3.1.3.1.3.2. Correspondence received from DHHS on emergent issues and non-emergent issues; and

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3.1.3.1.4 Outline the MCO integrated organizational structure including NH-based resources and its support from its parent company, affiliates, or Subcontractors.

3.1.3.2 On an annual basis, the MCO shall submit to DHHS either a certification of “no change” to the Program Management Plan or a revised Program Management Plan together with a redline that reflects the changes made to the Program Management Plan since the last submission.

3.1.4 Key Personnel Contact List

3.1.4.1.1 The MCO shall submit a Key Personnel Contact List to DHHS that includes the positions and associated information indicated in Section 3.15.1 (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program. Thereafter, the MCO shall submit an updated Contact List immediately upon any Key Personnel staff changes.

3.2 Agreement Elements

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

- 3.2.1.1 General Provisions, Form Number P-37
- 3.2.1.2 Exhibit A: Scope of Services.
- 3.2.1.3 Exhibit B: Method and Conditions Precedent to Payment
- 3.2.1.4 Exhibit C: Special Provisions
- 3.2.1.5 Exhibit C-1: Revisions to General Provisions
- 3.2.1.6 Exhibit D: Certification Regarding Drug Free Workplace Requirements
- 3.2.1.7 Exhibit E: Certification Regarding Lobbying
- 3.2.1.8 Exhibit F: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- 3.2.1.9 Exhibit G: Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections
- 3.2.1.10 Exhibit H: Certification Regarding Environmental Tobacco Smoke
- 3.2.1.11 Exhibit I: Health Insurance Portability Act Business Associate
- 3.2.1.12 Exhibit J: Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.
- 3.2.1.13 Exhibit K: DHHS Information Security Requirements.

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- 3.2.1.14 Exhibit L: MCO's Implementation Plan
- 3.2.1.15 Exhibit M: Reserved
- 3.2.1.16 Exhibit N: Liquidated Damages Matrix
- 3.2.1.17 Exhibit O: Quality and Oversight Reporting Requirements
- 3.2.1.18 Exhibit P: The MCOs Program Management Plan

3.3 Conflicts Between Documents

3.3.1 In the event of any conflict or contradiction between or among the documents which comprise the Agreement, as listed in Section 3.2 (Agreement Elements) above, the documents shall control in the order of precedence as follows:

- 3.3.1.1 First: P-37, Exhibit A Scope of Services, Exhibit B Method and Conditions Precedent to Payment, Exhibit C Special Provisions and Exhibit C-1 Revisions to General Provisions, Exhibit N Liquidated Damages Matrix, Exhibit O Quality and Oversight Reporting Requirements
- 3.3.1.2 Exhibit I Health Insurance Portability Act Business Associate and Exhibit K DHHS Information Security Requirements
- 3.3.1.3 Third: Exhibits D through H, Exhibit J, and Exhibit L, Exhibit P, Exhibit M.

3.4 Delegation of Authority

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

3.5 Authority of the New Hampshire Insurance Department

3.5.1 Pursuant to this Agreement or under the laws and rules of the state of NH, the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.5.2 The MCO is subject to (and as subsequently amended) RSA 420-B; Managed Care Law and Rules NH RSA. 420-J; and Admin Rules 2700; compliance with Bulletin INSNO. 12-015-AB, and further updates made by the NHID; and the NH Comprehensive Health Care Information System (CHIS) data reporting submission under NHID rules/bulletins.

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3.6 Time of the Essence

3.6.1 In consideration of the need to ensure uninterrupted and continuous services under the MCM program, time is of the essence in the performance of the MCO's obligations under the Agreement.

3.7 CMS Approval of Agreement and Any Amendments

3.7.1 This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to the approval of CMS.

3.7.2 This Agreement submission shall be considered complete for CMS's approval if: 1) all pages, appendices, attachments, etc. were submitted to CMS; and 2) any documents incorporated by reference (including but not limited to State statute, regulation, or other binding document, such as a Member Handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS. As part of this Agreement, DHHS shall submit to CMS for review and approval the MCO rate certifications concurrent with the review and approval process for this Agreement. [42 CFR 438.7(a)]

3.7.3 DHHS shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement initiatives based on DHHS's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.8 Cooperation With Other Vendors and Prospective Vendors

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

3.8.2 The MCO is required to notify DHHS within eight (8) hours of a Member reporting an allegation of a serious criminal offense against the Member by any employee or vendor of the MCO. For the purpose of this Agreement, a serious criminal offense should be defined to include murder, arson, rape, sexual assault, assault, burglary, kidnapping, criminal trespass, or attempt thereof. The MCO's notification must be to a member of senior management of DHHS such as the Commissioner, Deputy Commissioner, Associate Commissioner, Medicaid Director, or Deputy Medicaid Director.

3.9 Renegotiation and Re-Procurement Rights

3.9.1 Renegotiation of Agreement

3.9.1.1 Notwithstanding anything in the Agreement to the contrary, DHHS may at any time during the Term exercise the option to notify the MCO that DHHS has elected to renegotiate certain terms of the

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Agreement. Upon the MCO's receipt of any notice pursuant to this Section 3.9 (Renegotiation and Re-Procurement Rights) of the Agreement, the MCO and DHHS will undertake good faith negotiations of the subject terms of the Agreement, and may execute an amendment to the Agreement.

3.9.2 Re-Procurement of the Services or Procurement of Additional Services

3.9.2.1 Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO's services and/or deliverables provided during any period of the Agreement, DHHS may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the scope of work covered by the Agreement or scope of work similar or comparable to the scope of work performed by the MCO under the Agreement.

3.9.2.2 DHHS shall give the MCO ninety (90) calendar days' notice of intent to replace another MCO participating in the MCM program or to add an additional MCO or other contractors to the MCM program.

3.9.2.3 If, upon procuring the services or deliverables or any portion of the services or deliverables from a Subcontractor in accordance with this section, DHHS elects to terminate this Agreement, the MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.10 Organization Requirements

3.10.1 General Organization Requirements

3.10.1.1 As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by NH RSA 420-B, and shall have all necessary registrations and licensures as required by the NHID and any relevant State and federal laws and regulations.

3.10.1.2 As a condition to entering this Agreement, and during the entire Agreement Term, the MCO must ensure that its articles of incorporation and bylaws do not prohibit it from operating as an HMO or performing any obligation required under this Agreement.

3.10.1.3 The MCO shall not be located outside of the United States. [42 CFR 438.602(i)] The MCO is prohibited from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.

3.10.2 Articles

3.10.2.1 The MCO shall provide, by the beginning of each Agreement year or at the time of any substantive changes, written assurance from

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MCO's legal counsel that the MCO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.10.3 Ownership and Control Disclosures

3.10.3.1 The MCO shall submit to DHHS the name of any persons or corporations with an ownership or control interest in the MCO that:

3.10.3.1.1 Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO's equity;

3.10.3.1.2 Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO's assets; or

3.10.3.1.3 Is an officer or director of an MCO organized as a corporation or is a partner in an MCO organized as a partnership. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

3.10.3.2 The submission shall include for each person or entity, as applicable:

3.10.3.2.1 The address, including the primary business address, every business location, and P.O. Box address, for every entity;

3.10.3.2.2 The date of birth (DOB) and social security number (SSN) of any individual;

3.10.3.2.3 Tax identification number(s) of any corporation;

3.10.3.2.4 Information on whether an individual or entity with an ownership or control interest in the MCO is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.10.3.2.5 Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.10.3.2.6 The name of any other disclosing entity, as such term is defined in 42 CFR 455.101, in which an owner of the MCO has an ownership or control interest;

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3.10.3.2.7 The name, address, DOB, and SSN of any managing employee of the MCO, as such term is defined by 42 CFR 455.101; and

3.10.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.10.3 (Ownership and Control Disclosures) to DHHS is accurate to the best of his or her information, knowledge, and belief.

3.10.3.3 The MCO and its Subcontractors shall disclose the information set forth in this Section 3.10.3 (Ownership and Control Disclosures) on individuals or corporations with an ownership or control interest in the MCO to DHHS at the following times:

3.10.3.3.1 At the time of Agreement execution;

3.10.3.3.2 When the Provider or disclosing entity submits a Provider application;

3.10.3.3.3 When the Provider or disclosing entity executes a Provider agreement with DHHS;

3.10.3.3.4 Upon request of DHHS during the revalidation of the Provider enrollment;

3.10.3.3.5 If DHHS renews this Agreement; and

3.10.3.3.6 Within thirty-five (35) calendar days after any change in ownership of the disclosing entity. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)]

3.10.3.4 DHHS will review the ownership and control disclosures submitted by the MCO and any Subcontractors. [42 CFR 438.602(c); 42 CFR 438.608(c)]

3.10.4 Change in Ownership or Proposed Transaction

3.10.4.1 The MCO shall inform DHHS and the NHID of its intent to merge with or be acquired, in whole or in part, by another entity or another MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO must receive prior written approval from DHHS and the NHID prior to taking such action.

3.10.5 Prohibited Relationships

3.10.5.1 Pursuant to Section 1932(d)(1)(A) of the Social Security Act (42 USC 1396u-2(d)(1)(A)), the MCO shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the MCO's equity who has been, or is affiliated with

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another person who has been, debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549]

3.10.5.2 The MCO shall not have an employment, consulting, or any other contractual agreement or engage a Subcontractor, vendor or Provider who is a Sanctioned Individual or entity. In accordance with Section 1128(b)(8) of the Social Security Act, a Sanctioned Individual means a person who:

3.10.5.2.1 Has a direct or indirect ownership or control interest of 5 percent (5%) or more in the entity, and:

3.10.5.2.1.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.1.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.1.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.2 Has an ownership or control interest (as defined in Section 1124(a)(3) of the Social Security Act) in the entity, and:

3.10.5.2.2.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.2.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.2.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.3 Is an officer, director, agent, or managing employee of the MCO, and:

3.10.5.2.3.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud, or

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3.10.5.2.3.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.3.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.4 No longer has direct or indirect ownership or control interest of 5 percent (5%) or more in the MCO or no longer has an ownership or control interest defined under Section 1124(a)(3) of the Social Security Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:

3.10.5.2.4.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.4.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.4.3. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Social Security Act]

3.10.5.3 The MCO shall retain any data, information, and documentation regarding the above described relationships for a period of no less than ten (10) years.

3.10.5.4 Within five (5) calendar days of discovery, the MCO shall provide written disclosure to DHHS, and Subcontractors shall provide written disclosure to the MCO, which shall provide the same to DHHS, of any individual or entity (or affiliation of the individual or entity) who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or prohibited affiliation under 42 CFR 438.610. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549]

3.10.5.5 If DHHS learns that the MCO has a prohibited relationship with an individual or entity that (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing

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Executive Order No. 12549, or if the MCO has relationship with an individual who is an affiliate of such an individual; (ii) is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, DHHS may:

3.10.5.5.1 Terminate the existing Agreement with the MCO;

3.10.5.5.2 Continue an existing Agreement with the MCO unless the HHS Secretary directs otherwise;

3.10.5.5.3 Not renew or extend the existing Agreement with the MCO unless the HHS Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation. [42 CFR 438.610(d)(2)-(3); 42 CFR 438.610(a); 42 CFR 438.610(b); Exec. Order No. 12549]

3.10.6 Background Checks and Screenings

3.10.6.1 The MCO shall perform criminal history record checks on its owners, directors, and managing employees, as such terms are defined in 42 CFR Section 455.101 and clarified in applicable subregulatory guidance such as the Medicaid Provider Enrollment Compendium.

3.10.6.2 The MCO shall conduct monthly background checks on all directors, officers, employees, contractors or Subcontractors to ensure that it does not employ or contract with any individual or entity:

3.10.6.2.1 Convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act;

3.10.6.2.2 Debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and/or

3.10.6.2.3 Is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. [[42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]

3.10.6.3 In addition, the MCO shall conduct screenings of its directors, officers, employees, contractors and Subcontractors to ensure that none of them appear on:

3.10.6.3.1 HHS-OIG's List of Excluded Individuals/Entities;

3.10.6.3.2 The System of Award Management;

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3.10.6.3.3 The Social Security Administration Death Master File;

3.10.6.3.4 The list maintained by the Office of Foreign Assets Control; and/or

3.10.6.3.5 To the extent applicable, NPPES (collectively, these lists are referred to as the "Exclusion Lists").

3.10.6.4 The MCO shall conduct screenings of all of its directors, officers, employees, contractors and Subcontractors monthly to ensure that none of the foregoing appear on any of the Exclusion Lists and that it continues to comply with Section 3.10.3 (Ownership and Control Disclosures) above. [SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]

3.10.6.5 The MCO shall certify to DHHS annually that it performs monthly screenings against the Exclusion Lists and that it does not have any director or officer or employ or contract, directly or indirectly, with:

3.10.6.5.1 Any individual or entity excluded from participation in the federal health care program;

3.10.6.5.2 Any entity for the provision of such health care, utilization review, medical social work, or administrative services through an excluded individual or entity or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

3.10.6.5.3 Any individual or entity excluded from Medicare, Medicaid or NH participation by DHHS per the DHHS system of record;

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

3.10.6.5.5 Any individual entity appearing on any of the Exclusion Lists.

3.10.6.6 In the event that the MCO identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.10.6 (Background Checks and Screenings) or Section 3.10.3 (Ownership and Control Disclosures) above, then the MCO should notify DHHS in writing and shall begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program.

3.10.7 Conflict of Interest

3.10.7.1 The MCO shall ensure that safeguards, at a minimum equal to federal safeguards (41 USC 423, Section 27), are in place to guard against conflict of interest. [Section 1923(d)(3) of the Social Security Act;

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SMDL 12/30/97]. The MCO must report transactions between the MCO and parties in interest to DHHS or other agencies and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.10.7.2 The MCO must report to DHHS and, upon request, to the HHS Secretary, the HHS Inspector General, and the Comptroller General a description of transactions between the MCO and a party in interest (as defined in Section 1318(b) of such Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the MCO and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and (iii) Any lending of money or other extension of credit between the MCO and such a party. [Section 1903(m)(4)(A) of the Social Security Act; Section 1318(b) of the Social Security Act]

3.11 Confidentiality

3.11.1 Confidentiality of DHHS Information and Records

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

3.11.2 Request to DHHS of MCO Confidential or Proprietary Data or Information

3.11.2.1 It is understood that DHHS may, in the course of carrying out its responsibilities under this Agreement, have or gain access to confidential or proprietary data or information owned or maintained by the MCO. Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential.

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3.11.2.2 The MCO acknowledges that DHHS is subject to the Right-to-Know Law NH RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified Confidential Information insofar as it is consistent with applicable laws, rules, or regulations, including but not limited to NH RSA Chapter 91-A.

3.11.2.3 In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO in writing and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense. If the MCO fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

3.12 Privacy and Security of Members' Information

3.12.1 The MCO shall be in compliance with privacy and security policies established by State or federal law, regulations or guidelines, including, without limitation, HIPAA of 1996 and Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and their respective implementing regulations, federal statutes and regulations governing the privacy of Substance Use Disorder patient records (42 CFR, Part 2), and all applicable State statutes, rules and regulations, including but not limited to RSA 167:30. The MCO shall protect the confidentiality of all DHHS records with identifying medical information in them. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)]

3.12.2 The MCO shall execute as part of this Agreement, a Business Associate Agreement, as such term is defined by HIPAA, and the DHHS information security requirements as outlined in Exhibit I (HIPAA Business Associate Agreement), governing the permitted uses, disclosure and security of Protected Health Information (PHI), as such term is defined by HIPAA, and as provided by DHHS to the MCO. The MCO shall ensure that if Member Substance Use Disorder records or data protected by 42 CFR Part 2 are created, maintained, or disclosed, any record or data shall be safeguarded according to the requirements found in 42 CFR Part 2, and that Member consent is obtained as required by 42 CFR Part 2.

3.12.3 The MCO shall ensure that it secures and protects the State and DHHS data when such data resides on the MCO's network, when in transit, and while stored and cached. State and DHHS data shall be encrypted while in transit.

3.12.4 The MCO shall ensure that it secures and protects DHHS data if any DHHS data or Member records or data are transmitted by fax, and shall ensure that appropriate notices relating to confidentiality or erroneous transmission are used with each fax transmission.

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3.12.5 With the exception of submission to the CHIS or other requirements of State or federal law or the terms of this Agreement, claims and Member data on NH Medicaid Members may not be released to any party without the express written consent of DHHS.

3.12.6 The MCO shall maintain written policies and procedures ensuring compliance with this Section 3.12 (Privacy and Security of Members' Information), which shall be available to DHHS upon request.

3.12.7 In the event that the MCO had a breach, as such term is defined by HIPAA, or had an unauthorized disclosure of State or DHHS data, the MCO shall notify DHHS within two (2) hours of knowledge that such breach or unauthorized disclosure has been confirmed. Failure to adequately protect Member information, DHHS claims, and other data may subject the MCO to sanctions and/or the imposition of liquidated damages.

3.13 Compliance With State and Federal Laws

3.13.1 General Requirements

3.13.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws). The MCO must comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]

3.13.1.2 The MCO shall comply specifically with:

3.13.1.2.1 Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. Section 1395 et seq.; Related rules: Title 42 Chapter IV;

3.13.1.2.2 Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. Section 1396 et seq. (specific to managed care: Section 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA); Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR Section 438; see also 431 and 435);

3.13.1.2.3 CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457;

3.13.1.2.4 Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

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- 3.13.1.2.5 State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;
- 3.13.1.2.6 State administrative rules and laws pertaining to confidentiality;
- 3.13.1.2.7 American Recovery and Reinvestment Act;
- 3.13.1.2.8 Title VI of the Civil Rights Act of 1964;
- 3.13.1.2.9 The Age Discrimination Act of 1975;
- 3.13.1.2.10 The Rehabilitation Act of 1973;
- 3.13.1.2.11 Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- 3.13.1.2.12 The ADA;
- 3.13.1.2.13 42 CFR Part 2; and
- 3.13.1.2.14 Section 1557 of the Affordable Care Act. [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]

3.13.2 Non-Discrimination

3.13.2.1 The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.13.1 (General Requirements) above, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. [42 CFR 438.3(d)(4)]

3.13.3 Reporting Discrimination Grievances

3.13.3.1 The MCO shall forward to DHHS copies of all grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability or gender identity for review and appropriate action within three (3) business days of receipt by the MCO. Failure to submit any such grievance within three (3) business days may result in the imposition of liquidated damages.

3.13.4 Americans with Disabilities Act

3.13.4.1 The MCO shall have written policies and procedures that ensure compliance with requirements of the ADA, and a written plan to monitor compliance to determine the ADA requirements are being met.

3.13.4.2 The ADA compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to

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accommodate the needs of Members who are qualified individuals with a disability. The ADA compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all Members who are qualified individuals with a disability, including but not limited to street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

3.13.4.3 A "Qualified Individual with a Disability," defined pursuant to 42 U.S.C. Section 12131(2), is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of Auxiliary Aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

3.13.4.4 The MCO shall require Participating Providers and Subcontractors to comply with the requirements of the ADA. In providing Covered Services, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid Members who are qualified individuals with disabilities covered by the provisions of the ADA.

3.13.4.5 The MCO shall survey Participating Providers of their compliance with the ADA using a standard survey document that will be provided by DHHS. Completed survey documents shall be kept on file by the MCO and shall be available for inspection by DHHS.

3.13.4.6 The MCO shall, in accordance with Exhibit G (Certification Regarding ADA Compliance), annually submit to DHHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the ADA, that it has complied with this Section 3.13.4 (Americans with Disabilities Act) of the Agreement, and that it has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.13.4.7 The MCO warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA. Where applicable, the MCO shall abide by the provisions of Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. Section 794, regarding access to programs and facilities by people with disabilities.

3.13.5 Non-Discrimination in Employment

3.13.5.1 The MCO shall not discriminate against any employee or applicant for employment because of age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin. The MCO will take

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affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The MCO agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

3.13.5.2 The MCO will, in all solicitations or advertisements for employees placed by or on behalf of the MCO, state that all qualified applicants will receive consideration for employment without regard to age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

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

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

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

3.13.5.6 The MCO will include the provisions described in this Section 3.13.5 (Non-Discrimination in Employment) in every contract with a Subcontractor or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each Subcontractor or vendor. The MCO will take such action with respect to any contract with a Subcontractor or purchase order as may be directed by the Secretary of Labor as a means

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of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event the MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.13.6 Non-Compliance

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

3.13.7 Changes in Law

3.13.7.1 The MCO shall implement appropriate program, policy or system changes, as required by changes to State and federal laws or regulations or interpretations thereof.

3.14 Subcontractors

3.14.1 MCO Obligations

3.14.1.1 The MCO shall maintain ultimate responsibility for adhering to, and otherwise fully complying with the terms and conditions of this Agreement, notwithstanding any relationship the MCO may have with the Subcontractor, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by the MCO. For the purposes of this Agreement, such work performed by any Subcontractor will be deemed performed by the MCO. [42 CFR 438.230(b)]

3.14.1.2 DHHS reserves the right to require the replacement of any Subcontractor or other contractor found by DHHS to be unacceptable or unable to meet the requirements of this Agreement, and to object to the selection or use of a Subcontractor or contract.

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

3.14.1.4 The MCO shall have oversight of all Subcontractors' policies and procedures for compliance with the False Claims Act (FCA) and other State and federal laws described in Section 1902(a)(68) of the Social

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Security Act, including information about rights of employees to be protected as whistleblowers.

3.14.2 Contracts with Subcontractors

3.14.2.1 The MCO shall have a written agreement between the MCO and each Subcontractor which includes, but shall not be limited to:

3.14.2.1.1 All required activities and obligations of the Subcontractor and related reporting responsibilities and safeguarding of Confidential Information according to State rules, and State and federal laws;

3.14.2.1.2 Full disclosure of the method and amount of compensation or other consideration received by the Subcontractor;

3.14.2.1.3 Amount, duration, and scope of services to be provided by the Subcontractor;

3.14.2.1.4 Term of the agreement, methods of extension, and termination rights;

3.14.2.1.5 The process to transition services when the agreement expires or terminates;

3.14.2.1.6 Information about the grievance and appeal system and the rights of the Member as described in 42 CFR 438.414 and 42 CFR 438.10(g);

3.14.2.1.7 Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement;

3.14.2.1.8 Requirements for the Subcontractor:

3.14.2.1.8.1. To hold harmless DHHS and its employees, and all Members served under the terms of this Agreement in the event of non-payment by the MCO;

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

3.14.2.1.9 Requirements that provide that:

3.14.2.1.9.1. The MCO, DHHS, NH Medicaid Fraud Control Unit (MFCU), NH Department of Justice (DOJ), U.S. DOJ, the OIG, and the Comptroller General or their

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respective designees shall have the right to audit, evaluate, and inspect, and that it shall make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under this Agreement; [42 CFR 438.230(c)(3)(i) & (ii); 42 CFR 438.3(k)]

3.14.2.1.9.2. The Subcontractor must further agree that it can be audited for ten (10) years from the final date of the Term or from the date of any completed audit, whichever is later; and [42 CFR 438.230(c)(3)(iii); 42 CFR 438.3(k)]

3.14.2.1.9.3. The MCO, DHHS, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit at any time if DHHS, MFCU, NH DOJ, U.S. DOJ, the OIG, and the Comptroller General or their respective designee determines that there is a reasonable possibility of fraud, potential Member harm or similar risk. [42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k)]

3.14.2.1.10 Subcontractor's agreement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority;

3.14.2.1.11 Require Subcontractor to submit ownership and controlling interest information as required by Section 3.10.3 (Ownership and Control Disclosures);

3.14.2.1.12 Require Subcontractors to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs and who is [42 CFR 455.106(a)]:

3.14.2.1.12.1. A person who has an ownership or control interest in the Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)]

3.14.2.1.12.2. An agent or person who has been delegated the authority to obligate or act on behalf of the Subcontractor or Participating Provider; or [42 CFR 455.101; 42 CFR 455.106(a)(1)]

3.14.2.1.12.3. An agent, managing employee, general manager, business manager, administrator, director, or

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other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Subcontractor or Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)]

3.14.2.1.13 Require Subcontractor to screen its directors, officers, employees, contractors and Subcontractors against each of the Exclusion Lists on a monthly basis and report to the MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program;

3.14.2.1.14 Require Subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements;

3.14.2.1.15 Prohibit Subcontractor from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories;

3.14.2.1.16 A provision for revoking delegation of activities or obligations, or imposing other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the MCO or DHHS;

3.14.2.1.17 Subcontractor's agreement to comply with the ADA, as required by Section 3.13.4 (Americans with Disabilities Act) above;

3.14.2.1.18 Include provisions of this Section 3.14.2 (Contracts with Subcontractors) in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965;

3.14.2.1.19 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as approved by DHHS, for reporting of all Overpayments identified, including embezzlement or receipt of Capitation Payments to which it was not entitled or recovered, specifying the Overpayments due to potential fraud, to the State.

3.14.2.1.20 Require any Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. [42 CFR 438.230(c)(2); 42 CFR 438.3(k)]

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3.14.2.1.21 Require any Subcontractor to comply with any other provisions specifically required under this Agreement or the applicable requirements of 42 CFR 438. [42 CFR 438.230]

3.14.2.2 The MCO shall notify DHHS in writing within one (1) business day of becoming aware that its Subcontractor is cited as non-compliant or deficient by any State or federal regulatory authority.

3.14.2.3 If any of the MCO's activities or obligations under the contract with the state are delegated to a Subcontractor:

3.14.2.3.1 The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCO and the Subcontractor; and

3.14.2.3.2 The contract or written arrangement between the MCO and the Subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i) - (iii); 42 CFR 438.3(k)]

3.14.2.4 Subcontractors or any other party performing utilization review are required to be licensed in NH.

3.14.3 Notice and Approval

3.14.3.1 The MCO shall submit all Subcontractor agreements and subcapitated Provider agreements to DHHS for prior approval at least sixty (60) calendar days prior to the anticipated implementation date of that Subcontractor agreement, any time there is a renewal or extension amendment to an approved Subcontractor agreement or there is a substantial change in scope or terms of the Subcontractor agreement. The MCO remains responsible for ensuring that all contract requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.14.3.2 The MCO shall notify DHHS of any change in Subcontractors and shall submit a new Subcontractor agreement for approval sixty (60) calendar days prior to the start date of the new Subcontractor Agreement.

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

3.14.3.4 DHHS may grant a written exception to the notice requirements of this Section 3.14.3 (Notice and Approval) if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

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3.14.3.5 The MCO shall notify DHHS within five (5) business days of receiving notice from a Subcontractor of its intent to terminate a Subcontractor agreement.

3.14.3.6 The MCO shall notify DHHS of any material breach by Subcontractor of an agreement between the MCO and the Subcontractor that may result in the MCO being non-compliant with or violating this Agreement within one (1) business day of validation that such breach has occurred. The MCO shall take any actions directed by DHHS to cure or remediate said breach by the Subcontractor.

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

3.14.4 MCO Oversight of Subcontractors

3.14.4.1 The MCO shall provide its Subcontractors with training materials regarding preventing fraud, waste and abuse and shall require the MCO's hotline to be publicized to Subcontractors' staff who provide services to the MCO.

3.14.4.2 The MCO shall oversee and be held accountable for any functions and responsibilities that it delegates to any Subcontractor in accordance with 42 CFR 438.230 and 42 CFR Section 438.3, including:

3.14.4.2.1 Prior to any delegation, the MCO shall evaluate the prospective Subcontractor's ability to perform the Social Security Activities to be delegated;

3.14.4.2.2 The MCO shall audit the Subcontractor's compliance with its agreement with the MCO and the applicable terms of this Agreement, at least annually and when there is a substantial change in the scope or terms of the Subcontractor agreement; and

3.14.4.2.3 The MCO shall identify deficiencies or areas for improvement, if any. The MCO shall prompt the Subcontractor to take corrective action.

3.14.4.3 The MCO shall develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and this Agreement.

3.14.4.4 If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affects compliance with this Agreement, the MCO shall notify DHHS and require the Subcontractor to develop a CAP within seven (7) calendar days of identification. The MCO shall provide DHHS with a copy of the Subcontractor's CAP, which is subject to DHHS approval [42 CFR 438.230 and 42 CFR Section 438.3]

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3.15 Staffing

3.15.1 Key Personnel

3.15.1.1 The MCO shall commit key personnel to the MCM program on a full-time basis. Positions considered to be key personnel include, along with any specific requirements for each position:

3.15.1.1.1 CEO/Executive Director: Individual shall have clear authority over the general administration and day-to-day business activities of this Agreement.

3.15.1.1.2 Finance Officer: Individual shall be responsible for accounting and finance operations, including all audit activities.

3.15.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the DHHS Medical Director. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health). The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

3.15.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.15.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement. The Compliance Officer will report directly to the NH-based CEO or the executive director thereof.

3.15.1.1.6 Network Management Director: Individual shall be responsible for development and maintenance of the MCO's Participating Provider network.

3.15.1.1.7 Provider Relations Manager: Individual shall be responsible for provision of all MCO Provider services activities.

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The manager shall have prior experience with individual physicians, Provider groups and facilities.

3.15.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities. The manager shall have prior experience with Medicaid populations.

3.15.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services. The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.

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

3.15.1.1.11 Encounter Manager: Individual shall be responsible for and qualified by training and experience to oversee encounter submittal and processing to ensure the accuracy, timeliness, and completeness of encounter reporting.

3.15.1.1.12 Claims Manager: Individual shall be responsible for and qualified by training and experience to oversee claims processing and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

3.15.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and will have five years' pharmacy experience as a practicing pharmacist. The individual will be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.11.6 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

3.15.1.1.14 Substance Use Disorder Physician: Individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine. The individual shall be responsible for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other

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evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for Members who visit an ED or are hospitalized for an overdose. The Substance Use Disorder Physician shall be available to the MCM program on a routine basis for consultations on MCO clinical policy related to Substance Use Disorders and the cases of individual Members, as needed.

3.15.1.2 Coordinators shall be responsible for overseeing Care Coordination and Care Management activities for MCO Members with complex medical, behavioral health, DD, and long term care needs; or for overseeing other activities. They shall also serve as liaisons to DHHS staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis:

3.15.1.2.1 Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.15.1.2.2 Developmental Disability Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals. The Developmental Disability Coordinator will be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.15.1.2.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. Individual shall have a minimum of

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eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and interpretation of clinical policies and procedures; and social determinants of health and community-based resources.

3.15.1.2.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder. The individual must have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders. This individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; and social determinants of health and community-based resources.

3.15.1.2.5 Long Term Care Coordinator: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

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3.15.1.2.6 Grievance Coordinator: Individual shall be responsible for overseeing the MCO's Grievance System.

3.15.1.2.7 Fraud, Waste, and Abuse Coordinator: Individual shall be responsible for tracking, reviewing, monitoring, and reducing fraud, waste and abuse.

3.15.1.2.8 Housing Coordinator: Individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options. The Housing Coordinator shall act as the MCO's central housing expert/resource, providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues. The Housing Coordinator shall be a dedicated staff person whose primary responsibility is housing-related work. The Housing Specialist shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO. The Housing Coordinator shall act as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building. The Housing Specialist shall have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing. The Coordinator must be familiar with the relevant public and private housing resources and stakeholders.

3.15.2 Other MCO Required Staff

3.15.2.1 Fraud, Waste, and Abuse Staff: The MCO shall establish a Special Investigations Unit (SIU), which shall be comprised of experienced fraud, waste and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein. At a minimum, the SIU must have at least two (2) fraud, waste and abuse investigators and a Fraud, Waste and Abuse Coordinator. The MCO must adequately staff fraud, waste and abuse to ensure that the MCO meets contract provisions of Section 5.3.2 (Fraud, Waste and Abuse).

3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO must supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to or at risk for Psychiatric Boarding. The number of such hospital-credentialed Providers must be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being

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placed on observation or inpatient status to await an inpatient psychiatric bed. The initial on-site assistance provided within these required timelines must include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility. Each such hospital-credentialed Provider must have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

3.15.2.3 Staff for Members at New Hampshire Hospital: The MCO shall designate an on-site liaison with privileges at New Hampshire Hospital to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital.

3.15.2.4 Additional Behavioral Health Staff: The MCO must designate one (1) or more staff who have behavioral health specific managed care experience to provide in-person housing assistance to Members who are homeless and oversee:

3.15.2.4.1 Behavioral health Care Management;

3.15.2.4.2 Behavioral health Utilization Management;

3.15.2.4.3 Behavioral health network development; and

3.15.2.4.4 The behavioral health Subcontract, as applicable.

3.15.2.5 Any subcontracted personnel or entity engaged in decision-making for the MCO regarding clinical policies related to Substance Use Disorder or mental health must have demonstrated experience working in direct care for Members with Substance Use Disorder or mental health.

3.15.2.6 The crisis lines and Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention calls and who have access to a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

3.15.3 On-Site Presence

3.15.3.1 The MCO shall have an on-site presence in NH. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel resides or reports to work every day in the State of New Hampshire. Without exception, the following personnel shall be located in NH:

3.15.3.1.1 CEO/Executive Director;

3.15.3.1.2 Medical Director;

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- 3.15.3.1.3 Quality Improvement Director;
- 3.15.3.1.4 Compliance Officer;
- 3.15.3.1.5 Network Management Director;
- 3.15.3.1.6 Provider Relations Manager;
- 3.15.3.1.7 Utilization Management Director;
- 3.15.3.1.8 Pharmacy Manager;
- 3.15.3.1.9 Substance Use Disorder Physician;
- 3.15.3.1.10 Special Needs Coordinator;
- 3.15.3.1.11 Behavioral Health Coordinator;
- 3.15.3.1.12 Substance Use Disorder Coordinator;
- 3.15.3.1.13 DD Coordinator;
- 3.15.3.1.14 Long Term Care Coordinator;
- 3.15.3.1.15 Housing Coordinator;
- 3.15.3.1.16 Grievance Coordinator;
- 3.15.3.1.17 Fraud, Waste, and Abuse Coordinator; and
- 3.15.3.1.18 Prior Authorization Coordinator and related personnel.

3.15.3.2 Upon DHHS's request, MCO required staff who are not located in NH shall travel to NH for in-person meetings.

3.15.3.3 The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) calendar days prior to the start of the program. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld. DHHS may grant a written exception to the notice requirements of this section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.15.4 General Staffing Provisions

3.15.4.1 The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely manner as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 5.5.2 (Liquidated Damages).

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

3.15.4.3 All key personnel shall be generally available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS. The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in NH with DHHS.

3.15.4.4 The MCO shall make best efforts to notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel. If a Member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit a transition plan with proposed alternate staff to DHHS for review and approval, for which approval shall not be unreasonably withheld.

3.15.4.5 The Staffing Transition Plan shall include, but is not limited to:

3.15.4.5.1 The allocation of resources to the Agreement during key personnel vacancy;

3.15.4.5.2 The timeframe for obtaining key personnel replacements within ninety (90) calendar days; and

3.15.4.5.3 The method for onboarding staff and bringing key personnel replacements/additions up-to-date regarding this Agreement.

4 PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.1 Overview of Covered Populations

4.1.1.1 The MCO shall provide and be responsible for the cost of managed care services to population groups deemed by DHHS to be eligible for managed care and to be covered under the terms of this Agreement, as indicated in the table below.

4.1.1.2 Members enrolled with the MCO who subsequently become ineligible for managed care during MCO enrollment shall be excluded from MCO participation. DHHS shall, base on State or federal statute, regulation, or policy, exclude other Members as appropriate.

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Medicaid Children Funded through the Children's Health Insurance Program	X	
Medicaid for Employed Adults with Disabilities Non-Dual	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

4.1.2.1 The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in more detail in Exhibit A (New Hampshire Medicaid Covered Services). Additional requirements for Behavioral Health Services are included in Section 4.11 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management). The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with the CMS-approved Medicaid State Plan and Alternative Benefit Plan State Plan. The MCO shall cover services consistent with 45 CFR 92.207(b).

4.1.2.2 While the MCO may provide a higher level of service and cover additional services than required by DHHS (as described in Section 4.1.3 (Covered Services Additional Provisions), the MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426.¹³ DHHS reserves the right to alter this list at any time by providing adequate notice to the MCO. [42 CFR 438.210(a)(1) and (2)]

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
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¹³ http://gencourt.state.nh.us/rules/state_agencies/he-w.html

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
Behavioral Health Crisis Treatment Center	X	
Certified Non-Nurse Midwife	X	
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families		X
Community Mental Health Services	X	
Crisis Intervention – Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage	X	
Family Planning Services	X	
Freestanding Birth Centers	X	

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Furnished Medical Supplies & Durable Medical Equipment	X	
Glenclyff Home		X
Home Based Therapy – Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	
Hospice	X	
Home and Community-Based Services-I Services		X
Inpatient Hospital	X	
Inpatient Hospital Swing Beds, Intermediate Care Facility		X
Inpatient Hospital Swing Beds, Skilled Nursing Facility	X	
Inpatient Psychiatric Facility Services Under Age Twenty-One (21) ¹⁴	X	
Inpatient Psychiatric Treatment in an Institution for Mental Disease, Excluding New Hampshire Hospital ¹⁵	X	
Intensive Home and Community-Based Services– Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities ¹⁶		X
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X

¹⁴ Under age 22 if individual admitted prior to age 21

¹⁵ Pursuant to 42 CFR 438.6 and 42 CFR 438.3(e)(2)(i) through (iii)

¹⁶ E.g., Cedarcrest

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Medical Services Clinic (mostly methadone clinic)	X	
Non-Emergent Medical Transportation ¹⁷	X	
Occupational Therapy ¹⁸	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital ¹⁹	X	
Personal Care Services	X	
Physical Therapy ²⁰	X	
Physicians Services	X	
Placement Services – Division for Children, Youth & Families		X
Podiatrist Services	X	
Prescribed Drugs	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children – Division for Children, Youth & Families		X
Psychology	X	
Rehabilitative Services Post Hospital Discharge	X	
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X

¹⁷ Also includes mileage reimbursement for Medically Necessary travel

¹⁸ Combined Physical Therapy, Occupational Therapy, Speech Therapy 20 visit limit in the CMS-approved Medicaid State Plan is equivalent to combined 20 hours

¹⁹ Including facility and ancillary services for dental procedures

²⁰ Combined Physical Therapy, Occupational Therapy, Speech Therapy 20 visit limit in the CMS-approved Medicaid State Plan is equivalent to combined 20 hours

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Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy ²¹	X	
Substance Use Disorder Services (Per He-W 513) – including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

4.1.3.1 Nothing in this Section 4.1.3 shall be construed to limit the MCO's ability to otherwise voluntarily provide any other services in addition to the services required to be provided under this Agreement. The MCO shall seek written approval from DHHS, bear the entire cost of the service, and the utilization and cost of such services shall not be included in determining payment rates.

4.1.3.2 All services shall be provided in accordance with 42 CFR 438.210 and 42 CFR 438.207(b). The MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS. The MCO shall adopt written policies and procedures to verify that services are actually provided. [42 CFR 455.1(a)(2)]

4.1.3.3 In Lieu Of Services

4.1.3.3.1 The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings included in the Medicaid State Plan that are more medically appropriate, cost-effective substitutes for the Medicaid State Plan services. The MCO may cover In Lieu Of Services if:

²¹ Combined PT, OT, ST 20 visit limit in the CMS-approved Medicaid State Plan is equivalent to combined 20 hours

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4.1.3.3.1.1. DHHS determines that the alternative service or setting is a medically appropriate and cost-effective substitute;

4.1.3.3.1.2. The Member is not required to use the alternative service or setting;

4.1.3.3.1.3. The In Lieu Of Service has been authorized by DHHS; and

4.1.3.3.1.4. The in Lieu Of Service has been offered to Members at the option of the MCO. [42 CFR 438.3(e)(2)(i) - (iii)]

4.1.3.3.2 DHHS may determine that the alternative service or setting is a medically appropriate and cost-effective substitute by either: prospectively providing to the MCO a list of services that the MCO may consider In Lieu Of Services; or by the MCO receiving approval from DHHS to implement an In Lieu Of Service.

4.1.3.3.3 DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS.

4.1.3.3.4 For the MCO to obtain approval for In Lieu Of Services not authorized by DHHS, the MCO shall submit an In Lieu Of Service request to DHHS for each proposed In Lieu of Service not yet authorized. The MCO shall monitor the cost-effectiveness of each approved In Lieu of Service by tracking utilization and expenditures and submit an annual update providing an evaluation of the cost-effectiveness of the alternative service during the previous twelve (12) months, in accordance with Exhibit O.

4.1.3.4 Institution for Mental Diseases (IMD)

4.1.3.4.1 Pursuant to 42 CFR 438.6, the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any Member who is receiving treatment in an IMD for the primary treatment of a psychiatric disorder that is not a state owned or operated facility. The MCO shall not pay for any days in a given month if the Member exceeds fifteen (15) days in an IMD for that month, unless otherwise indicated by DHHS and permitted as a result of a federal waiver or other authority. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for In Lieu of Services at 42 CFR 438.3(e)(2)(i)-(iii).

4.1.3.5 Telemedicine

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4.1.3.5.1 The MCO shall comply with provisions of RSA 167:4(d)²² by providing access to telemedicine services to Members in certain circumstances. The MCO shall develop a telemedicine clinical coverage policy and submit the policy to DHHS for review and approval. Covered telemedicine modalities must comply with all local, State and federal laws including the HIPAA and record retention requirements. The clinical policy must demonstrate how each covered telemedicine modality ensures security of PHI, including data security and encryption policies.

4.1.3.6 Non-Participating Indian Health Care Providers

4.1.3.6.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health Care Providers from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.6.2 The MCO shall allow any American Indian/Alaska Native Member who is eligible to receive services from an IHCP PCP that is a Participating Provider, to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services. [American Reinvestment and Recovery Act 5006(d); SMDL 10-001; 42 CFR 438.14(b)(3)]

4.1.3.7 Moral and Religious Grounds

4.1.3.7.1 An MCO that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(a)(2)]

4.1.3.7.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO must furnish information about the services it does not cover to DHHS with its application for a Medicaid contract and any time thereafter when it adopts such a policy during the Term of this Agreement. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(b)(1)(i)(A)(1)-(2)]

4.1.3.7.3 If the MCO does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, DHHS will provide that information to potential Members upon request. [42 CFR 438.10(e)(2)(v)(C)]

²² Available at: <http://www.gencourt.state.nh.us/rsa/html/XII/167/167-4-d.htm>

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4.1.4 Cost Sharing

4.1.4.1 Any cost sharing imposed on Medicaid Members must be in accordance with NH's Medicaid Cost Sharing State Plan Amendment and Medicaid FFS requirements pursuant to 42 CFR 447.50 through 42 CFR 447.82. [Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act; 42 CFR 438.108; 42 CFR 447.50 - 82; SMDL 6/16/06]

4.1.4.2 With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) Copayment for services for Members deemed by DHHS to have annual incomes at or above one hundred percent (100%) of the FPL as follows:

4.1.4.3 A Copayment of one dollar (\$1.00) will be required for each preferred prescription drug and each refill of a preferred prescription drug;

4.1.4.4 A Copayment of two dollars (\$2.00) will be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug will be one dollar (\$1.00);

4.1.4.5 A Copayment of one dollar (\$1.00) will be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and

4.1.4.6 The following services are exempt from co-payments: emergency services, family planning services, preventive services provided to children, pregnancy-related services, services resulting from potentially preventable events, and Cloraryl (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.7 Members are exempt from Copayments when:

4.1.4.7.1 The Member falls under the designated income threshold (one hundred percent (100%) or below the FPL);

4.1.4.7.2 The Member is under eighteen (18) years of age;

4.1.4.7.3 The Member is in a nursing facility or in an ICF for Members with IDs;

4.1.4.7.4 The Member participates in one (1) of the HCBS waiver programs;

4.1.4.7.5 The Member is pregnant and receiving services related to their pregnancy or any other medical condition that might complicate the pregnancy;

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4.1.4.7.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within sixty (60) calendar days after the month the pregnancy ended;

4.1.4.7.7 The Member is in the Breast and Cervical Cancer Treatment Program;

4.1.4.7.8 The Member is receiving hospice care; or

4.1.4.7.9 The Member is an American Indian/Alaska Native.

4.1.4.8 Any American Indian/Alaskan Native who has ever received or is currently receiving an item or service furnished by an IHCP or through referral under contract health services shall be exempt from all cost sharing including Copayments and Premiums. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001]

4.1.5 Emergency Services

4.1.5.1 The MCO shall cover and pay for Emergency Services at rates that are no less than the equivalent DHHS FFS rates if the Provider that furnishes the services has an agreement with the MCO. [Section 1852(d)(2) of the Social Security Act; 42 CFR 438.114(b); 42 CFR 422.113(c)]

4.1.5.2 If the Provider that furnishes the Emergency Services does not have an agreement with the MCO, the MCO shall cover and pay for the Emergency Services in compliance with Section 1932(b)(2)(D) of the Social Security Act, 42 CFR 438.114(c)(1)(i), and the SMDL 3/20/98.

4.1.5.3 The MCO must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating Provider. The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the DHHS FFS system in place at the time the service was provided. [SMDL 3/31/06; Section 1932(b)(2)(D) of the Social Security Act]

4.1.5.4 The MCO shall not deny treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition. The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)].

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4.1.5.5 The MCO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or DHHS of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. [42 CFR 438.114(d)(1)(i) - (ii)]

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

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

4.1.6 Post-Stabilization Services

4.1.6.1 Post-Stabilization Services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for Post-Stabilization Services:

4.1.6.1.1 Obtained within or outside the MCO that are pre-approved by a Participating Provider or other MCO representative;

4.1.6.1.2 Obtained within or outside the MCO that are not pre-approved by a Participating Provider or other MCO representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services; and/or

4.1.6.1.3 Administered to maintain, improve or resolve the Member's stabilized condition without preauthorization, and regardless of whether the Member obtains the services within the MCO network if:

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

4.1.6.1.3.2. The MCO cannot be contacted; or

4.1.6.1.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or

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one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

4.1.6.2 The MCO shall limit charges to Members for Post-Stabilization Services to an amount no greater than what the organization would charge the Member if the Member had obtained the services through the MCO. [[42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)]

4.1.6.3 The MCO's financial responsibility for Post-Stabilization Services, if not pre-approved, ends when:

4.1.6.3.1 The MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

4.1.6.3.2 The MCO physician assumes responsibility for the Member's care through transfer;

4.1.6.3.3 The MCO representative and the treating physician reach an agreement concerning the Member's care; or

4.1.6.3.4 The Member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i) - (iv)]

4.1.7 Value-Added Services

4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services will not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided.

4.1.8 Early and Periodic Screening, Diagnostic, and Treatment

4.1.8.1 The MCO must provide the full range of preventive, screening, diagnostic and treatment services including all medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions for EPSDT eligible beneficiaries ages birth to twenty-one in accordance with 1905(r) of the Social Security Act. [42 CFR 438.210(a)(5)]

4.1.8.2 The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age

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21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

4.1.8.3 Upon conclusion of an individualized review of medical necessity, the MCO shall cover all Medically Necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. Section 1396d(a), regardless of whether such services are covered under the Medicaid State Plan and regardless of whether the request is labeled as such, with the exception of all services excluded from the MCO.

4.1.8.4 The MCO may provide Medically Necessary services in the most economic mode possible, as long as:

4.1.8.4.1 The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;

4.1.8.4.2 The determination process does not delay the delivery of the needed service; and

4.1.8.4.3 The determination does not limit the Member's right to a free choice of Participating Providers within the MCO's network.

4.1.8.5 Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it must be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

4.1.8.6 The MCO shall not require Prior Authorization for Non-Symptomatic Office Visits (early and periodic screens/wellness visits) for Members less than twenty-one (21) years of age. The MCO may require Prior Authorization for other diagnostic and treatment products and services provided under EPSDT.

4.1.8.7 The MCO shall conduct Prior Authorization reviews using current clinical documentation, and must consider the individual clinical condition and health needs of the child Member. The MCO shall not make an adverse benefit determination on a service authorization request for a Member less than twenty-one (21) years of age until the request is reviewed per EPSDT criteria.

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4.1.8.8 The MCO shall permit that while an EPSDT request is under review, the MCO may suggest alternative services that may be better suited to meet the Member's needs, engage in clinical or educational discussions with Members or Providers, or engage in informal attempts to resolve Member concerns as long as the MCO makes clear that the Member has the right to request authorization of the services he or she wants to request.

4.1.8.9 The MCO shall develop effective methods to ensure that Members less than twenty-one (21) years of age receive all elements of preventive health screenings recommended by the AAP in the Academy's most currently published Bright Futures preventive pediatric health care periodicity schedule using a validated screening tool. The MCO shall be responsible for requiring in contracts that all Participating Providers that are PCPs perform such screenings.

4.1.8.10 The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening:

4.1.8.10.1 Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders;

4.1.8.10.2 Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool;

4.1.8.10.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.10.4 Comprehensive, unclothed physical examination;

4.1.8.10.5 All appropriate immunizations, in accordance with the schedule for pediatric vaccines, laboratory testing (including blood lead screening appropriate for age and risk factors); and

4.1.8.10.6 Health education and anticipatory guidance for both the child and caregiver.

4.1.8.11 The MCO shall include the following information related to EPSDT in the Member Handbook:

4.1.8.11.1 The benefits of preventive health care;

4.1.8.11.2 Services available under the EPSDT program and where and how to obtain those services;

4.1.8.11.3 That EPSDT services are not subject to cost-sharing; and

4.1.8.11.4 That the MCO will provide scheduling and transportation assistance for EPSDT services upon request by the Member.

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4.1.8.12 The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis. The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.13 The MCO shall submit its EPSDT plan for review and approval as part of the readiness review and annually sixty (60) calendar days prior to the first day of each contract year, in accordance with Exhibit O.

4.1.9 Non-Emergency Medical Transportation

4.1.9.1 The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO. The MCO shall provide the most cost-effective and least expensive mode of transportation to its Members. However, the MCO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The MCO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements.

4.1.9.2 The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family member with a car, who can drive them to their Medically Necessary service. A Member with a car who does not want to enroll in the Family and Friends Program must meet one (1) of the following criteria to qualify for transportation services:

4.1.9.2.1 Does not have a valid driver's license;

4.1.9.2.2 Does not have a working vehicle available in the household;

4.1.9.2.3 Is unable to travel or wait for services alone; or

4.1.9.2.4 Has a physical, cognitive, mental or developmental limitation.

4.1.9.3 On a quarterly basis, at least fifty percent (50%) of the total NEMT one-way rides provided by the MCO to Members utilizing NEMT shall be through the Family and Friends Mileage Reimbursement Program.

4.1.9.4 If no car is owned or available, the Member shall take public transportation if:

4.1.9.4.1 The Member lives less than half a mile from a bus route;

4.1.9.4.2 The Provider is less than half a mile from the bus route; and

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4.1.9.4.3 The Member is an adult under the age of sixty-five (65).

4.1.9.5 Exceptions the above public transportation requirement are:

4.1.9.5.1 The Member has two (2) or more children under age six (6) who must travel with the parent;

4.1.9.5.2 The Member has one (1) or more children over age six (6) who has limited mobility and must accompany the parent to the appointment; or

4.1.9.5.3 The Member has at least one (1) of the following conditions:

4.1.9.5.3.1. Pregnant or up to six (6) weeks post-partum,

4.1.9.5.3.2. Moderate to severe respiratory condition with or without an oxygen dependency,

4.1.9.5.3.3. Limited mobility (walker, cane, wheelchair, amputee, etc.),

4.1.9.5.3.4. Visually impaired,

4.1.9.5.3.5. Developmentally delayed,

4.1.9.5.3.6. Significant and incapacitating degree of mental illness, or

4.1.9.5.3.7. Other exception by Provider approval only.

4.1.9.6 If public transportation is not an option, the MCO shall ensure that the Member is provided transportation from a transportation Subcontractor. The MCO shall be required to perform background checks on all non-emergent medical transportation providers and/or Subcontractors.

4.1.9.7 The MCO shall assure that ninety-five percent (95%) of all Member scheduled rides for non-methadone services are delivered within fifteen (15) minutes of the scheduled pick-up time.

4.1.9.8 The MCO shall provide to DHHS reports related to NEMT requests, authorizations, trip results, service use, late rides, and cancellations, in accordance with Exhibit O.

4.2 **Pharmacy Management**

4.2.1 **MCO and DHHS Covered Prescription Drugs**

4.2.1.1 The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which DHHS provides coverage as defined in Section 1927(k)(2) of the

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Social Security Act [42 CFR 438.3(s)(1)], with the exception of select drugs for which DHHS will provide coverage to ensure Member access as identified by DHHS in separate guidance. The MCO shall not include drugs by manufacturers not participating in the OBRA 90 Medicaid rebate program on the MCO formulary without DHHS consent.

4.2.1.2 The MCO shall pay for all prescription drugs – including specialty and office administered drugs, with the exception of those specifically indicated by DHHS as not covered by the MCO in separate guidance – consistent with the MCO's formulary and pharmacy edits and Prior Authorization criteria that have been reviewed and approved by DHHS, and are consistent with the DHHS PDL as described in Section 4.2.2 (MCO Formulary) below. Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO, unless such drugs are specified in DHHS guidance as covered by DHHS.

4.2.1.3 The MCO shall pay for, when Medically Necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a “compassionate-use basis” and imported from a foreign country.

4.2.2 MCO Formulary

4.2.2.1 The PDL is established by DHHS. The MCO shall develop a formulary that adheres to DHHS's PDL for drug classes included in the PDL and is consistent with Section 4.2.1 (MCO and DHHS Covered Prescription Drugs). In the event that DHHS makes changes to the PDL, DHHS shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.2.2 For any drug classes not included in the DHHS PDL, the MCO shall determine the placement on its formulary of products within that drug class, provided the MCO covers all products for which a federal manufacturer rebate is in place and the MCO is in compliance with all DHHS requirements in this Agreement.

4.2.2.3 DHHS shall maintain a uniform review and approval process through which the MCO may submit additional information and/or requests for the inclusion of additional drug or drug classes on the DHHS PDL. DHHS will invite the MCO's Pharmacy Director to attend meetings of the NH Medicaid DUR Board.

4.2.2.4 The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary must be available to Members and Participating Providers electronically, in a machine-

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readable file and format, and must at minimum contain information related to:

4.2.2.4.1 Which medications are covered, including whether it is the generic and/or the brand drug; and

4.2.2.4.2 What tier each medication is on. [42 CFR 438.10(i)(1) - (3)]

4.2.2.5 The MCO shall adhere to State law with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, law 2004, Senate Bill 383-FN, Sect. IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

4.2.2.5.1 Allergy to all medications within the same class on the PDL;

4.2.2.5.2 Contraindication to or drug-to-drug interaction with all medications within the same class on the PDL;

4.2.2.5.3 History of unacceptable or toxic side effects to all medications within the same class on the PDL;

4.2.2.5.4 Therapeutic failure of all medications within the same class on the PDL;

4.2.2.5.5 An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal FDA-approved indication;

4.2.2.5.6 An age-specific indication;

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

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

4.2.3 Clinical Policies and Prior Authorizations

4.2.3.1 The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.11.1.8 (Prior Authorization).

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4.2.3.2 The MCO's pharmacy Prior Authorization criteria, including any pharmacy policies and programs, shall be submitted to DHHS prior to the implementation of this Agreement, shall be subject to DHHS approval, and shall be submitted to DHHS prior to the MCO's implementation of a modification to the criteria, policies, and/or programs.

4.2.3.3 The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.11.6.12 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.3.3.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship. The opt-out program will not apply to specialty pharmacy.

4.2.3.3.2 The MCO must conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT. The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, vivitrol, etc.).

4.2.3.4 The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date. Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.5 The MCO shall implement and operate a DUR program that must be in compliance with Section 1927(g) of the Social Security Act and include:

4.2.3.5.1 Prospective DUR;

4.2.3.5.2 Retrospective DUR; and

4.2.3.5.3 An educational program for Participating Providers, including prescribers and dispensers.[42 CFR 456, subpart K; 42 CFR 438.3(s)(4)]

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4.2.3.6 The MCO shall submit to DHHS a detailed description of its DUR program prior to the implementation of this Agreement and, if the MCO's DUR program changes, annually thereafter.

4.2.3.6.1 In accordance with Section 1927 (d)(5)(A) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization one hundred percent (100%) of the time and reimburse for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation when Prior Authorization cannot be obtained. [42 CFR 438.210(d)(3)]

4.2.3.7 The MCO shall develop or participate in other state of NH pharmacy-related quality improvement initiatives, as required by DHHS and in alignment with the MCO's QAPI, further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.2.3.8 The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed and approved by DHHS, and complies with requirements included in Section 4.11.6.12 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from DHHS, implement Lock-In Programs for other medical services.

4.2.4 Systems, Data, and Reporting Requirements

4.2.4.1 Systems Requirements

4.2.4.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to, systems maintenance, software upgrades, and National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP). Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.4.2 Data and Reporting Requirements

4.2.4.2.1 To demonstrate its compliance with the DHHS PDL, the MCO shall submit to DHHS information regarding its PDL compliance rate.

4.2.4.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, DHHS shall be responsible

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for collecting OBRA 90 CMS rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the Encounter Data file within seven (7) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement. The drug utilization information reported to DHHS shall, at a minimum, include information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed, per DHHS encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.4.2.3 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to DHHS. [428 CFR 438.3(s)(3)]

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

4.2.4.2.5 The MCO shall adhere to federal regulations with respect to providing pharmacy data required for DHHS to complete and submit to CMS the Annual Medicaid DUR Report. [42 CFR 438.3(s)(4),(5)]

4.2.4.2.6 The MCO shall provide DHHS reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O.

4.2.4.2.7 As specified in Exhibit L (the MCO's Implementation Plan), the MCO shall provide to DHHS detailed information regarding providing PCPs and behavioral health Providers access to their patients' pharmacy data and for providing prescriber information to the State PDMP. This data shall be provided in a manner prescribed by DHHS as permitted by State and federal law.

4.2.5 Medication Management

4.2.5.1 Medication Management for All Members

4.2.5.1.1 The MCO shall at least annually offer Comprehensive Medication Review (CMR) and counseling by a pharmacist or

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other health care professional to adult Members dispensed five (5) or more drugs over a sixty (60) day period (or the equivalent of five (5) drugs over a sixty (60) day period, for drugs dispensed for several months at a time). In the event the Member does not respond to the MCO's offer to provide medication review and counseling, the MCO shall continue to attempt to provide such services to the Member on an at least monthly basis or until the Member actively accepts or denies receipt of Medicaid management services.

4.2.5.1.2 CMR is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. The counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve patients' knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self-manage their medications and their health conditions.

4.2.5.1.2.1. The MCO shall operate a DUR program in accordance with Section 1927(g) of the Social Security Act and 42 CFR 456, subpart K, which includes:

4.2.5.1.2.2. Prospective DUR;

4.2.5.1.2.3. Retrospective DUR; and

4.2.5.1.2.4. An educational program for Participating Providers, including prescribers and dispensers.

4.2.5.1.3 The MCO shall routinely monitor and address the appropriate use of behavioral health medications in children by encouraging the use of and reimbursing for consultations with child psychiatrists.

4.2.5.1.4 The MCO may, for purposes of satisfying Medication Management, permit a Subcontract with retail-dispensing pharmacist(s) as part of a medication therapy management program, provided that the MCO ensures that the retail-dispensing pharmacist has access to all Member dispensing information, the MCO retains final oversight and accountability, and the MCO receives DHHS approval prior to implementation of the program.

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4.2.5.2 Medication Management for Children with Special Health Care Needs

4.2.5.2.1 The MCO shall be responsible for active and comprehensive medication management for Children with Special Health Care Needs. The MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that may include the following:

4.2.5.2.1.1. Performing or obtaining necessary health assessments;

4.2.5.2.1.2. Formulating a medication treatment plan according to therapeutic goals agreed upon by prescriber and the Member, parent and caregiver;

4.2.5.2.1.3. Selecting, initiating, modifying, recommending changes to, or administering medication therapy;

4.2.5.2.1.4. Monitoring—which could include lab assessments—and evaluating Member's response to therapy;

4.2.5.2.1.5. Consulting with social service agencies on medication management services;

4.2.5.2.1.6. Initial and on-going CMR to prevent medication-related problems and address drug reconciliation, including adverse drug events, followed by targeted medication reviews;

4.2.5.2.1.7. Documenting and communicating information about care delivered to other appropriate health care Providers;

4.2.5.2.1.8. Member education to enhance understanding and appropriate use of medications; and

4.2.5.2.1.9. Coordination and integration of medication therapy management services with broader health Care Management services to ensure access to Medically Necessary medications wherever Member is placed, including access to out of network pharmacies.

4.2.5.2.1.10. Review of medication use shall be based on the following:

4.2.5.2.1.10.1 Pharmacy claims;

4.2.5.2.1.10.2 Provider progress reports;

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- 4.2.5.2.1.10.3 Comprehensive Assessments and care plans;
- 4.2.5.2.1.10.4 Contact with the Member's Providers;
- 4.2.5.2.1.10.5 Current diagnoses;
- 4.2.5.2.1.10.6 Current behavioral health functioning;
- 4.2.5.2.1.10.7 Information from the family, Provider, DHHS and residential or other treatment entities or Providers; and
- 4.2.5.2.1.10.8 Information shared, to the extent allowable by State and federal law, with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1 DHHS has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether the individual will be enrolled in the MCM program. The MCO shall comply with eligibility decisions made by DHHS.

4.3.1.2 The MCO and its Subcontractors shall ensure that ninety-nine percent (99%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond twenty-four (24) hours.

4.3.1.3 The Accredited Standards Committee (ASC) X12 834 enrollment file will limit enrollment history to eligibility spans reflective of any assignment of the Member with the MCO.

4.3.1.4 To ensure appropriate Continuity of Care, DHHS will provide up to six (6) months (as available) of all FFS paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all FFS Medicaid Members assigned to the MCO. For Members transitioning from another MCO, DHHS will also provide such claims data as well as available encounter information regarding the Member supplied by other MCOs.

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4.3.1.5 The MCO must notify DHHS within five (5) business days when it identifies information in a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. [42 CFR 438.608(a)(3)]

4.3.2 MCO Role in Work and Community Engagement Requirements for Granite Advantage Members

4.3.2.1 The MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members, including but not limited to the activities described in Section 4.3.1.1.1 (General Outreach and Member Education Activities) through 4.3.1.1.4 (Status Tracking and Targeted Outreach) of this Agreement.

4.3.3 General Outreach and Member Education Activities

4.3.3.1 The MCO shall provide general outreach and education to Granite Advantage Members regarding work and community engagement requirements set forth in the Granite Advantage waiver program and State administrative rules. MCO responsibilities include the following:

4.3.3.1.1 The MCO shall require that Member Services staff participate in DHHS training on work and community engagement requirements;

4.3.3.1.2 The MCO shall modify all Member Services call center scripts and Member Handbooks to provide information and assistance related to work and community engagement requirements;

4.3.3.1.3 In instances in which a Granite Advantage Member contacts the MCO and requires additional information about work and community engagement requirements and exemptions, the MCO shall coordinate with DHHS to directly connect, via a "warm transfer" the Member to the appropriate DHHS contact; and

4.3.3.1.4 The MCO shall participate in and support additional outreach and education initiatives related to work and community engagement requirements for Granite Advantage Members as defined by DHHS.

4.3.3.2 Member Support Services

4.3.3.2.1 The MCO shall provide Granite Advantage Members with support related to work and community engagement requirements, including:

4.3.3.2.1.1. Assistance with DHHS processes for reporting compliance, obtaining good cause or other

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exemptions: in the event a Member contacts the MCO seeking to report his/her compliance with work requirements or obtain a good cause or other exemption, the MCO must help the Member navigate DHHS's process for demonstrating such compliance and/or exemption;

4.3.3.2.1.2. Connection to other sources of coverage, when applicable: As indicated in the Special Terms and Conditions of the Granite Advantage waiver approved by CMS, in the event the Member becomes ineligible for Medicaid coverage due to the work requirement, the MCO is required to support the State in the screening of eligibility for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).

4.3.3.2.1.3. Providing Information on options for Members to satisfy the work and community engagement requirements.

4.3.3.2.2 Identification of Exempt or Potentially Exempt Members

4.3.3.2.2.1. The MCO shall notify DHHS, through a mechanism specified by DHHS, of any Granite Advantage Members that the MCO identifies as potentially exempt.

4.3.3.2.2.2. The MCO shall conduct analyses of claims and Encounter Data to identify Granite Advantage Members who may be exempt from work and community engagement requirements as defined by the Granite Advantage waiver program. The MCO shall conduct claims analysis for all Granite Advantage Members on an ongoing basis, at the frequency defined by DHHS. The MCO shall review all sources of data that may support its understanding of Granite Advantage Members' status related to work and community engagement requirements, including but not limited to:

4.3.3.2.2.2.1 Information regarding Members' hospitalization;

4.3.3.2.2.2.2 Information regarding Members' diagnoses and conditions; and

4.3.3.2.2.2.3 Information regarding any circumstances that would exempt or potentially exempt a Member from being subject to work and community engagement requirements.

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4.3.3.2.2.3. The MCO shall also monitor its Care Management systems and the Admissions, Discharge and Transfers (ADT) feed, and as applicable monitor its Subcontractors' Care Management system(s), for hospitalizations, diagnoses, or indications of circumstances that would exempt or potentially exempt Granite Advantage Members from work and community engagement requirements.

4.3.3.2.2.4. For Granite Advantage Members identified as potentially exempt from work and community engagement requirements based on the MCO's claims and Encounter Data analysis, the MCO shall attempt to support the Member in obtaining physician certification of the exemption.

4.3.3.2.2.5. The MCO shall transmit to DHHS, through a mechanism to be specified by DHHS, information for Members who are exempt or may be exempt. The MCO shall indicate to DHHS that the Granite Advantage Member is potentially exempt from work and community engagement requirements if, based on the MCO's claims analysis, physician certification, and/or Care Management data, the MCO can determine that the Member is exempt. The MCO shall indicate that the Member is potentially exempt if the MCO has determined that the individual meets the criteria for a diagnosis-based exemption, but the MCO has not been able to obtain the required physician certification.

4.3.3.2.3 Status Tracking and Targeted Outreach

4.3.3.2.3.1. The MCO will receive from DHHS information generated via electronic file related to Granite Advantage Members' work and community engagement requirement status; for example, this information will indicate that the Granite Advantage Member is either "exempt," "mandatory compliant," or "mandatory non-compliant" with the work and community engagement requirements. The MCO shall be able to receive and process new information in the format designated by DHHS.

4.3.3.2.4 For Granite Advantage Members identified by DHHS as "mandatory non-compliant," the MCO shall perform targeted outreach activities and provide assistance designed to support the Member in becoming compliant with requirements to avoid coverage suspension or termination, as specified by DHHS. The

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MCO's outreach to "mandatory non-compliant" Granite Advantage Members shall include, but is not limited to:

4.3.3.2.4.1. Telephonic outreach, including outreach above and beyond the initial Member welcome call;

4.3.3.2.4.2. Distribution of DHHS-approved mailings or other educational materials; and/or

4.3.3.2.4.3. Transmittal of electronic notification(s), including text messaging.

4.3.4 Enrollment

4.3.4.1 Pursuant to 42 CFR 438.54, Members who do not select an MCO as part of the Medicaid application process will be auto-assigned to an MCO. All newly eligible Medicaid Members will be given ninety (90) calendar days to either remain in the assigned MCO or select another MCO, if they choose. Members may not change from one (1) MCO to another outside the ninety (90) day plan selection period unless they meet the "cause" criteria as described in Section 4.3.5 (Disenrollment) of this Agreement.

4.3.4.2 The MCO shall accept all Members who choose to enroll in or who were assigned to the MCO by DHHS. The MCO shall accept for automatic re-enrollment Members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less. [42 CFR 438.56(g)]

4.3.4.3 The MCO shall allow each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member. When assigning a PCP, the MCO shall include the following methodology, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.5 Non-Discrimination

4.3.5.1 The MCO shall accept new enrollment from individuals in the order in which they apply, without restriction, unless authorized by CMS. [42 CFR 438.3(d)(1)]

4.3.5.2 The MCO shall not discriminate against eligible persons or Members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions. [42 CFR 438.3(d)(3)] The MCO shall not discriminate in enrollment, disenrollment, and re-enrollment against

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individuals on the basis of health status or need for health care services.
[42 CFR 438.3(q)(4)]

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

4.3.5.4 In accordance with HB 1319, the MCO shall not discriminate on the basis of gender identity.²³

4.3.6 Auto-Assignment

4.3.6.1 DHHS will use the following factors for auto-assignment in an order to be determined by DHHS:

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

4.3.6.1.2 Previous MCO enrollment, when applicable;

4.3.6.1.3 Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438.54(d)(7); and

4.3.6.1.4 Equitable distribution among the MCOs.

4.3.6.2 DHHS may revise its auto-assignment methodology to reward those MCOs that demonstrate superior performance on one (1) or more key dimensions of performance as determined by DHHS. The implementation of a performance factor shall be at DHHS's discretion and would potentially precede the equitable distribution factor.

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

4.3.7 Disenrollment

4.3.7.1 Member Disenrollment Request

4.3.7.1.1 A Member may request disenrollment "with cause" to DHHS at any time during the coverage year when:

4.3.7.1.1.1. The Member moves out of state;

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

4.3.7.1.1.3. Other reasons, including but not limited to poor quality of care, lack of access to services covered

²³ Available at http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&id=1022&txtFormat=pdf&v=current

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under the Agreement, violation of rights, or lack of access to Providers experienced in dealing with the Member's health care needs. [42 CFR 438.56(d)(2)]

4.3.7.1.2 A Member may request disenrollment "without cause" at the following times:

4.3.7.1.2.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into the MCO or the date of the DHHS Member notice of the initial auto-assignment/enrollment, whichever is later;

4.3.7.1.2.2. For Members who have an established relationship with a PCP that is only in the network of a non-assigned MCO, the Member can request disenrollment during the first twelve (12) months of enrollment at any time and enroll in the non-assigned MCO;

4.3.7.1.2.3. Every twelve (12) months;

4.3.7.1.2.4. During enrollment related to renegotiation and re-procurement;

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

4.3.7.1.2.6. When DHHS imposes a sanction on the MCO. [42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]

4.3.7.1.3 The MCO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period. The notice shall include an explanation of all of the Member's disenrollment rights as specified in this Agreement. [42 CFR 438.56(f)]

4.3.7.1.4 If a Member is requesting disenrollment, the Member (or his or her authorized representative) shall submit an oral or written request to DHHS. [42 CFR 438.56(d)(1)]

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

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4.3.7.1.6 Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the following month in which the Member files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e); 42 CFR 438.56(d)(3); 42 CFR 438.3(q); 42 CFR 438.56(c)]

4.3.7.2 MCO Disenrollment Request

4.3.7.2.1 The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons:

4.3.7.2.1.1. Member has established out of state residence;

4.3.7.2.1.2. Member death;

4.3.7.2.1.3. Determination that the Member is ineligible for enrollment due to being deemed part of an excluded population;

4.3.7.2.1.4. Fraudulent use of the Member identification card; or

4.3.7.2.1.5. In the event of a Member's threatening or abusive behavior that jeopardizes the health or safety of Members, staff, or Providers. [42 CFR 438.56(b)(1); 42 CFR 438.56(b)(3)]

4.3.7.2.2 The MCO shall not request disenrollment because of:

4.3.7.2.2.1. An adverse change in the Member's health status;

4.3.7.2.2.2. The Member's utilization of medical services;

4.3.7.2.2.3. The Member's diminished mental capacity;

4.3.7.2.2.4. The Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either the particular Member or other Members); or

4.3.7.2.2.5. The Member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse. [Section 1903(m)(2)(A)(v) of the Social Security Act; 42 CFR 438.56(b)(2)]

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4.3.7.2.3 If an MCO is requesting disenrollment of a Member, the MCO shall:

4.3.7.2.3.1. Specify the reasons for the requested disenrollment of the Member; and

4.3.7.2.3.2. Submit a request for involuntary disenrollment to DHHS along with documentation and justification, for review and approval.

4.3.7.2.4 Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the following month in which the MCO files the request. If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e)]

4.3.8 Relationship with Enrollment Services

4.3.8.1 The MCO shall furnish information to DHHS or its designee to ensure that, before enrolling, the recipient receives from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

4.4 Member Services

4.4.1 Member Information

4.4.1.1 The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members, including Granite Advantage Members in accordance with DHHS guidance and the responsibilities described in Section 4.3.1.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members).

4.4.1.2 Primary Care Provider Information

4.4.1.2.1 The MCO shall send a letter to a Member upon initial enrollment, and anytime the Member requests a new PCP, confirming the Member's PCP and providing the PCP's name, address, and telephone number.

4.4.1.3 Member Identification Card

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

4.4.1.3.1.1. The Member's name;

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4.4.1.3.1.2. The Member's DOB;

4.4.1.3.1.3. The Member's Medicaid identification number assigned by DHHS at the time of eligibility determination;

4.4.1.3.1.4. The name of the MCO;

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

4.4.1.3.1.6. How to file an appeal or grievance.

4.4.1.3.2 The MCO shall reissue a Member identification card if:

4.4.1.3.2.1. A Member reports a lost card;

4.4.1.3.2.2. A Member has a name change; or

4.4.1.3.2.3. Any other reason that results in a change to the information disclosed on the identification card.

4.4.1.4 Member Handbook

4.4.1.4.1 The MCO shall publish and provide Member information in the form of a Member Handbook at the time of Member enrollment in the plan and, at a minimum, on an annual basis thereafter. The Member Handbook shall be based upon the model Member Handbook developed by DHHS. [42 CFR 438.10(g)(1), 45 CFR 147.200(a); 42 CFR 438.10(c)(4)(ii)]

4.4.1.4.2 The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives. The MCO shall submit the Member Handbook to DHHS for approval at the time it is developed as part of readiness reviews and after any substantive revisions at least thirty (30) calendar days prior to the effective date of such change.

4.4.1.4.3 The Member Handbook shall be in easily understood language, and include, but not be limited to, the following information:

4.4.1.4.3.1. General Information:

4.4.1.4.3.1.1 A table of contents;

4.4.1.4.3.1.2 How to access Auxiliary Aids and services, including additional information in alternative formats or languages [42 CFR

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438.10(g)(2)(xiii) - (xvi), 42 CFR 438.10(d)(5)(i) - (iii)];

4.4.1.4.3.1.3 DHHS developed definitions: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital, outpatient care, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

4.4.1.4.3.1.4 The necessity definitions used in determining whether services will be covered;

4.4.1.4.3.1.5 A reminder to report to DHHS any change of address, as Members will be liable for premium payments paid during period of ineligibility;

4.4.1.4.3.1.6 Information and guidance as to how the Member can effectively use the managed care program [42 CFR 438.10(g)(2)];

4.4.1.4.3.1.7 Appointment procedures;

4.4.1.4.3.1.8 How to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center that can provide all Members and potential Members choice counseling and information on managed care;

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

(1) The toll-free telephone number for Member Services,

(2) The toll-free telephone number for Medical Management, and

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- (3) The toll-free telephone number for any other unit providing services directly to Members [42 CFR 438.10(g)(2)(xiii) - (xvi)];
- 4.4.1.4.3.1.10 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;
- 4.4.1.4.3.1.11 The policies and procedures for disenrollment;
- 4.4.1.4.3.1.12 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];
- 4.4.1.4.3.1.13 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];
- 4.4.1.4.3.1.14 A description of utilization review policies and procedures used by the MCO;
- 4.4.1.4.3.1.15 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];
- 4.4.1.4.3.1.16 Information on how to report suspected fraud or abuse [42 CFR 438.10(g)(2)(xiii) - (xvi)];
- 4.4.1.4.3.1.17 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];
- 4.4.1.4.3.1.18 Non-Participating Providers and cost-sharing on any benefits carved out and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];
- 4.4.1.4.3.1.19 How to exercise Advance Directives [42 CFR 438.10(g)(2)(xii), 42 CFR 438.3(j)];
- 4.4.1.4.3.1.20 Advance Directive policies which include a description of current State law. [42 CFR 438.3(j)(3)];
- 4.4.1.4.3.1.21 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.11.4.1 (Parity);

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4.4.1.4.3.1.22 Any information pertaining to Granite Advantage Members as required by Section 4.3.1.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members); and

4.4.1.4.3.1.23 Any restrictions on the Member's freedom of choice among Participating Providers [42 CFR 438.10(g)(2)(vi) - (vii)].

4.4.1.4.3.2. Benefits:

4.4.1.4.3.2.1 How and where to access any benefits provided, including [42 CFR 438.10(g)(2)(i)-(ii)]:

- (1) Maternity services,
- (2) Family Planning Services [42 CFR 438.10(g)(2)(vi) - (vii)],
- (3) NEMT services;

4.4.1.4.3.2.2 Detailed information regarding the amount, duration, and scope of all available benefits so that Members understand the benefits to which they are entitled [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.2.3 How to access EPSDT services and component services if Members under age twenty-one (21) entitled to the EPSDT benefit are enrolled in the MCO;

4.4.1.4.3.2.4 How and where to access EPSDT benefits delivered outside the MCO, if any [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.5 How transportation is provided for any benefits carved out of this Agreement and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.6 Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO must inform Members that the service is not covered and how Members can obtain information from DHHS about how to access those services [42 CFR 438.10(g)(2)(ii)(A) - (B), 42 CFR 438.102(b)(2)];

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4.4.1.4.3.2.7 A description of pharmacy policies and pharmacy programs; and

4.4.1.4.3.2.8 How emergency care is provided, including:

(1) The extent to which, and how, after hours and emergency coverage are provided,

(2) What constitutes an Emergency Service and an Emergency Medical Condition,

(3) The fact that Prior Authorization is not required for Emergency Services, and

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

4.4.1.4.3.3. Service Limitations:

4.4.1.4.3.3.1 An explanation of any service limitations or exclusions from coverage;

4.4.1.4.3.3.2 An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider [42 CFR 438.10(g)(2)(vii)];

4.4.1.4.3.3.3 A description of all pre-certification, Prior Authorization criteria, or other requirements for treatments and services;

4.4.1.4.3.3.4 Information regarding Prior Authorization in the event the Member chooses to transfer to another MCO and the Member's right to continue to utilize a Provider specified in a Prior Authorization for a period of time regardless of whether the Provider is participating in the MCO network;

4.4.1.4.3.3.5 The policy on referrals for specialty care and for other Covered Services not furnished by the Member's PCP [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.3.6 Information on how to obtain services when the Member is out-of-state and for after-hours coverage [42 CFR 438.10(g)(2)(v)]; and

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4.4.1.4.3.3.7 A notice stating that the MCO shall be liable only for those services authorized by or required of the MCO.

4.4.1.4.3.4. Rights and Responsibilities:

4.4.1.4.3.4.1 Member rights and protections, outlined in Section 4.4.3 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i) - (vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)].

4.4.1.4.3.5. Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.1.4.3.5.1 The right to file grievances and appeals;

4.4.1.4.3.5.2 The requirements and timeframes for filing grievances or appeals;

4.4.1.4.3.5.3 The availability of assistance in the filing process for grievances and appeals;

4.4.1.4.3.5.4 The right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and

4.4.1.4.3.5.5 The right to have benefits continue pending the appeal or request for state fair hearing if the decision involves the reduction or termination of benefits, however if the Member receives an adverse decision then the Member may be required to pay for the cost of service furnished while the appeal or State fair hearing is pending. [42 CFR 438.10(g)(2)(xi)(A)-(E)]

4.4.1.4.4 Member Handbook Dissemination

4.4.1.4.4.1. The MCO shall mail the Member Handbook to new Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.2. The MCO shall advise the Member in paper or electric form that the Member Handbook information is available on the internet, and include the applicable

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internet address, provided that Members with disabilities who cannot access this information online are provided Auxiliary Aids and services upon request at no cost. [42 CFR 438.10(d)(3)] Alternatively, the MCO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information. The MCO shall provide the Member Handbook information by email after obtaining the Member's agreement to receive the information electronically. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.3. The MCO shall notify all Members, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the MCO's website. [42 CFR 438.10(g)(3)(i) - (iv)] The Member information appearing on the website (also available in paper form) shall include the following, at a minimum:

4.4.1.4.4.3.1 Information contained in the Member Handbook;

4.4.1.4.4.3.2 Information on how to file grievances and appeals;

4.4.1.4.4.3.3 Information on the MCO's Provider network for all Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- (1) Names and any group affiliations;
- (2) Street addresses;
- (3) Office hours;
- (4) Telephone numbers;
- (5) Website (if applicable);
- (6) Specialty (if any),
- (7) Description of accommodations offered for people with disabilities;
- (8) The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at

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the Provider's office, and whether the Provider has completed cultural competence training;

(9) Gender of the Provider;

(10) Identification of Providers that are not accepting new Members; and

(11) Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi) - (vii)]

4.4.1.4.4.4. The MCO shall produce a revised Member Handbook, or an insert, informing Members of changes to Covered Services, upon DHHS notification of any change in Covered Services, and at least thirty (30) calendar days prior to the effective date of such change. This includes notification of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the Member can access those services. [42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)]

4.4.1.4.4.5. The MCO shall use Member notices, as applicable, in accordance with the model notices developed by DHHS. [42 CFR 438.10(c)(4)(ii)] For any change that affects Member rights, filing requirements, time frames for grievances, appeals, and State fair hearing, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. The MCO shall also notify all Members of their disenrollment rights, at a minimum, annually. The MCO must utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.1.5 Provider Directory

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

4.4.1.5.2 The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning

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Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- 4.4.1.5.2.1. Names and any group affiliations;
 - 4.4.1.5.2.2. Street addresses;
 - 4.4.1.5.2.3. Office hours;
 - 4.4.1.5.2.4. Telephone numbers;
 - 4.4.1.5.2.5. Website (if applicable);
 - 4.4.1.5.2.6. Specialty (if any),
 - 4.4.1.5.2.7. Gender;
 - 4.4.1.5.2.8. Description of accommodations offered for people with disabilities;
 - 4.4.1.5.2.9. The cultural and linguistic capabilities of Participating Providers, including languages (including ASL) offered by the Participating Provider or a skilled medical interpreter at the Provider's office, and whether the Participating Provider has completed cultural competence training;
 - 4.4.1.5.2.10. Hospital affiliations (if applicable);
 - 4.4.1.5.2.11. Board certification (if applicable);
 - 4.4.1.5.2.12. Identification of Participating Providers that are not accepting new patients; and
 - 4.4.1.5.2.13. Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(h)(1)(i) - (viii); 42 CFR 438.10(h)(2)]
- 4.4.1.5.3 The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the Member to the Provider Directory on the MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request. The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2 (Practice Guidelines and Standards). [42 CFR 438.236(c)]
- 4.4.1.5.4 The MCO shall notify all Members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the MCO's website in a machine readable file and format as specified

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by CMS. The MCO shall update the paper copy of the Provider Directory at least monthly and shall update an electronic directory no later than thirty (30) calendar days after the MCO receives updated information. [42 CFR 438.10(h)(3-4)]

4.4.1.5.5 The MCO shall post on its website a searchable list of all Participating Providers. At a minimum, this list shall be searchable by Provider name, specialty, location, and whether the Provider is accepting new Members. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory.

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

4.4.1.5.7 Upon the termination of a Participating Provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify Members who received their primary care from, or was seen on a regular basis by, the terminated Provider. [42 CFR 438.10(f)(1)]

4.4.2 Language and Format of Member Information

4.4.2.1 The MCO shall have in place mechanisms to help potential Members and Members understand the requirements and benefits of the MCO. [42 CFR 438.10(c)(7)]

4.4.2.2 The MCO shall use the DHHS developed definitions consistently in any form of Member communication. The MCO shall develop Member materials utilizing readability principles appropriate for the population served. For example, refer to the methods and principles described in the CMS health literacy resource, "Toolkit for Making Written Material Clear and Effective."²⁴ The MCO shall provide all enrollment notices, information materials, and instructional materials relating to Members and potential Members in a manner and format that may be easily understood and readily accessible in a font size no smaller than twelve (12) point. [42 CFR 438.10(c)(1), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.3 The MCO's written materials shall be developed in compliance with all applicable communication access requirements at the request of the Member or prospective Member at no cost. Information shall be communicated in an easily understood language and format, including

²⁴ Centers for Medicare and Medicaid Services, "Toolkit for Making Written Material Clear and Effective," available at <https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html>

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alternative formats and in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or LEP. The MCO shall inform Members that information is available in alternative formats and how to access those formats. [42 CFR 438.10(d)(3), 42 CFR 438.10(d)(6)(i) - (iv)]

4.4.2.4 The MCO shall make all written Member information available in English, Spanish, and any other state-defined prevalent non-English languages of MCM Members. [42 CFR 438.10(d)(1)] All written Member information shall include at the bottom taglines in large print and in the non-English languages prevalent among MCM Members, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and teletypewriter (TTY)/TDD telephone number of the MCO's Member Services Center. [42 CFR 438.10(d)(3)]

4.4.2.5 The large print tagline shall include information on how to request Auxiliary Aids and services, including materials in alternative formats. Upon request, the MCO shall provide all written Member information in large print with a font size no smaller than eighteen (18). [42 CFR 438.10(d)(2-3), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.6 Written Member information shall include at a minimum:

- 4.4.2.6.1 Provider Directories;
- 4.4.2.6.2 Member Handbooks;
- 4.4.2.6.3 Appeal and grievance notices; and
- 4.4.2.6.4 Denial and termination notices.

4.4.2.7 The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that DHHS identifies as languages of other major population groups. Members shall not be charged for interpretation services. [42 CFR 438.10(d)(4)]

4.4.2.8 The MCO shall notify Members that oral interpretation is available for any language and written information is available in languages prevalent among MCM Members; the MCO shall notify Members of how to access those services. [42 CFR 438.10(d)(4), 42 CFR 438.10(d)(5)(i) - (iii)]

4.4.2.9 The MCO shall provide Auxiliary Aids such as TTY/TDD and ASL interpreters free of charge to Members or potential Members who require these services. [42 CFR 438.10(d)(4)] The MCO shall take into consideration the special needs of Members or potential Members with disabilities or LEP. [42 CFR 438.10(d)(5)(i) - (iii)]

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4.4.3.1 The MCO must have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:

4.4.3.1.1 Receive information on the MCM program and the MCO to which the Member is enrolled;

4.4.3.1.2 Be treated with respect and with due consideration for his or her dignity and privacy and the confidentiality of his or her PHI and PI as safeguarded by State rules and State and federal laws;

4.4.3.1.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

4.4.3.1.4 Participate in decisions regarding his/her health care, including the right to refuse treatment;

4.4.3.1.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

4.4.3.1.6 Request and receive a copy of his/her medical records free of charge, and to request that they be amended or corrected;

4.4.3.1.7 Request and receive any MCO's written Physician Incentive Plans;

4.4.3.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers;

4.4.3.1.9 Have a Second Opinion; and

4.4.3.1.10 Exercise these rights without the MCO or its Participating Providers treating the Member adversely. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)-(vi); 42 CFR 438.100(c); 42 CFR 438.10(f)(3); 42 CFR 438.10(g)(2)(vi) - (vii); 42 CFR 438.10(g)(2)(ix); 42 CFR 438.3(i)]

4.4.4 Member Communication Supports

4.4.4.1 The MCO shall embrace and further the concept of "every door for Members is the right door" to eliminate barriers and create a more flexible and responsive approach to person-centered service delivery. The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal. In advance of the program's initial start date, the MCO shall provide a blueprint of its Member portal for approval by DHHS as specified in Exhibit L (MCO's Implementation Plan).

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4.4.4.2 Member Call Center

4.4.4.2.1 The MCO shall operate a toll-free NH specific call center Monday through Friday, except for DHHS approved holidays. The MCO shall submit the holiday calendar to DHHS for review and approval ninety (90) calendar days prior to the end of the calendar year.

4.4.4.2.2 The MCO must ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.11.1.12 (Member Service Line), works efficiently to resolve issues, and is adequately staffed with qualified personnel who are trained to accurately respond to Members. At a minimum, the Member Call Center shall be operational:

4.4.4.2.2.1. Two (2) days per week: eight (8:00) am Eastern Standard Time (EST) to five (5:00) pm EST;

4.4.4.2.2.2. Three (3) days per week: eight (8:00) am EST to eight (8:00) pm EST; and

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

4.4.4.2.3 The Member Call Center shall meet the following minimum standards, which DHHS reserves the right to modify at any time:

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

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

4.4.4.2.3.3. Voicemail or answering service messages shall be responded to no later than the next business day.

4.4.4.2.4 The MCO shall develop a means of coordinating its Member Call Center with the DHHS Customer Service Center to include, at a minimum, the development of a warm transfer protocol for Members.

4.4.4.3 Welcome Call

4.4.4.3.1 The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO. A minimum of three (3) attempts should be made at various times of the day, on different days for new Members.

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4.4.4.3.2 The welcome call shall, at a minimum:

4.4.4.3.2.1. Assist the Member in selecting a PCP or confirm selection of a PCP;

4.4.4.3.2.2. Arrange for a wellness visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs), which must include:

4.4.4.3.2.2.1 Assessments of both physical and behavioral health,

4.4.4.3.2.2.2 Screening for depression, mood, suicidality, and Substance Use Disorder, and

4.4.4.3.2.2.3 Development of a health, wellness and care plan;

4.4.4.3.2.3. Include a Health Risk Assessment Screening as required in Section 4.10.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement;

4.4.4.3.2.4. Screen for special needs, physical and behavioral health, and services of the Member;

4.4.4.3.2.5. Answer any other Member questions about the MCO;

4.4.4.3.2.6. Ensure Members can access information in their preferred language; and

4.4.4.3.2.7. Remind Members to report to DHHS any change of address, as Members will be liable for premium payments paid during period of ineligibility.

4.4.4.4 Member Hotline

4.4.4.4.1 The MCO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays. The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for Members to leave messages. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day. The MCO may substitute a live answering service in place of an automated system.

4.4.4.5 Program Website

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4.4.4.5.1 The MCO shall develop and maintain, consistent with DHHS standards and other applicable State and federal laws, a website to provide general information about the MCO's program, its Participating Provider network, its formulary, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance and Appeal Processes. The MCO shall ensure that any PHI, PI or other Confidential Information solicited shall not be stored or captured on the website and shall not be further disclosed except as provided by this Agreement. The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit N (Liquidated Damages Matrix) and all applicable State and federal regulation.

4.4.4.5.2 If the MCO chooses to provide required information electronically to Members, it must:

4.4.4.5.2.1. Be in a format and location that is prominent and readily accessible;

4.4.4.5.2.2. Be provided in an electronic form which can be electronically retained and printed;

4.4.4.5.2.3. Be consistent with content and language requirements;

4.4.4.5.2.4. Notify the Member that the information is available in paper form without charge upon request; and

4.4.4.5.2.5. Provide, upon request, information in paper form within five (5) business days. [42 CFR 438.10(c)(6)(i) - (v)]

4.4.4.5.3 The MCO program content included on the website shall be:

4.4.4.5.3.1. Written in English, Spanish, and any other of the commonly encountered languages of MCM Members;

4.4.4.5.3.2. Culturally appropriate;

4.4.4.5.3.3. Appropriate to the reading literacy of the population served; and

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

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4.4.4.5.4 The MCO's website shall be compliant with the federal DOJ "Accessibility of State and Local Government Websites to People with Disabilities."²⁵

4.4.5 Marketing

4.4.5.1 The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The MCO shall submit all MCO Marketing material to DHHS for approval before distribution. DHHS will identify any required changes to the Marketing Materials within thirty (30) business days. If DHHS has not responded to a request for review by the thirtieth business day, the MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

4.4.5.2 The MCO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll. The MCO Marketing Materials shall not contain false or materially misleading information. The MCO shall not offer other insurance products as inducement to enroll. The MCO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or DHHS. The MCO's Marketing Materials shall not contain any written or oral assertions or statements that:

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

4.4.5.2.2 The MCO is endorsed by CMS, the State or federal government, or a similar entity. [42 CFR 438.104(b)(2)(i) - (ii)]

4.4.5.3 The MCO shall distribute Marketing Materials to the entire state. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO will not release and make public statements or press releases concerning the program without the prior consent of DHHS. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

4.4.6 Member Engagement Strategy

4.4.6.1 The MCO shall develop and facilitate an active Member Advisory Board that is composed of Members who represent its Member population.

4.4.6.2 Member Advisory Board

²⁵ U.S. Department of Justice, "Accessibility of State and Local Government Websites to People with Disabilities," June 2003, available at https://www.ada.gov/websites2_prnt.pdf

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4.4.6.2.1 Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program. The advisory board shall meet at least four (4) times a year. The advisory board shall meet in-person or through interactive technology, including but not limited to a conference call or webinar and provide Member perspective to influence the MCO's QAPI program changes (as further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program)). All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.6.3 In-Person Regional Member Meetings

4.4.6.3.1 The MCO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the MCO can ask questions and obtain feedback from Members. Regional meetings shall be held at least twice each Agreement year in demographically different locations in NH. The MCO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the MCO shall use alternate technologies as available for all meetings. The MCO shall report on the activities of these meetings including a summary of meeting dates, attendees, topics discussed and actions taken in response to Member contributions to DHHS in the MCM Comprehensive Annual Report, in accordance with Exhibit O.

4.4.7 Cultural and Accessibility Considerations

4.4.7.1 The MCO shall participate in DHHS's efforts to promote the delivery of services in a culturally and linguistically competent manner to all Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)]

4.4.7.2 The MCO shall ensure that Participating Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities. [42 CFR 438.206(c)(3)]

4.4.7.3 Cultural Competency Plan

4.4.7.3.1 In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and

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translators in accordance with Exhibit O. The Cultural Competency Plan shall describe how the Participating Providers, Members, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity. The MCO shall work with the DHHS Office of Minority Health Equity to address cultural and linguistic considerations.

4.4.7.4 Communication Access

4.4.7.4.1 The MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

4.4.7.4.2 The MCO shall develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking Members' needs for communication assistance for health encounters including preferred spoken language for all encounters, need for interpreter, and preferred language for written information.

4.4.7.4.3 The MCO must adhere to certain quality standards in delivering language assistance services, including using only Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators:

4.4.7.4.3.1. Qualified Bilingual/Multilingual Staff means an employee of a covered entity's workforce who is designated by the covered entity to provide oral language assistance as part of the employee's current, assigned job responsibilities and who has demonstrated to the covered entity that he or she:

4.4.7.4.3.1.1 Is proficient in speaking and understanding both spoken English and at least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and

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4.4.7.4.3.1.2 Is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

4.4.7.4.3.2. Qualified Interpreter for a Member with a Disability means an interpreter who, via a remote interpreting service or an on-site appearance:

4.4.7.4.3.2.1 Adheres to generally accepted interpreter ethics principles, including client confidentiality; and

4.4.7.4.3.2.2 Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

4.4.7.4.4 For a Member with a disability, Qualified Interpreters can include, for example, sign language interpreters, oral transliterators (employees who represent or spell in the characters of another alphabet), and cued language transliterators (employees who represent or spell by using a small number of handshapes).

4.4.7.4.4.1. Qualified Interpreter for a Member with LEP means an interpreter, who via a remote interpreting service or an on-site appearance:

4.4.7.4.4.1.1 Adheres to generally accepted interpreter ethics principles, including Member confidentiality;

4.4.7.4.4.1.2 Has demonstrated proficiency in speaking and understanding both spoken English and at least one (1) other spoken language; and

4.4.7.4.4.1.3 Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

4.4.7.4.4.2. Qualified Translator means a translator who:

4.4.7.4.4.2.1 Adheres to generally accepted translator ethics principles, including Member confidentiality;

4.4.7.4.4.2.2 Has demonstrated proficiency in writing and understanding both written English and

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at least one (1) other written non-English language;
and

4.4.7.4.4.2.3 Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. [45 CFR 92.4, 92.201(d)-(e)]

4.4.7.4.5 The MCO must ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. The MCO shall not:

4.4.7.4.5.1. Require a Member with LEP to provide his or her own interpreter;

4.4.7.4.5.2. Rely on an adult accompanying a Member with LEP to interpret or facilitate communication, except:

4.4.7.4.5.2.1 In an emergency involving an imminent threat to the safety or welfare of the Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available, or

4.4.7.4.5.2.2 Where the Member with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

4.4.7.4.5.3. Rely on a minor to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of a Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.7.4.5.4. Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.201(e)]

4.4.7.4.6 The MCO shall ensure interpreter services are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services exclusive of inpatient services. The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e. will provide meaningful access) for all Members in all situations. The

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most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member. Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the Provider of the encounter service.

4.4.7.4.7 The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Interpreters are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.7.4.7.1. Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

4.4.7.4.7.2. A sharply delineated image that is large enough to display the interpreter's face and the participating Member's face regardless of the Member's body position;

4.4.7.4.7.3. A clear, audible transmission of voices; and

4.4.7.4.7.4. Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. [45 CFR 92.201(f)]

4.4.7.4.8 The MCO shall bear the cost of interpretive services and communication access, including ASL interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision-impaired. The MCO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.4.7.4.9 If the Member declines free interpretation services offered by the MCO, the MCO must have in place a process for informing the Member of the potential consequences of declination with the assistance of a competent interpreter to assure the Member's understanding, as well as a process to document the Member's declination. Interpreter services must be

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re-offered by the MCO at every new contact. Every declination requires new documentation by the MCO of the offer and decline.

4.4.7.4.10 The MCO shall comply with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin.

4.4.7.4.11 As clarified by Executive Order 13166, Improving Access to Services for Persons with LEP, and resulting agency guidance, national origin discrimination includes discrimination on the basis of LEP. To ensure compliance with Title VI of the Civil Rights Act of 1964, the MCO must take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

4.4.7.4.12 Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The MCO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the MCO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.5 Member Grievances and Appeals

4.5.1 General Requirements

4.5.1.1 The MCO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The MCO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.5.1.2 The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS's review and approval prior to the first readiness review. Any proposed changes to the Grievance System must be approved by DHHS thirty (30) calendar days prior to implementation.

4.5.1.3 The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal

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is related to a Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement. In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

4.5.1.4 The MCO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The MCO must:

4.5.1.4.1 Give Members any reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.5.1.4.2 Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member or authorized Provider requests expedited resolution [42 CFR 438.406(b)(1); 42 CFR 438.228(a)];

4.5.1.4.3 Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making [42 CFR 438.406(b)(2)(i); 42 CFR 438.228(a)];

4.5.1.4.4 Ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 438.406(b)(2)(iii); 42 CFR 438.228(a)];

4.5.1.4.5 Ensure that, if deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the Member's condition or disease:

4.5.1.4.5.1. An appeal of a denial based on lack of medical necessity;

4.5.1.4.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

4.5.1.4.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A) - (C); 42 CFR 438.228(a)].

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4.5.1.4.6 Ensure that Members may file appeals and State fair hearings after receiving notice that an adverse action is upheld [42 CFR 438.402(c)(1); 42 CFR 438.408].

4.5.1.5 The MCO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

4.5.1.6 The MCO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contract or Subcontract. The information shall include, but is not limited to:

4.5.1.6.1 The Member's right to file grievances and appeals and their requirements and timeframes for filing;

4.5.1.6.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.5.1.6.3 The availability of assistance with filing;

4.5.1.6.4 The toll-free numbers to file oral grievances and appeals;

4.5.1.6.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.5.1.6.6 The Provider's right to appeal the failure of the MCO to pay for or cover a service.

4.5.1.7 The MCO shall make available training to Providers in supporting and assisting Members in the Grievance Process.

4.5.1.8 The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)] At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the Member, the dates received, the dates of each review, the dates of the grievance or appeal, the resolution and the date of resolution. [42 CFR 438.416(b)(1) - (6)]

4.5.1.9 In accordance with Exhibit O, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.5.1.10 The MCO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The MCO shall regularly review appeals data for

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process improvement which should include but not be limited to reviewing:

4.5.1.10.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

4.5.1.10.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.11 The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.2 Grievance Process

4.5.2.1 The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2 The MCO shall allow a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3 The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4 The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance even if the MCO does not have all the information necessary to make the decision, for one hundred percent (100%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)] If the Member requests disenrollment, then the MCO

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shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the following month in which the Member requests disenrollment. [42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)]

4.5.2.5 The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues must be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.6 Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3 Appeal Process

4.5.3.1 The MCO shall develop, implement, and maintain an Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2 The MCO shall allow a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal orally or in writing of any MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3 The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4 The MCO shall allow a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)] The MCO shall ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the Member or the authorized Provider requests expedited resolution. [42 CFR 438.406(b)(3)] An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution. [42 CFR 438.402(c)(3)(ii)]

4.5.3.5 If DHHS receives a request to appeal an action of the MCO, DHHS will forward relevant information to the MCO and the MCO will contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care

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professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.7 The MCO shall allow the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.8 The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, including medical records, and any other documents and records considered during the Appeal Process free of charge prior to the resolution. [42 CFR 438.406(b)(5); 438.408(b) - (c)]

4.5.3.9 The MCO may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.5.3.10 The MCO shall resolve one hundred percent (100%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)] The date of filing shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest. Or, in the case of a Provider filing an appeal on behalf of the Member, the date of filing shall be considered the date upon which the MCO receives authorization from the Member for the Provider to file an appeal on the Member's behalf.

4.5.3.11 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in violation of 42 CFR 42 CFR 438, subpart K may file an appeal.

4.5.3.12 If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.5.4 Actions

4.5.4.1 The MCO shall allow for the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 Denial, in whole or in part, of payment for a service;

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4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1) MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5 Expedited Appeal

4.5.5.1 The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

4.5.5.2 The MCO must inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

4.5.5.3 The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)] The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The MCO shall also make reasonable efforts to provide oral notice. The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

4.5.5.4 If the MCO extends the timeframes not at the request of the Member, it must:

4.5.5.4.1 Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on

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different days within two (2) calendar days of the MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.4.2 Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision;

4.5.5.4.3 Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2)-(3)]

4.5.5.5 The MCO shall meet the timeframes above for one hundred percent (100%) of requests for expedited appeals.

4.5.5.6 The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.7 If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

4.5.5.8 The Member has a right to file a grievance regarding the MCO's denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6 Content of Notices

4.5.6.1 The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice must meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.2 Each notice of adverse action shall conform with 42 CFR 431.210, contain and explain:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

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4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b) - (c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits [42 CFR 438.404(b)(6)].

4.5.6.3 The MCO shall ensure that all notices of adverse action be in writing and must meet the following language and format requirements:

4.5.6.3.1 Written notice must be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice must include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 Notices must use easily understood language and format, and must be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members and potential Members must be informed that information is available in alternative formats and how to access those formats.

4.5.6.4 The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction will result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

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4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

4.5.6.4.9 The transfer or discharge from a facility will occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7 Timing of Notices

4.5.7.1 For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2 For denial of payment, the MCO shall provide Members written notice on the date of action when the adverse action is a denial of payment or reimbursement. [42 CFR 438.404(c)(2)]

4.5.7.3 For standard service authorization denials or partial denials, the MCO shall provide Members written notice as expeditiously as the Member's health condition requires and not to exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services. [42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3)] An extension of up to an additional fourteen (14) calendar days is permissible, if:

4.5.7.3.1 The Member or the Provider requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4 When the MCO extends the timeframe, the MCO must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or

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she disagrees with that decision. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i)] Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii)]

4.5.7.5 For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6 The MCO may extend the three (3) business days' time period by up to seven (7) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7 The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. [42 CFR 438.404(c)(5)]

4.5.8 Continuation of Benefits

4.5.8.1 The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2. The intended effective date of the MCO's proposed action;

4.5.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.3 The services was ordered by an authorized Provider;

4.5.8.1.4 The authorization period has not expired;

4.5.8.1.5 The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

4.5.8.1.6 The Member requests extension of benefits, orally or in writing. [42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii)]

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4.5.8.2 If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]

4.5.8.3 If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4 A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9 Resolution of Appeals

4.5.9.1 The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision must be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

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4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it must:

4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2 Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3 The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.5.9.4 The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.9.5 For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6 For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

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4.5.10 State Fair Hearing

4.5.10.1 The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F. The parties to the State fair hearing include the MCO as well as the Member and his or her representative or the representative of a deceased Member's estate.

4.5.10.2 The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.2.1 That Members must exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

4.5.10.2.2 That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date on the MCO's notice of the resolution of the appeal.

4.5.10.3 If the Member requests a fair hearing, the MCO shall provide to DHHS and the Member, upon request, and within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.4 A Member may request an expedited resolution of a State fair hearing if the Administrative Appeals Unit determines that the time otherwise permitted for a State fair hearing could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, and:

4.5.10.4.1 The MCO adversely resolved the Member's appeal wholly or partially; or

4.5.10.4.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.5 If the Member requests an expedited State fair hearing, the MCO shall provide to DHHS and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.6 If the Administrative Appeals Unit grants the Member's request for an expedited State fair hearing, then the AAU shall resolve the appeal

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within three (3) business days after the Unit receives from the MCO the case file and any other necessary information.

4.5.10.7 The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit. The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate and at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost.

4.5.10.8 The DHHS Administrative Appeals Unit shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11 Effect of Adverse Decisions of Appeals and Hearings

4.5.11.1 If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2 If the MCO or DHHS reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12 Survival

4.5.12.1 The obligations of the MCO to fully resolve all grievances and appeals, including but not limited to providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

4.6 Provider Appeals

4.6.1 General

4.6.1.1 The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider Adverse Action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

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4.6.1.2 The MCO shall provide to DHHS a complete description of its Provider Appeals Process, in writing, including all policies and procedures, notices and forms, of its proposed Provider Appeals Process for DHHS's review and approval prior to the first readiness review. Any proposed changes to the Provider Appeals Process must be approved by DHHS at least thirty (30) calendar days in advance of implementation.

4.6.1.3 The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference in the Provider agreement.

4.6.1.4 The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.4.1 Gives reasonable assistance to Providers requesting an appeal of a Provider Adverse Action;

4.6.1.4.2 Ensures that the decision makers involved in the Provider Appeals Process and their subordinates were not involved in previous levels of review or decision making of the Provider's Adverse Action;

4.6.1.4.3 Ensures that decision makers take into account all comments, documents, records, and other information submitted by the Provider to the extent such materials are relevant to the appeal; and

4.6.1.4.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

4.6.2 Provider Adverse Actions

4.6.2.1 The Provider shall have the right to file an appeal with the MCO and utilize the Provider Appeals Process for any Adverse Action, in accordance with RSA 126-A:5, VIII, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). The Provider shall have the right to file an appeal within thirty (30) calendar days of the date of the MCO's Notice of Adverse Action to the Provider. Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when DHHS, MFCU or other government agency has required the MCO to terminate such agreement;

4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

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4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2 The MCO shall not be precluded from taking an immediate Adverse Action even if the Provider requests an appeal; provided that, if the Adverse Action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the Adverse Action within ten (10) calendar days.

4.6.3 Provider Appeal Process

4.6.3.1 The MCO shall provide written notice to the Provider of Adverse Action, and include in its notice a description of the basis of the Adverse Action, and the right to appeal the Adverse Action.

4.6.3.2 Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within thirty (30) calendar days of:

4.6.3.2.1 The date on the MCO's written notice advising the Provider of the Adverse Action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3 The MCO shall be permitted to extend the decision deadline by an additional thirty (30) calendar days to allow the Provider to submit evidence or supportive documentation, and for other good cause determined by the MCO.

4.6.3.4 The MCO shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject of the Provider Appeal.

4.6.3.5 The MCO may offer peer-to-peer review support, with a like clinician, upon request for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.6.3.6 The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

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4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7 If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Appeals Process and may initiate a State fair hearing.

4.6.3.8 MCO Resolution of Provider Appeals

4.6.3.8.1 The MCO shall provide written notice of resolution of the Provider appeal (Resolution Notice) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.3.8.2 The Resolution Notice shall include without limitation:

4.6.3.8.2.1. The MCO's decision;

4.6.3.8.2.2. The reasons for the MCO's decision;

4.6.3.8.2.3. The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.3.8.2.4. For overturned appeals, the MCO shall take all steps to reverse the Adverse Action within ten (10) calendar days.

4.6.3.9 State Fair Hearing

4.6.3.9.1 The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement. The parties to the State fair hearing include the MCO as well as the Provider. The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing. If a Participating Provider requests a State fair hearing, the MCO shall provide to DHHS and the Participating Provider, upon request, and within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to any transcript(s), records, or written decision(s).

4.6.3.9.2 The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and availability of the Medical Director or other staff as appropriate at no cost.

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4.6.3.9.3 The MCO shall appear and defend its decision before the DHHS Administrative Appeals Unit . Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.3.9.4 The DHHS Administrative Appeals Unit shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.

4.6.3.9.5 The MCO shall:

4.6.3.9.5.1. Not object to the State intervening in any such appeal;

4.6.3.9.5.2. Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.3.9.5.3. Take all steps to reverse any overturned Adverse Action within ten (10) calendar days.

4.6.3.9.6 Reporting

4.6.3.9.6.1. The MCO shall provide to DHHS, as detailed in Exhibit O, Provider complaint and appeal logs. [42 CFR 438.66(c)(3)]

4.7 Access

4.7.1 **Provider Network**

4.7.1.1 The MCO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2 The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH population;

4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Providers limiting NH Medicaid patients or not accepting new or any NH Medicaid patients;

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4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;

4.7.1.2.8 Adequacy of the primary care network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

4.7.1.2.9 Required access standards identified in this Agreement; and

4.7.1.2.10 Required access standards set forth by the NHID, including NH RSA. 420-J; and Admin Rule 2700.

4.7.1.3 The MCO shall meet the network adequacy standards included in this Agreement in all geographic areas in which the MCO operates for all Provider types covered under this Agreement.

4.7.1.4 The MCO shall ensure that services are as accessible to Members in terms of timeliness, amount, duration and scope as those that are available to Members covered by DHHS under FFS Medicaid within the same service area.

4.7.1.5 The MCO shall ensure Participating Providers comply with the accessibility standards of the ADA. Participating Providers must demonstrate physical access, reasonable accommodations, and accessible equipment for all Members including those with physical or cognitive disabilities. [42 CFR 438.206(c)(3)]

4.7.1.6 The MCO shall demonstrate that there are sufficient Participating Indian Health Care Providers in the Participating Provider network to ensure timely access to services for American Indians who are eligible to receive services. If Members are permitted by the MCO to access out-of-state Indian Health Care Providers, or if this circumstance is deemed to be good cause for disenrollment, the MCO will be considered to have met this requirement. [42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7 The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory, as specified in Section 4.4.1.4 (Provider Directory) of this Agreement.

4.7.2 Assurances of Adequate Capacity and Services

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4.7.2.1 The MCO's network shall have Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all Covered Services to meet the geographic standards in Section 4.7.3 (Time and Distance Standards), the timely provision of services requirements in Section 4.7.5 (Timely Access to Service Delivery), Equal Access, and reasonable choice by Members to meet their needs [42 CFR 438.207(a)].

4.7.2.2 The MCO shall submit documentation to DHHS, in the format and frequency specified by DHHS in Exhibit O, that fulfills the following requirements:

4.7.2.2.1 The MCO shall give assurances and provide supporting documentation to DHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHHS's standards for access and timeliness of care. [42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)].

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 4.7.5.1 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 The MCO is complying with DHHS's requirements for Substance Use Disorder treatment services as specified in Section 4.11.6 (Substance Use Disorder) and mental health services as specified in Section 4.11.5 (Mental Health), including Providers required to reduce Psychiatric Boarding; and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3 To allow DHHS to determine if access to private duty nursing services is increasing, as indicated by DHHS in Exhibit O, the MCO shall provide to DHHS the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

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4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4 The MCO shall submit documentation to DHHS to demonstrate that it maintains an adequate network of Participating Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, in accordance with Exhibit O:

4.7.2.4.1 During the readiness review period, prior to the Program Start Date;

4.7.2.4.2 Semi-annually; and

4.7.2.4.3 At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, geographic service area, or payments; and/or enrollment of a new population in the MCO. [42 CFR 438.207(b) - (c)]

4.7.2.5 For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by DHHS.

4.7.3 Time and Distance Standards

4.7.3.1 The MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members. [42 CFR 438.68(b)(1)(i) - (viii); 42 CFR 438.68(b)(3)]

Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

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Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
Tertiary or Specialized Services (Trauma, Neonatal, etc.)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupational Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2 The MCO shall report semi-annually how specific provider types meet the time and distance standards for Members in each county within NH in accordance with Exhibit O.

4.7.3.3 DHHS will continue to assess where additional access requirements, whether time and distance or otherwise, shall be incorporated (for example, to ensure appropriate access to home health services). DHHS may provide additional guidance to the MCO regarding its network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.4 Additional Provider Standards

Provider/Service	Requirement
MLADCs	The MCO's Participating Provider Network must include seventy percent (70%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region (found at https://nhphn.org/) unless there are less than two (2) such Providers in

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	the region
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider Network must include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region (found at https://nhphn.org/) unless there are less than two (2) such Providers in the region
Buprenorphine Prescribers	The Network must include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Residential Substance Use Disorder Treatment Programs	The Network must include fifty percent (50%) of all such Providers licensed and practicing in NH and no less than two (2) in any public health region unless there are less than two (2) such Providers in the region
Peer Recovery Programs	The MCO's Participating Provider Network must include one hundred percent (100%) of all such willing Programs in NH

4.7.4 Standards for Geographic Accessibility

4.7.4.1 The MCO may request exceptions from these standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. DHHS reserves the right at its discretion to approve or disapprove these requests.

4.7.4.2 Should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with the help of DHHS, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days after start date, Liquidated Damages, as described in Section 5.5.2 (Liquidated Damages) shall not apply.

4.7.4.3 Except in a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with the help of DHHS, continue to be unable to meet geographic and timely access to service delivery standards DHHS may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4 At any time the provisions of this section may apply, the MCO will work with DHHS to ensure that Members have access to needed services.

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4.7.4.5 The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6 Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the network adequacy standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. [42 CFR 438.68(d)(1)] DHHS will grant the MCO an exception in the event that:

4.7.4.6.1.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the network adequacy standards in this Agreement and as otherwise defined by the NHID and DHHS;

4.7.4.6.1.2. The MCO demonstrates to DHHS's satisfaction that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

4.7.4.7 The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies approved by DHHS, but the MCO shall not use telemedicine to meet the State's network adequacy standards unless DHHS has specifically approved a Request for Exception.

4.7.4.8 The MCO shall report on network adequacy and exception requests in accordance with Exhibit O.

4.7.5 Timely Access to Service Delivery

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4.7.5.1 The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2 The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3 The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)].

4.7.5.4 The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5 The MCO's network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6 The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days. A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

4.7.5.6.2 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days. A Non-Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.3 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.4 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within seven (7) calendar days of discharge from

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inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.6.5 Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.

4.7.5.7 The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide a semi-annual report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v), in accordance with Exhibit O.

4.7.5.8 The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.9 The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

4.7.5.10 Access Standards for Children with Special Health Care Needs

4.7.5.10.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

4.7.5.10.2 In addition to the "specialty care" Provider network adequacy requirements, the MCO shall contract with the following pediatric specialists:

4.7.5.10.2.1. Pediatric Critical Care;

4.7.5.10.2.2. Pediatric Child Development Providers;

4.7.5.10.2.3. Pediatric Genetics;

4.7.5.10.2.4. Pediatric Physical Medicine and Rehabilitation;

4.7.5.10.2.5. Pediatric ambulatory tertiary care Providers;

4.7.5.10.2.6. Neonatal-Perinatal Medicine;

4.7.5.10.2.7. Pediatrics-Adolescent Medicine; and

4.7.5.10.2.8. Pediatric Psychiatrist.

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4.7.5.11 The MCO shall have adequate networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.12 The MCO shall specify in their listing of mental health and Substance Use Disorder Provider directories which Providers specialize in children's services.

4.7.5.13 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.14 The MCO shall allow a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

4.7.5.15 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.16 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.17 Access Standards for Behavioral Health

4.7.5.17.1 The MCO shall have in its network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.17.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.17.2.1. Within six (6) hours for a non-life threatening emergency;

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4.7.5.17.2.2. Within forty-eight (48) hours for urgent care;
and

4.7.5.17.2.3. Within ten (10) business days for a routine
office visit appointment.

4.7.5.17.3 American Society of Addiction Medicine Level of Care

4.7.5.17.3.1. The MCO shall ensure Members timely
access to care through a network of Participating Providers
in each ASAM Level of Care. During the readiness review
process and in accordance with Exhibit O:

4.7.5.17.3.1.1 The MCO shall submit a plan
describing on-going efforts to continually work to
recruit and maintain sufficient networks of
Substance Use Disorder service Providers so that
services are accessible without reasonable delays;
and

4.7.5.17.3.1.2 The MCO shall have a specified
number of Providers able to provide services at
each level of care required; if supply precludes
compliance, the MCO shall notify DHHS and, within
thirty (30) calendar days, submit an updated plan
that identifies the specific steps that shall be taken
to increase capacity, including milestones by which
to evaluate progress.

4.7.5.18 The MCO shall ensure that Providers under contract to provide
Substance Use Disorder services shall respond to inquiries for Substance
Use Disorder services from Members or referring agencies as soon as
possible and no later than two (2) business days following the day the call
was first received. The Substance Use Disorder Provider is required to
conduct an initial eligibility screening for services as soon as possible,
ideally at the time of first contact (face-to-face communication by meeting
in person or electronically or by telephone conversation) with the Member
or referring agency, but not later than two (2) business days following the
date of first contact.

4.7.5.19 The MCO shall ensure that Members who have screened
positive for Substance Use Disorder services shall receive an ASAM
Level of Care Assessment within two (2) business days of the initial
eligibility screening and a clinical evaluation (as identified in the NH Code
of Administrative Rules, Chapter He-W 500, Part He-W 513)²⁶ as soon
as possible following the ASAM Level of Care Assessment and no later
than (3) business days after admission.

²⁶ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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4.7.5.20 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.21 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by this agency they are then responsible for making a closed loop referral to a Provider of that type of service (for the identified level of care) within fourteen (14) calendar days from initial contact and to provide interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

4.7.5.22 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.23 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

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

4.7.5.23.2 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

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4.7.5.24 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6 Women's Health

4.7.6.1 The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

4.7.6.2 The MCO shall provide access to Family Planning Services to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3 Family Planning Services shall include, but not be limited to, the following:

4.7.6.3.1 Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

4.7.6.3.2 Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

4.7.6.3.3 Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

4.7.6.3.4 Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

4.7.6.3.5 Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and HPV vaccine.

4.7.6.4 Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

4.7.6.5 The MCO shall only provide for abortions in the following situations:

4.7.6.5.1 If the pregnancy is the result of an act of rape or incest; or

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4.7.6.5.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.6 The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement [42 CFR 441.202].

4.7.7 Access to Special Services

4.7.7.1 The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2 The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, and hospice programs. To the extent that the above specialty services are available within NH, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3 The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows, written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4 The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8 Non-Participating Providers

4.7.8.1 If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner

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cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2 The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3 The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider, the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.4 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

4.7.9 Access to Providers During Transitions of Care

4.7.9.1 The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 In the case of a child with Special Health Care Needs as defined in Section 4.10.3 (Priority Populations).

4.7.9.2 The MCO shall allow that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one

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that has terminated its agreement with DHHS) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), regardless of whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member was determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3 The MCO shall allow that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4 The MCO shall allow that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

4.7.9.4.2 The Member is pregnant and in the second (2nd) or third (3rd) trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member was determined to be terminally ill at the time of the transition, the Member may continue seeing his or her

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Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5 The MCO shall maintain a Transition Plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The Transition Plan shall describe how Members will be identified by the MCO and how Continuity of Care will be provided.

4.7.9.6 The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7 The MCO shall notify DHHS and affected current Members in writing of a Provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Affected Members include all Members assigned to a PCP and/or all Members who have been receiving ongoing care from the terminated Provider. Within three (3) calendar days prior to the effective date of the termination the MCO shall have a Transition Plan in place for all affected Members.

4.7.9.8 In addition to notification of DHHS of provider terminations, the MCO shall provide reporting in accordance with Exhibit O.

4.7.9.9 If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a Transition Plan for the affected Members. If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.9.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.9.2 Explain that the Member will be assigned to a PCP if they do not actively select one; and

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4.7.9.9.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.10 If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.11 The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Manager team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant. To minimize disruptions in care, the MCO must:

4.7.9.11.1 With the exception of Members in their second or third trimester of pregnancy, provide continuation of the terminating Provider for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Participating Provider without disruption of care, whichever is less; and

4.7.9.11.2 For Members in their second or third trimester of pregnancy, allow continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10 Second Opinion

4.7.10.1.1 The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook.

4.7.11 Provider Choice

4.7.11.1.1 The MCO shall allow each Member to choose his or her Provider to the extent possible and appropriate [42 CFR 438.3(l)].

4.8 Utilization Management

4.8.1 Policies and Procedures

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4.8.1.1 The MCO's policies and procedures related to the authorization of services shall be in compliance with 42 CFR 438.210 and NH RSA Chapter 420-E:2.27

4.8.1.2 The MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3 Amount, Duration, and Scope

4.8.1.3.1 The MCO must ensure that each service provided to adults is furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid. [42 CFR 438.210(a)(2)] The MCO must also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.2 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.2.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.2.2. Personal Care Attendant (PCA) authorizations shall be issued for no less than one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

4.8.1.3.2.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of eighty (80) units shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for rehabilitative purposes directed at functional impairments.

4.8.1.4 Written Utilization Management Policies

4.8.1.4.1 The MCO must develop, operate, and maintain a Utilization Management program that is documented through a

²⁷ Available at <http://www.gencourt.state.nh.us/rsa/html/nhtoc/NHTOC-XXXVII-420-E.htm>

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program description and defined structures, policies, and procedures that are reviewed and approved by DHHS. The MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);

4.8.1.4.1.4. Are applied based on individual needs and circumstances (including social determinants of health needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.12.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum, Second Opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information. Clinical review criteria and changes in criteria shall be communicated to Participating Providers and Members at least thirty (30) calendar days in advance of the changes.

4.8.1.4.3 The Utilization Management Program descriptions shall be submitted by the MCO to DHHS for review and approval prior to the Program Start Date. Thereafter, the MCO shall report

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on the Utilization Management Program as part of annual reporting in accordance with Exhibit O. The MCO must also communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation. The MCO's written Utilization Management policies, procedures, and criteria shall be made available upon request to DHHS, Participating Providers, and Members.

4.8.1.4.4 The MCO shall annually provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O. [42 CFR 438.66 (c)(7)]

4.8.1.5 Service Limit

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6 Prior Authorization

4.8.1.6.1 The MCO and, if applicable, its Subcontractors must have in place and follow written policies and procedures as described in its Utilization Management policies for processing requests for initial and continuing authorizations of services and including conditions under which retroactive requests will be considered. Any Prior Authorization for Substance Use Disorder shall comply with NH RSA 420-J:18 as described in Section 4.11.6.12 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

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4.8.1.6.2 Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person-centered planning process. [42 CFR 438.210(b)(2)(iii)] The MCO's Prior Authorization requirements must comply with parity in mental health and Substance Use Disorder, as described in Section 4.11.4.3 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.3 The MCO shall use the NH MCM standard Prior Authorization form. The MCO shall also work in good faith with DHHS, as initiated by DHHS, to develop other Prior Authorization forms with consistent information and documentation requirements from Providers wherever feasible. Providers shall be able to submit the Prior Authorizations forms electronically, by mail, or fax.

4.8.1.6.4 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.5 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

4.8.1.6.6 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member. The MCO must comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.7 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement. The MCO shall allow Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations.

4.8.1.6.8 Compensation to individuals or entities that conduct Utilization Management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. [42 CFR 438.210(e)]

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4.8.1.6.9 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.10 Upon receipt of Prior Authorization information from DHHS, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.1 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.11 The MCO shall also, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO. In the event that the Prior Authorization specifies a specific Provider, that MCO will continue to utilize that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network. The MCO will ensure that the Member's needs are met continuously and will continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.12 The MCO shall ensure that Subcontractors or any other party performing utilization review are licensed in NH in accordance with Section 3.14.2 (Contracts with Subcontractors).

4.8.2 Practice Guidelines and Standards

4.8.2.1 The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO must be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field, must consider the needs of the MCO's Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1)-(3); 42 CFR 438.236(b)(4)] Further, the MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

4.8.2.2 In select areas, the MCO shall adopt Practice Guidelines consistent with the standards of care and evidence-based practices of

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specific professional specialty groups, as identified by DHHS. These include, but are not limited to:

4.8.2.2.1 ASAM, as further described in Section 4.11.6.4 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.2.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adults, rated A or B;

4.8.2.2.3 The preventative services recommended by the AAP Bright Futures program; and

4.8.2.2.4 The Zero Suicide Consensus Guide for Emergency Departments²⁸

4.8.2.3 The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is approved by DHHS prior to implementation.

4.8.2.4 The MCO shall disseminate Practice Guidelines to DHHS and all affected Providers and make Practice Guidelines available, including but not limited to the web, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

4.8.2.5 The MCO's decisions regarding Utilization Management, Member education, and coverage of services must be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3 Medical Necessity Determination

4.8.3.1 The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

²⁸ Suicide Prevention Resource Center, "Care for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments," 2015, available at https://www.sprc.org/sites/default/files/EDGuide_full.pdf

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4.8.3.1.2.1. The prevention, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2 For Members twenty-one (21) years of age and older the following definition of medical necessity shall be used: "Medically Necessary" means health care services that a licensed health care Provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that, in accordance with He-W 530.01(e)²⁹, are:

4.8.3.2.1 Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

4.8.3.2.2 Not primarily for the convenience of the Member or the Member's family, caregiver, or health care Provider;

4.8.3.2.3 No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

4.8.3.2.4 Not experimental, investigative, cosmetic, or duplicative in nature.

4.8.3.3 For Members under twenty-one (21) years of age, per EPSDT, the following definition of medical necessity shall be used: "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to collect or ameliorate the defects and physical and behavioral illnesses or conditions.

4.8.4 Notices of Coverage Determinations

4.8.4.1 The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or

²⁹ http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2 Urgent Determinations and Continued/Extended Services

4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)] In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request and shall advise the Member or Member's representative of the specific information necessary to make a determination. The Member or Member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the MCO's receipt of the specified additional information; or the end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.2.1.2. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

4.8.4.3 All Other Determinations

4.8.4.3.1 The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed

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fourteen (14) calendar days for ninety-five percent (95%) of requests after the receipt of a request. An extension of up to fourteen (14) calendar days is permissible for non-diagnostic radiology determinations if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.2 If an extension is necessary due to a failure of the Member or Member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the Member or Member's representative shall be given at least forty-five (45) calendar days from receipt of the notice within which to provide the specified information.

4.8.4.3.3 Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of: the MCO's receipt of the specified additional information; or the end of the period afforded the Member or Member's representative to provide the specified additional information. When the MCO extends the timeframe, the MCO must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO must issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.8.4.3.4 The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the Member fails to provide sufficient information to determine the request, the MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information. The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.5 Whenever there is an adverse determination, the MCO shall notify the ordering Provider and the Member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

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4.8.4.3.6 The MCO shall provide Utilization Management data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O.

4.8.5 Advance Directives

4.8.5.1 The MCO shall adhere to all State and federal laws pertaining to Advance Directives, including but not limited to NH RSA 137-J.30

4.8.5.2 The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489. The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100. The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)] The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

4.8.5.3 The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.4 The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.1.3 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.5 The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9 Member Education and Incentives

4.9.1 General Provisions

4.9.1.1 The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by DHHS, including the National Diabetes Prevention Program. The MCO shall also participate in other public health initiatives at the direction of DHHS.

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

³⁰ Available at <http://www.gencourt.state.nh.us/rsa/html/x/137-j/137-j-mrg.htm>

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4.9.1.3 The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. DHHS shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2 Member Health Education

4.9.2.1 The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

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

4.9.3 Member Cost Transparency

4.9.3.1 The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2 The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to allow Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3 The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) below.

4.9.4 Member Incentive Programs

4.9.4.1 The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this Section 4.9.4 (Member Incentive Programs) of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the MCOs and Providers described in Section 4.14 (Alternative Payment Models) of this Agreement as appropriate.

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4.9.4.2 For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 Do not, in a given fiscal year for any one (1) Member, exceed a total monetary value of two hundred and fifty dollars (\$250.00).

4.9.4.3 The MCO shall, prior to implementation of all Member Incentive Programs, obtain approval for the incentive program by submitting a member incentive plan proposal. Within the plan proposal, the MCO shall include adequate assurances, as assessed by DHHS, that:

4.9.4.3.1 The program meets the requirements of 1112(a)(5) of the Social Security Act; and

4.9.4.3.2 The program meets the criteria determined by DHHS as described in Section 4.9.4.1 (Healthy Behavior Incentive Programs) and Section 4.9.4.2 (Reference-Based Pricing Incentive Programs) below.

4.9.4.4 The MCO shall report to DHHS at least annually the results of any Member Incentive Programs in effect in the prior twelve (12) months, including the following metrics and those indicated by DHHS, in accordance with Exhibit O:

4.9.4.4.1 The number of Members in the program's target population, as determined by the MCO;

4.9.4.4.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.4.4.3 The total value of the incentive payments;

4.9.4.4.4 An analysis of the statistically relevant results of the program; and

4.9.4.4.5 Identification of goals and objectives for the next year informed by the data.

4.9.4.5 Healthy Behavior Incentive Programs

4.9.4.5.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.4.5.1.1. Incorporate incentives for Members who complete a Health Risk Assessment Screening, in

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compliance with Section 4.10.2 of this Agreement (Health Risk Assessment Screening);

4.9.4.5.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.9.4.5.1.3. Address obesity;

4.9.4.5.1.4. Prevent diabetes;

4.9.4.5.1.5. Support smoking cessation;

4.9.4.5.1.6. Increase lead screening rates in one- and two-year old Members; and/or

4.9.4.5.1.7. Other similar types of healthy behavior incentive programs in consultation with the Division of Public Health within DHHS and in alignment with the DHHS Quality Strategy and the MCO's QAPI, as described in Section 4.9.3 (Member Cost Transparency).

4.9.4.6 Reference-Based Pricing Incentive Programs

4.9.4.6.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO on its website in compliance with the Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.6.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5 Collaboration with New Hampshire Tobacco Cessation Programs

4.9.5.1 The MCO shall promote and utilize the DHHS-approved tobacco cessation quitline and tobacco cessation program to provide:

4.9.5.1.1 Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;

4.9.5.1.2 Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;

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4.9.5.1.3 The following FDA-approved over-the-counter agents: patch; gum; lozenge; and any future FDA-approved therapies, as indicated by DHHS; and

4.9.5.1.4 Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.

4.9.5.2 The MCO shall provide tobacco cessation treatment to include, at a minimum:

4.9.5.2.1 Tobacco cessation coaching/counseling in addition to the quitline;

4.9.5.2.2 In addition to the quitline, the following FDA-approved over-the-counter agents: patch; gum; lozenge; and any future FDA-approved therapies, as indicated by DHHS;

4.9.5.2.3 In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release;

4.9.5.2.4 Rebateable FDA-approved non-nicotine prescription medications; and

4.9.5.2.5 Rebateable FDA-approved prescription inhalers and nasal sprays.

4.9.5.3 The MCO shall report on tobacco cessation activities in accordance with Exhibit O.

4.10 Care Coordination and Care Management

4.10.1 Care Coordination and Care Management General Requirements

4.10.1.1 The MCO shall be responsible for the management, coordination, and Continuity of Care for all Members, and shall develop and maintain policies and procedures to address this responsibility. The MCO shall implement Care Coordination and Care Management procedures to ensure that each Member has an ongoing source of care appropriate to their needs. [42 CFR 438.208(b)]

4.10.1.2 The MCO shall provide the services described in this Section 4.10 (Care Coordination and Care Management) for all Members who need Care Coordination and Case Management services regardless of their acuity level. The MCO shall either provide these services directly or shall Subcontract with Local Care Management entities as described in

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Section 4.10.8 (Local Care Management) to perform Care Coordination and Care Management functions.

4.10.1.3 Care Coordination means the interaction with established local community based Providers of care including Local Care Management entities to address the physical, mental and psychosocial needs of the Member.

4.10.1.4 Care Management means direct contact with a Member focused on the provision of various aspects of the Member's physical, mental, Substance Use Disorder status and needed social supports that will enable the Member in achieving the best health outcomes.

4.10.1.5 The MCO shall implement Care Coordination and Care Management in order to achieve the following goals:

4.10.1.5.1 Improve care of Members;

4.10.1.5.2 Improve health outcomes;

4.10.1.5.3 Reduce inpatient hospitalizations including readmissions;

4.10.1.5.4 Improve Continuity of Care;

4.10.1.5.5 Improve transition planning;

4.10.1.5.6 Improve medication management;

4.10.1.5.7 Reduce utilization of unnecessary Emergency Services;

4.10.1.5.8 Reduce unmet resource needs (related to social determinants of health);

4.10.1.5.9 Decrease total costs of care; and

4.10.1.5.10 Increase Member satisfaction with the health care experience.

4.10.1.6 The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, behavioral health Providers, and social service resources; the process must include but not be limited to the designation of a Care Manager who will be responsible for leading the coordination of care. The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from any other MCO. [42 CFR 438.208(b)(2)(ii)] The MCO shall also implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives in FFS Medicaid, including dental services for children under the age of twenty-one (21). [42 CFR 438.208(b)(2)(iii)]

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4.10.2 Health Risk Assessment Screening

4.10.2.1 The Health Risk Assessment screening process shall identify the need for Care Coordination and Care Management services and the need for clinical and non-clinical services including referrals to specialists and community resources.

4.10.2.2 The MCO shall conduct a Health Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) days of the effective date of MCO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs [42 CFR 438.208(c)(1)]. The MCO is not required to conduct a Health Risk Assessment Screening of Members residing in a nursing facility more than one hundred (100) consecutive calendar days.

4.10.2.3 The Health Risk Assessment screening may be conducted by telephone, in person or completion of the form in writing by the Member. The MCO shall make at least three (3) reasonable attempts to contact a Member at the phone number most recently reported by the Member. [42 CFR 438.208(b)(3)] Documentation of the three (3) attempts shall be included in the MCO electronic Care Management record. Reasonable attempts shall occur on not less than three (3) different calendar days, at different hours of the day including day and evening hours and after business hours. If after the three (3) attempts are unsuccessful, the MCO shall send a letter to the Member's last reported residential address with the Health Risk Assessment form for completion.

4.10.2.4 The MCO may also Subcontract with a Designated Local Care Management Entity, community agency or a primary care practice who will engage the Member to complete the Health Risk Assessment screening in-person either in agency office/clinic setting, during a scheduled home visit or medical appointment. All completed Health Risk Assessments shall be shared with the Member's assigned PCP for inclusion in the Member's medical record and within seven (7) calendar days of completing the screening. The MCO shall report annually the number of Members who received a Health Risk Assessment, in accordance with Exhibit O.

4.10.2.5 The MCO shall share with DHHS or other MCOs the results of any identification and assessment of that Member's needs to prevent duplication of activities. [42 CFR 438.208(b)(4)]

4.10.2.6 The MCO must report to DHHS its performance against Health Risk Assessment requirements, as described in Exhibit O. The Health Risk Assessments for Members must be completed for fifty percent (50%) of the total required Members, or the MCO must provide to DHHS additional documentation that describes the MCO's reasoning for failure to successfully complete Health Risk Assessments for fifty percent (50%) of Members. The MCO's reasoning will be considered by DHHS prior to

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imposing Liquidated Damages, as described in Section 5.5.2 of this Agreement.

4.10.2.7 The Health Risk Assessment screening tool utilized shall be evidence-based and be subject to prior approval from DHHS as part of the readiness review process and annually thereafter. The screening tool shall identify at minimum the following information about Members:

4.10.2.7.1 Demographics;

4.10.2.7.2 Chronic and/or acute conditions;

4.10.2.7.3 Chronic pain;

4.10.2.7.4 The unique needs of children with developmental delays, Special Health Care Needs or involved with the juvenile justice system and child protection agencies (i.e. DCYF);

4.10.2.7.5 Behavioral health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.11.1.9 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.3 (Provision of Substance Use Disorder Services);

4.10.2.7.6 The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;

4.10.2.7.7 Tobacco Cessation needs;

4.10.2.7.8 Social determinants of health needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and

4.10.2.7.9 Other factors or conditions about which the MCO will need to be aware to arrange available interventions for the Member.

4.10.2.8 Wellness Visits

4.10.2.8.1 For all Members, inclusive of Granite Advantage Members, the MCO shall support the Member to arrange a wellness visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs. The wellness visit shall include appropriate assessments of:

4.10.2.8.1.1. Both physical and behavioral health, including screening for depression;

4.10.2.8.1.2. Mood, suicidality; and

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4.10.2.8.1.3. Substance Use Disorder, for the purpose of developing a health wellness and care plan.

4.10.3 Priority Populations

4.10.3.1.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs:

4.10.3.1.1.1. Adults with Special Health Care Needs. Adults with Special Health Care Needs shall mean those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age. This includes, but is not limited to Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain;

4.10.3.1.1.2. Children with Special Health Care Needs. Children with Special Health Care Needs shall mean those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with NAS; in high stress social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with an SED, I/DD or Substance Use Disorder diagnosis;

4.10.3.1.1.3. Members receiving services under HCBS waivers;

4.10.3.1.1.4. Members identified as those with rising risk. The MCO shall establish criteria that define Members at rising risk for approval by DHHS as part of the readiness review process and reviewed annually;

4.10.3.1.1.5. Individuals with high unmet resources needs. Individuals with high unmet resource needs means MCM Members who: are homeless; experiencing domestic violence or perceived lack of personal safety; and/or demonstrate unmet resource needs as further described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care);

4.10.3.1.1.6. Recently incarcerated;

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- 4.10.3.1.1.7. Mothers of babies born with NAS;
- 4.10.3.1.1.8. Pregnant women with Substance Use Disorders;
- 4.10.3.1.1.9. IV Drug Users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use;
- 4.10.3.1.1.10. Members who have been in the ED for an overdose event in the last twelve (12) months;
- 4.10.3.1.1.11. Members with an I/DD diagnosis; and/or
- 4.10.3.1.1.12. Other Priority Populations as determined by the MCO and/or by DHHS.

4.10.4 Risk Scoring and Stratification

4.10.4.1 The MCO will use a Risk Scoring and Stratification methodology to identify Members who are part of a Priority Population for Care Management and who should receive a Comprehensive Assessment. The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level including details regarding the algorithm and data sources used to identify Members eligible for Care Management. Protocols will be reviewed as part of the readiness review process and annually thereafter. Risk Scoring and Stratification of Members should be conducted at MCO program roll out and monthly thereafter.

4.10.4.2 The MCO's Risk Scoring and Stratification methodology shall take into account, at a minimum, the following information:

- 4.10.4.2.1 Results of the health risk assessment screening;
- 4.10.4.2.2 Claims history and Encounter Data;
- 4.10.4.2.3 Pharmacy data;
- 4.10.4.2.4 Immunizations;
- 4.10.4.2.5 ADT of Members to and from inpatient facilities;
- 4.10.4.2.6 Provider referral;
- 4.10.4.2.7 Member self-referral;
- 4.10.4.2.8 Hospital stays of more than two weeks;
- 4.10.4.2.9 Members without a secure and stable housing post hospital discharge;
- 4.10.4.2.10 Three or more ED visits within a single calendar quarter;

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4.10.4.2.11 Discharge from inpatient Behavioral Health Services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; and

4.10.4.2.12 Neonatal Intensive Care Unit discharges.

4.10.4.3 The MCO will document and submit to DHHS for approval the detail of its Risk Scoring and Stratification methodology as part of its readiness review and annually thereafter. This submission shall include:

4.10.4.3.1 Information and data to be utilized;

4.10.4.3.2 Description of the methodology;

4.10.4.3.3 Methodology for identifying high risk/high need Members who are not Priority Populations;

4.10.4.3.4 Number of risk strata;

4.10.4.3.5 Criteria for each risk stratum; and

4.10.4.3.6 Approximate expected population in each stratum.

4.10.4.4 The MCO shall submit to DHHS any significant change in its risk stratification methodologies, for approval, prior to the change being implemented.

4.10.4.5 The MCO will report annually the number and percentage of Members who are identified in each of the risk strata in accordance with Exhibit O.

4.10.5 Comprehensive Assessment for High-Risk and High-Need Members

4.10.5.1 The MCO and its Subcontractors shall implement mechanisms to conduct a Comprehensive Assessment for each Medicaid Member in order to identify whether they have Special Health Care Needs and any on-going special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.210(b)(1)]

4.10.5.2 The MCO shall identify Members who may require a Comprehensive Assessment for Care Management through multiple sources to include but not be limited to:

4.10.5.2.1 Health risk assessment screenings;

4.10.5.2.2 Risk Scoring and Stratification;

4.10.5.2.3 Claims/encounter analysis;

4.10.5.2.4 Provider referrals;

4.10.5.2.5 Member/caregiver self-referral; and

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4.10.5.2.6 Referrals from community based medical, mental health, Substance Use Disorder Providers, or social service entities.

4.10.5.3 The Comprehensive Assessment will identify a Member's health condition that requires a course of treatment that is either episodic, which is limited in duration or significance to a particular medical episode, or requires ongoing Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder). The Comprehensive Assessment will be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that will inform whether the Member should receive Care Management and will inform the Member's ongoing care plan and treatment. The MCO shall incorporate into the Comprehensive Assessment information obtained as a result of Provider referral, the wellness visit or otherwise.

4.10.5.4 The MCO will make best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more Priority Populations, identified through Risk Scoring and Stratification or having received a referral for Care Management.

4.10.5.5 The MCO may not withhold any Medically Necessary Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.10.5.6 The MCO will conduct the Comprehensive Assessment in a location of the Member's choosing and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as Family Members, paid and natural supports as agreed upon and appropriate to the Member/Member's parents to the maximum extent practicable. Additionally participation in the Comprehensive Assessment shall be extended to the Member's local community care team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs and Special Medical Services 1915(i) Care Management Entities/case managers as practicable.

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4.10.5.7 The MCO will develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

- 4.10.5.7.1 Members' immediate care needs;
- 4.10.5.7.2 Demographics;
- 4.10.5.7.3 Education;
- 4.10.5.7.4 Housing;
- 4.10.5.7.5 Employment and entitlements;
- 4.10.5.7.6 Legal involvement;
- 4.10.5.7.7 Risk assessment including suicide risk;
- 4.10.5.7.8 Other State or local community and family support services currently used;
- 4.10.5.7.9 Medical and other health conditions;
- 4.10.5.7.10 Physical, I/DDs;
- 4.10.5.7.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living (IADL)) including cognitive functioning;
- 4.10.5.7.12 Medications;
- 4.10.5.7.13 Available informal, caregiver, or social supports, including peer supports;
- 4.10.5.7.14 Current and past mental health and substance use status and/or disorders;
- 4.10.5.7.15 Social determinants of health needs; and
- 4.10.5.7.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).

4.10.5.8 The MCO will provide to DHHS a copy of the Comprehensive Assessment Form and all policies and procedures relating to conducting the Comprehensive Assessment for DHHS approval as part of the readiness approval process and annually thereafter.

4.10.5.9 The MCO will conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing care management:

- 4.10.5.9.1 At least annually;
- 4.10.5.9.2 When the Member's circumstances or needs change significantly;

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4.10.5.9.3 At the Member's request; and/or

4.10.5.9.4 Upon DHHS's request.

4.10.5.10 The MCO will share the results of the Comprehensive Assessment in writing with the Member's local community based care team within fourteen (14) calendar days to inform care planning and treatment planning, with Member consent to the extent required by State and federal law.

4.10.5.11 The MCO will report annually to DHHS the following in accordance with Exhibit O:

4.10.5.11.1 Assessments conducted as percent (%) of total Members and by Priority Population category;

4.10.5.11.2 Assessments completed by a Subcontractor entity, such as but not limited to IDNs, CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.10.5.11.3 Timeliness of assessments;

4.10.5.11.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other Members of the local community based care team; and

4.10.5.11.5 Quarterly report of unmet resource needs aggregated by county based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O.

4.10.6 Care Management for High Risk and High Need Members

4.10.6.1 The MCO will provide Care Management for Members identified as "high-risk"/"high-need" through the Comprehensive Assessment. Every high risk/high need Member identified as needing Care Management will be assigned a designated Care Manager.

4.10.6.2 Care Management for high-risk/high-need Members must be conducted for at least 15 percent (15%) of the total Members or the MCO must provide to DHHS documentation of how fewer Members were determined not to meet the MCO's criteria for in need of Care Management.

4.10.6.3 Members selected for Care Management will be informed of:

4.10.6.3.1 The nature of the Care Management engagement relationship;

4.10.6.3.2 Circumstances under which information will be disclosed to third parties, consistent with State and federal law;

4.10.6.3.3 The availability of a grievance and appeals process;

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4.10.6.3.4 The rationale for implementing Care Management services; and

4.10.6.3.5 The processes for opting out of and terminating Care Management services.

4.10.6.4 The MCO's Care Management responsibilities include, at a minimum:

4.10.6.4.1 Coordination of physical, mental health, Substance Use Disorder and social services;

4.10.6.4.2 Quarterly medication reconciliation;

4.10.6.4.3 Monthly telephonic contact with the Member;

4.10.6.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the care plan for dissemination to care team participants;

4.10.6.4.5 Referral follow-up monthly;

4.10.6.4.6 Peer support;

4.10.6.4.7 Support for unmet resource needs;

4.10.6.4.8 Training on disease self-management, as relevant; and

4.10.6.4.9 Transitional Care Management as defined in Section 4.10.9 (Transitional Care Management).

4.10.6.5 The MCO will convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs, including but not limited to the Member, caretaker(s), PCP, behavioral health Provider(s), specialist, HCBS case managers, school personnel as needed nutritionist, and/or pharmacist. The care team shall be chosen by the Member whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.10.6.6 The MCO shall identify what information is to be shared and how that information is communicated among all of the care team participants concerned with a Member's care to achieve safer and more effective health care including how the Care Coordination program interfaces with the Member's PCP and/or specialist Providers and existing community resources and supports.

4.10.6.7 The MCO shall develop a care plan for each high-risk/high need Member identified through a Comprehensive Assessment who is in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)] The MCO's care plan must be regularly updated and incorporate input from the local community based care team

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participants and the Member. The care plan will be comprehensively updated:

4.10.6.7.1 At least quarterly;

4.10.6.7.2 When a Member's circumstances or needs change significantly;

4.10.6.7.3 At the Member's request;

4.10.6.7.4 When a re-assessment occurs; and

4.10.6.7.5 Upon DHHS's request.

4.10.6.8 The care plan format shall be submitted to DHHS for approval as part of the readiness review process and annually thereafter.

4.10.6.9 The MCO will track the Member's progress through routine care team conferences, the frequency to be determined by the MCO based on the Member's level of need. The MCO will develop policies and procedures that describe when Members should be discharged from the Care Management program, should the care team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring. Policies and procedures for discharge will include a Member notification process.

4.10.6.10 For high-risk/high-needs Members who have been determined through a Comprehensive Assessment to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to allow such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.10.6.11 The MCO shall ensure that each Provider furnishing services to Members maintains and shares a Member health record in accordance with professional standards. [42 CFR 438.208(b)(5)] The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with confidentiality requirements in 45 CFR 160 and 164. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164] The MCO shall develop and implement a strategy to comply with the 2018 Interoperability Standards Advisory standards to the maximum extent feasible.

4.10.7 Care Managers

4.10.7.1 The MCO shall formally designate a Care Manager that is primarily responsible for coordinating services accessed by the Member. The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

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4.10.7.2 Care Managers, whether hired by the MCO or subcontracted through a Designated Local Care Management Entity, must have the qualifications and competency in the following areas:

4.10.7.2.1 All aspects of person-centered needs assessments and care planning;

4.10.7.2.2 Motivational interviewing and self-management;

4.10.7.2.3 Trauma-informed care;

4.10.7.2.4 Cultural and linguistic competency;

4.10.7.2.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and

4.10.7.2.6 Adverse childhood experiences and trauma.

4.10.7.3 Care Managers must be trained in the following:

4.10.7.3.1 Disease self-management;

4.10.7.3.2 Person-centered needs assessment and care planning including coordination of care needs;

4.10.7.3.3 Integrated and coordinated physical and behavioral health;

4.10.7.3.4 Behavioral health crisis response (for Care Managers with assigned Members with behavioral health needs);

4.10.7.3.5 Cultural and linguistic competency;

4.10.7.3.6 Family support; and

4.10.7.3.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.

4.10.7.4 Care Managers must remain conflict-free which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.

4.10.8 Local Care Management

4.10.8.1 Local Care Management shall mean that the MCO will provide real-time, high-touch, in-person Care Management and consistent follow up with Providers and Members to assure that selected Members are making progress with their care plans.

4.10.8.2 The MCO will design an effective Local Care Management structure for fifty percent (50%) of high-risk or high-need Members, including those who are medically and socially complex or high utilizers.

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The MCO must ensure that the fifty percent (50%) requirement is met by ensuring access to Local Care Management in all regions of New Hampshire; the MCO will be considered out of compliance should any one (1) region have less than twenty five percent (25%) of high-risk or high-need Members receiving Local Care Management, unless the MCO receives DHHS approval as part of the MCO's Local Care Management Plan (further described in this Section 4.10.8).

4.10.8.3 The MCO is encouraged to leverage Local Care Management by contracting with designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements, that will assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members.

4.10.8.4 The MCO, or its Designated Local Care Management Entity, must designate Care Managers who will provide in-person Care Management for Members either in the community setting, provider outpatient setting, hospital, or ED. The MCO must ensure there is a clear delineation of roles and responsibilities between the MCO and Designated Local Care Management Entities that are responsible for Care Management in order to ensure no gaps or duplication in services.

4.10.8.5 The MCO or its designated Local Care Managers must be embedded in one (1) outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based Care Management.

4.10.8.6 Designated Local Care Management Entities shall include:

4.10.8.6.1 IDNs that have been certified as Local Care Management entities by DHHS;

4.10.8.6.2 Health Homes, if DHHS elects to implement Health Homes under Medicaid State Plan Amendment authority;

4.10.8.6.3 Designated community based agencies or Care Management entities, inclusive of IDNs that meet requirements and DHHS designated regional substance use disorder hubs, that will assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members; and

4.10.8.6.4 Other contracted entities capable of performing Local Care Management for a designated cohort of Members, as identified by the MCO as part of its Local Care Management Plan (further described in this Section 4.10.8) and approved by DHHS.

4.10.8.7 DHHS shall evaluate whether IDNs are able to provide effective Local Care Management services to selected populations; if and

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when one (1) or more IDNs are certified, the MCO is required to directly contract with the certified IDN(s) for the delivery of Local Care Management services.

4.10.8.8 For any IDN that is not certified by DHHS, the MCO is not required to directly contract with the uncertified IDN for the delivery of Local Care Management services (either because the individual IDN was not certified and/or DHHS has not yet instituted its certification process). In this instance the MCO shall enter into a memorandum of understanding with the non-certified IDN(s). The memorandum of understanding shall identify roles and responsibilities with respect to Members served by the MCO and the IDN(s), and provide for the timely exchange of data between the MCO and the IDN(s) on such Members.

4.10.8.9 The MCO must also work with IDNs to leverage regional access point services. The MCO is required to contract with and enter into a payment arrangement with qualified IDNs, providing for reimbursement on terms specified by DHHS in guidance unless otherwise approved by DHHS.

4.10.8.10 Any Care Coordination and Care Management requirements that apply to the MCO shall also apply to the MCOs' Designated Local Care Management Entities.

4.10.8.11 The MCO shall submit to DHHS its Local Care Management Plan in accordance with Exhibit O for prior approval by DHHS as part of the readiness review and annually thereafter. The Plan shall include the structure of the Local Care Management to be provided, the percentage (%) of high-risk/high-need Members who will receive Local Care Management, the list of Designated Local Care Management Entities that will conduct the Local Care Management, and a description of the geography and Priority Populations the Designated Local Care Management Entities will serve.

4.10.8.12 The MCO shall report annually against their Local Care Management Plans in accordance with Exhibit O, including:

4.10.8.12.1 Volume of Care Management outreach attempts;

4.10.8.12.2 Number of Members receiving Local Care Management by intensity of engagement;

4.10.8.12.3 Duration of sustained Local Care Management activities;

4.10.8.12.4 Number and percent (%) of Members receiving face-to-face Care Management; and

4.10.8.12.5 Type of staff conducting face-to-face Local Care Management

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4.10.8.13 Data Sharing with Local Care Management Entities

4.10.8.13.1 Utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information and to facilitate the provision of services and Care Management as intended by this Contract, the MCO shall provide Member-level data on a monthly basis to Local Care Management Entities, all Care Management entities with which the MCO otherwise subcontracts for purposes of providing Care Management and care coordination to MCM Members, and IDNs regarding:

4.10.8.13.1.1. Each Member's diagnosis(es);

4.10.8.13.1.2. Utilization of services;

4.10.8.13.1.3. Total cost of care

4.10.8.13.1.4. Point of access to service.

4.10.8.13.2 The MCO shall, as described in Section 4.10.9 (Transitional Care Management), demonstrate that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or near real time. The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management Entities, and all other Care Management Entities within twelve (12) hours of the admission, discharge, or transfer.

4.10.8.13.3 The MCO shall, as directed by DHHS and demonstrated during the readiness period, collaborate with the IDNs to utilize the event notification and shared care plan system employed by IDNs as applicable for exchanging Member information necessary to provide Care Management and care coordination services to Members served by an IDN and, as applicable, other Local Care Management Entities.

4.10.9 Transitional Care Management

4.10.9.1 The MCO shall be responsible for managing transitions of care for all Members moving from one (1) clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

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4.10.9.2 The MCO shall develop policies and procedures for DHHS approval, as part of the readiness review process and annually thereafter, which describe how transitions of care between settings will be effectively managed including data systems that trigger notification that a Member is in transition. The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(1)-(2)]

4.10.9.3 The MCO shall have a documented process to, at a minimum:

4.10.9.3.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.10.9.3.2 Manage home to foster care placement; foster care to independent living; return from foster care placement to community; or change in legal status from foster care to adoption.

4.10.9.3.3 Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's care plan when a Member is hospitalized;

4.10.9.3.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.11.5.18 (New Hampshire Hospital); and

4.10.9.3.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.10.9.4 The MCO shall have an established process to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs. The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.10.9.5 The MCO shall demonstrate at a minimum that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or near real time. The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management Entities, and all other Care Management Entities within twelve (12) hours of the admission, discharge, or transfer.

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4.10.9.6 The MCO will ensure that Transitional Care Management includes:

4.10.9.6.1 Care Management or other services to ensure the Member's care plan continues;

4.10.9.6.2 Facilitating clinical hand-offs;

4.10.9.6.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

4.10.9.6.4 Communicating with the Member's PCP about discharge plans and any changes to the care plan;

4.10.9.6.5 Conducting medication reconciliation within 48 hours of discharge;

4.10.9.6.6 Ensuring that a Care Manager is assigned to manage the transition;

4.10.9.6.7 Follow-up by the assigned Care Manager within 48 business hours of discharge to the Member;

4.10.9.6.8 Determining when a follow up visit should be conducted in a Member's home

4.10.9.6.9 Ensuring that outpatient appointments are kept; and

4.10.9.6.10 A process to assist with the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered.

4.10.9.7 The MCO shall ensure coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information. The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.10.9.7.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.10.9.7.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an

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appropriate placement or housing site shall be secured prior to discharge);

4.10.9.7.3 An evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.10.9.7.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented

4.10.10 Coordination and Integration with Social Services and Community Care

4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]

4.10.10.2 The MCO's Care Management must include help for Members in addressing unmet resource needs through strategies including, at a minimum:

4.10.10.2.1 How the MCO identifies available community support services and facilitates referrals to those entities for Members with identified needs;

4.10.10.2.2 Providing in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications;

4.10.10.2.3 Having a housing specialist on staff or on contract who can assist Members who are homeless in securing housing; and

4.10.10.2.4 Providing access to medical-legal partnership for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance Providers.

4.10.10.3 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. The MCO must establish Care Management competencies, as outlined below:

4.10.10.3.1 Health Risk Assessment Screening, Claims Analysis, and/or Member or Provider Referral: the MCO ensure that a care needs screening, including social determinants of health questions, is conducted.

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4.10.10.3.2 Risk Scoring and Stratification by Member Level of Need: The MCO must identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, must ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and transportation.

4.10.10.3.3 High Risk/High-Need Members: The MCO must ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment must include questions regarding social determinants of health. The MCO must provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services must include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community.

4.10.10.4 For Members who do not require such intensive services, the MCO must provide guidance/navigational coordination, which includes:

4.10.10.4.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs;

4.10.10.4.2 Coordinating services provided by community and social support Providers;

4.10.10.4.3 Linking Members to community resources and social supports; and

4.10.10.4.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant–related Care Coordination services, in accordance with Exhibit O.

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

4.10.10.5.1 Juvenile Justice and Adult Community Corrections;

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

4.10.10.5.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.10.10.5.4 Public Health Agencies;

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- 4.10.10.5.5 Schools;
- 4.10.10.5.6 The court system;
- 4.10.10.5.7 ServiceLink Resource Network;
- 4.10.10.5.8 Housing; and
- 4.10.10.5.9 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.10.10.6 The MCO shall report on the number of referrals for social services and community care provided to Members by Member type, consistent with the format and content requirements in accordance with Exhibit O.

4.11 **Behavioral Health**

4.11.1 **General Coordination Requirements**

4.11.1.1 This section describes the delivery and coordination of Behavioral Health Services and supports, for both mental health and Substance Use Disorder, delivered to children, youth and transition-aged youth/young adults, and adults.

4.11.1.2 The MCO shall deliver services in a manner that is both clinically and developmentally appropriate and that considers the Members, parents, caregivers and other networks of support the Member may rely upon. The delivery of service must also be Member-centered and align with the principles of system of care and Recovery and resiliency.

4.11.1.3 The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal law and regulations. The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services; ensuring continuity and coordination between Covered physical health and Behavioral Health Services; and requiring collaboration between physical health and behavioral health Providers.

4.11.1.4 Consistent with He-M 425, the MCO shall be required to enter into a capitation model of contracting with CMH Programs and CMH Providers, which is essential to supporting NH's Delivery System Reform Incentive Payment Program (DSRIP) waiver and furthering physical and behavioral health integration in the MCM program. As described in DHHS guidance, the MCO must comply with key administrative functions and processes, which may include but are not limited to:

- 4.11.1.4.1 Processing timely prospective payment from a Member eligibility list provided by the CMH Program/CMH Provider;

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4.11.1.4.2 Determining whether Members are eligible for the DHHS-required Capitation Payments, or should be paid on a FFS basis to the CMH Program/CMH Provider;

4.11.1.4.3 Providing detailed MCO data submissions to DHHS and the CMH Program or CMH Provider for purposes of reconciling payments and performance (e.g., 835 file);

4.11.1.4.4 Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Providers (by region); and

4.11.1.4.5 All additional capabilities set forth by DHHS in the corresponding guidance.

4.11.1.5 Behavioral Health Subcontracts

4.11.1.5.1 If the MCO enters into a Subcontractor relationship with a behavioral health (mental health or Substance Use Disorder) Subcontractor to provide or manage Behavioral Health Services, the MCO must provide a copy of the agreement between the MCO and the Subcontractor to DHHS for review and approval, including but not limited to any agreements with CMH Programs and CMH Providers as required in Section 4.11.5.1 (Contracting for Community Mental Health Services). Such contracts must address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting. The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that the Subcontractor adheres to all requirements and guidelines, as outlined in Section 3.14 (Subcontractors).

4.11.1.6 Promotion of Integrated Care

4.11.1.6.1 The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible. In accordance with Exhibit O, the MCO shall include in its Behavioral Health Strategy Plan and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.11.1.7 Approach to Behavioral Health Services

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4.11.1.7.1 The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA³¹ and reflect a focus on Recovery and resiliency.³² The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s). The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices. In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO must ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.11.1.8 Behavioral Health Strategy Plan and Report

4.11.1.8.1 The MCO must submit to DHHS an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. In accordance with Exhibit O, the initial Plan shall address but not be limited to how the MCO will:

4.11.1.8.1.1. Assure Participating Providers meet SAMHSA standards for co-located and Integrated Care;

4.11.1.8.1.2. Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.11.1.8.1.3. Assure the promotion of Integrated Care;

4.11.1.8.1.4. Reduce Psychiatric Boarding described in Section 4.11.5.17 (Reducing Psychiatric Boarding);

4.11.1.8.1.5. Reduce Behavioral Health Readmissions described in Section 4.11.5.18.4 (Reduction in Behavioral Health Readmissions);

4.11.1.8.1.6. Support the NH 10-Year Plan outlined in Section 4.11.5.15 (Implementation of New Hampshire's 10-Year Mental Health Plan);

³¹ Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at <https://www.samhsa.gov/ncic/trauma-interventions>

³² Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at <https://www.samhsa.gov/recovery>

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4.11.1.8.1.7. Assure the appropriateness of psychopharmacological medication;

4.11.1.8.1.8. Assure access to appropriate services;

4.11.1.8.1.9. Implement a training plan that includes but is not limited to Trauma-Informed Care and Integrated Care; and

4.11.1.8.1.10. Other information in accordance with Exhibit O.

4.11.1.8.2 On an annual basis and in accordance with Exhibit O, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which will include an effectiveness analysis of the initial Plan's program, policies and procedures. The analysis will include MCO interventions which require improvement, including improvements in co-located and Integrated Care, continuity, coordination, and collaboration for physical health and Behavioral Health Services.

4.11.1.9 Collaboration with DHHS

4.11.1.9.1 At the discretion of DHHS, the MCO shall provide mental health and Substance Use Disorder updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.1.9.2 To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO will meet with behavioral health programs and DHHS at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

4.11.1.9.3 Quarterly meetings will also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O. Progress and data reports will be produced and exchanged between the MCO and DHHS two (2) weeks prior to the quarterly meetings.

4.11.1.9.4 At each meeting, the MCO should update DHHS on the following topics:

4.11.1.9.4.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.11.1.9.4.2. Results of the MCO's quarterly crisis line;

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4.11.1.9.4.3. Utilization of ACT services and any waitlists for ACT services;

4.11.1.9.4.4. Current EBSE rates;

4.11.1.9.4.5. Current compliance with New Hampshire Hospital discharge performance standards;

4.11.1.9.4.6. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.11.1.9.4.7. Updates regarding services identified in Section 4.11 (Behavioral Health);

4.11.1.9.4.8. Updates on Mental Health and Substance Use Disorder PIPs; and

4.11.1.9.4.9. Other topics requested by DHHS.

4.11.1.9.5 For all Members, the MCO shall work in collaboration with DHHS and the NH Suicide Prevention Council to promote suicide prevention awareness programs, including the Zero Suicide program.

4.11.1.9.6 The MCO shall submit to DHHS, as specified by DHHS in Exhibit O, its implementation plan for incorporating the "Zero Suicide" program its operations; the plan should include, in addition to any other requirements specified in Exhibit O related to the plan, how the MCO will:

4.11.1.9.6.1. Incorporate efforts to implement standardized provider screenings and other preventative measures

4.11.1.9.6.2. Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines).

4.11.1.10 Primary Care Provider Screening for Behavioral Health Needs

4.11.1.10.1 The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment. At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary. The MCO shall encourage PCPs and other Providers to use a screening tool approved by DHHS, as well as other mechanisms to facilitate early identification of

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behavioral health needs. The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process: demographic, medical, Substance Use Disorder, housing, family & support services, education, employment and entitlement, legal, risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.11.1.10.2 The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

4.11.1.10.2.1. Depression screening (e.g., PHQ 2 & 9); and

4.11.1.10.2.2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.11.1.11 Referrals

4.11.1.11.1 The MCO shall ensure through its Health Risk Assessment Screening (described in Section 4.10.2) and its Risk Scoring and Stratification methodology that Members with a potential need for Behavioral Health Services, particularly Priority Population Members as described in Section 4.10.3 (Priority Populations), are appropriately and timely referred to behavioral health Providers if co-located care is not available. This shall include education about Behavioral Health Services, including the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s). The MCO shall develop a referral process to be used by Participating Providers, including what information must be exchanged and when to share this information, as well as notification to the Member's Care Manager. The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know when and how to refer Members who need specialty Behavioral Health Services.

4.11.1.11.2 The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health

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needs when Integrated Care is not available. The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider. The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.11.1.12 Prior Authorization

4.11.1.12.1 As of September 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 51733 for behavioral health drugs, including use of the universal online Prior Authorization form provided by DHHS for drugs used to treat mental illness. The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.11.1.13 Comprehensive Assessment and Care Plans for Behavioral Health Needs

4.11.1.13.1 The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a care plan. For Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by an integrated Provider team, the MCO shall ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and care plan development process as well as the ongoing provision of services.

4.11.1.14 Written Consent

4.11.1.14.1 Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both, and primary care. The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O.

³³ House Bill 517: Uniform Prior Authorization Implementation available at <https://www.dhhs.nh.gov/ombp/caremgmt/hb517.htm>

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4.11.1.15 Coordination Among Behavioral Health Providers

4.11.1.15.1 The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.11.1.15.1.1. Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.11.1.15.1.2. Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.11.1.15.1.3. Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.11.1.15.1.4. Description of how treatment plans will be coordinated among Behavioral Health Service Providers; and

4.11.1.15.1.5. Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.11.1.16 Member Service Line

4.11.1.16.1 As further outlined in Section 4.4.4.1 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services. The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a "warm transfer"). The MCO shall not require a Member to call a separate number regarding Behavioral Health Services. If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.11.1.17 Provision of Services Required by Courts

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4.11.1.17.1 The MCO shall pay for all NH Medicaid State Plan services, to include assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care.

4.11.1.18 Sentinel Event Review

4.11.1.18.1 The MCO shall participate in Sentinel Event Reviews conducted in accordance with the DHHS policy as requested by DHHS.

4.11.1.19 Behavioral Health Member Experience of Care Survey

4.11.1.19.1 The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis. The survey shall be designed by DHHS and the MCO's results shall be reported in accordance with Exhibit O. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.11.2 Emergency Services

4.11.2.1 The MCO shall ensure, through its contracts with local Providers, that statewide crisis lines and Emergency Services are in place twenty-four (24) hours a day, seven (7) days a week for Members experiencing a mental health or Substance Use Disorder crisis. The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services. Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program/Provider.

4.11.2.2 Described in Section 3.15.2 (Other MCO Required Staffing), and pursuant to administrative rule, these crisis lines and Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention calls and who have access to a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization. The MCO must be able to demonstrate by the readiness review stage identified in Section 4.16.2 (Emergency Response Plan) that its crisis line can effectively link Members to Emergency Services or other behavioral health crisis services and supports. As directed by DHHS, the MCO shall contract with DHHS specified crisis service teams for both adults and children to meet these requirements.

4.11.2.3 At the discretion of DHHS, the MCO shall provide updates as requested by DHHS during regular Behavioral Health meetings between the MCO and DHHS on innovative and cost-effective models of providing mental health crisis and emergency response services that provide the

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maximum clinical benefit to the Member while also meeting DHHS's objectives to reduce admissions and increase community tenure.

4.11.2.4 In accordance with Exhibit O, the MCO shall submit quarterly crisis line data that lists the total calls received by the statewide crisis line attributable to Members, including the ultimate disposition of the call (e.g., educational, referral to care, no referral to care, etc.).

4.11.3 Behavioral Health Training Plan

4.11.3.1 In accordance with Exhibit O, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health capacity for Members within the state and support the efforts of CMH Programs/Providers to hire, retain and train qualified staff. The MCO shall coordinate with DHHS to reduce duplication of training efforts and submit the training plan to DHHS prior to program start and annually thereafter, inclusive of the training schedule and target Provider audiences. As part of the training plan, the MCO shall promote Provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

4.11.3.2 The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.11.3.2.1 Trauma Focused Cognitive Behavioral Therapy;

4.11.3.2.2 Trauma Informed Care;

4.11.3.2.3 Motivational Interviewing;

4.11.3.2.4 Interventions for Nicotine Education and Treatment;

4.11.3.2.5 Dialectical Behavioral Therapy (DBT);

4.11.3.2.6 Cognitive Behavioral Therapy;

4.11.3.2.7 Client Centered Treatment Planning;

4.11.3.2.8 Family Psychoeducation;

4.11.3.2.9 Crisis Intervention;

4.11.3.2.10 SBIRT for PCPs;

4.11.3.2.11 Depression Screening for PCPs;

4.11.3.2.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.11.3.2.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

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4.11.3.3 The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.11.3.3.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

4.11.3.3.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.11.3.3.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.11.3.3.4 Cross training to ensure that mental health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive mental health training;

4.11.3.3.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.11.3.3.6 Clinical care integration models to Participating Providers; and

4.11.3.3.7 Community-based resources to address social determinants of health.

4.11.3.4 The MCO shall offer a minimum of two (2) hours of training each contract year to all contracted CMH Program/Provider staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the DHHS's objective of reducing the number of suicides in NH. The MCO shall also provide, on at least an annual basis, training on appropriate billing practices, to Participating Providers. DHHS reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

4.11.3.5 In accordance with Exhibit O, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.11.4 Parity

4.11.4.1 The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.11.4.2 Semi-Annual Report on Parity

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4.11.4.2.1 The MCO shall complete the DHHS Parity Compliance Report which shall include:

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

4.11.4.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.11.4.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.11.4.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.11.4.2.1.5. Any other requirements identified in Exhibit O. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.11.4.2.2 The MCO must review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities. The MCO must submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

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

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4.11.4.2.4 A Member enrolled in any MCO may file a complaint with DHHS at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance. As described in Section 4.4 (Member Services), the MCO must describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.11.4.3 Prohibition on Lifetime or Annual Dollar Limits

4.11.4.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

4.11.4.4 Restrictions on Treatment Limitations

4.11.4.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.11.4.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.11.4.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO must provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.11.4.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for mental health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.11.4.5 Medical Necessity Determination

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4.11.4.5.1 The MCO must provide the criteria for medical necessity determinations for mental health or Substance Use Disorder benefits to any Member, potential Member, or Participating Provider upon request at no cost.

4.11.5 Mental Health

4.11.5.1 Contracting for Community Mental Health Services

4.11.5.1.1 The MCO shall contract with CMH Programs and CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who qualify for such services in accordance with He-M 401.34

4.11.5.1.2 The MCO's contract shall provide for monitoring of CMH Program/CMH Provider performance through quality metrics and oversight procedures of the CMH Program/CMH Provider. The contract must be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors). The contract must, at minimum, address:

4.11.5.1.2.1. The scope of services to be covered;

4.11.5.1.2.2. Compliance with the requirements of this Agreement;

4.11.5.1.2.3. The role of the MCO versus the CMH Program/CMH Provider;

4.11.5.1.2.4. Procedures for communication and coordination between the MCO and the CMH Program/CMH Provider, other Providers serving the same Member and DHHS;

4.11.5.1.2.5. Data sharing on Members;

4.11.5.1.2.6. Data reporting between the CMH Program/CMH Provider and the MCO and DHHS; and

4.11.5.1.2.7. Oversight, enforcement, and remedies for contract disputes.

4.11.5.2 Payment to Community Mental Health Programs and Community Mental Health Providers

4.11.5.2.1 The MCO is required to enter into a capitated payment arrangement with CMH Programs to deliver Community Mental Health Services, providing for reimbursement on terms specified by DHHS in guidance.

³⁴ Available at http://www.gencourt.state.nh.us/rules/About_Rules/listagencies.htm

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4.11.5.2.2 The MCO shall reach agreement and enter into a contract with all CMH Programs that meet the terms specified by DHHS no later than 90 calendar days after Agreement execution. For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in January 2019.

4.11.5.3 Provision of Community Mental Health Services

4.11.5.3.1 The MCO shall ensure that Community Mental Health Services are provided in accordance with the Medicaid State Plan and He-M 400.35. This includes, but is not limited, to ensuring that the full range of Community Mental Health Services are appropriately provided to eligible Members. Eligible Members must receive an individualized service plan created and updated regularly, consistent with State and federal requirements, including but not limited to He-M 401; eligible Members must be offered the provisions of supports for illness self-management and Recovery; and eligible Members must be provided with coordinated care when entering and leaving a designated receiving facility. The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.11.5.3.2 As described in He-M 400, a Member may be deemed eligible for Community Mental Health Services if the Member has a:

- 4.11.5.3.2.1. Severe or persistent mental illness (SPMI) for an adult;
- 4.11.5.3.2.2. SMI for an adult;
- 4.11.5.3.2.3. SPMI or SMI with low service utilization for an adult;
- 4.11.5.3.2.4. SED for a child; or
- 4.11.5.3.2.5. SED and interagency involvement for a child.

4.11.5.3.3 Any MCO quality monitoring or audits of the performance of the CMH Programs/CMH Providers shall be available to DHHS upon request.

4.11.5.3.4 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO will meet with CMH Programs/CMH

³⁵ *Ibid.*

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Providers and DHHS at least quarterly to coordinate data collection and ensure data sharing. At a minimum, this will include sharing of quality assurance activities conducted by the MCO and DHHS and a review of quality improvement plans, data reports, Care Coordination activities, and outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.11.5.3.5 The MCO shall work in collaboration with DHHS, CMH Programs/CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.11.5.4 Comprehensive Assessment and Care Plans

4.11.5.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of DHHS administered quality service reviews for adults, that Community Mental Health Services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall ensure that initial and updated care plans are based on a Comprehensive Assessment conducted using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA). If the MCO or a CMH Program/CMH Provider acting on behalf of the MCO elects to allow clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO must notify and receive approval of the specific tool from DHHS. The assessment must include the domains of the DSRIP Comprehensive Core Standardized Assessment and elements under review in the DHHS quality service review.

4.11.5.4.2 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within one hundred and twenty (120) calendar days of implementation by DHHS of a web-based training and certification system. The MCO shall require that certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by DHHS for any newly evaluated Member and for an existing Member no later than at the Member's first eligibility renewal following certification. The CMH Long Term Care Eligibility Tool, specified in He-M 40136,

³⁶ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-m.html

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shall continue to be utilized until such time as the clinician is certified in the use of the CANS, ANSA, or an alternative evidenced-based assessment tool approved by DHHS and the Member annual review date has passed.

4.11.5.5 Assertive Community Treatment Teams

4.11.5.5.1 The MCO shall work in collaboration with DHHS and CMH Programs/CMH Providers to ensure that ACT teams include at least one certified Peer Support Specialist and are available to Medicaid Members twenty-four (24) hours a day, seven (7) days a week, with on-call availability from 12:00 am to 8:00 am. At the sole discretion of DHHS, as defined in separate guidance, the MCO shall reimburse CMH Programs/CMH Providers at an enhanced rate for the cost of providing at least fair fidelity ACT services to eligible Medicaid Members.

4.11.5.5.2 The MCO shall obtain annual fidelity review reports from DHHS to inform the ACT team's adherence to fidelity. In collaboration with DHHS, the MCO will support CMH Programs/CMH Providers to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with DHHS to achieve full implementation of ACT. In accordance with Exhibit O, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services. The MCO shall provide updates on any waitlists maintained for ACT services during regular behavioral health meetings between the MCO and DHHS.

4.11.5.6 Mental Health Performance Improvement Project

4.11.5.6.1 As outlined in Section 4.12.3.1 (Performance Improvement Projects), the MCO shall engage in at least one (1) mental health PIP. The MCO shall satisfy this requirement by implementing a PIP designed to reduce Psychiatric Boarding in the ED.

4.11.5.7 Services for the Homeless

4.11.5.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services. The MCO shall have one (1) or more Housing Coordinator on staff or under contract to provide in-person housing assistance to Members who are homeless, as described in Section 3.15.1 (Key Personnel). The Housing Coordinator(s) will coordinate with housing case managers at the CMH Programs, New Hampshire Hospital, the Bureau of Mental

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Health Services, Bureau of Housing Supports and other CMH Providers to coordinate referrals. In coordination with CMH Programs/CMH Providers, the MCO shall ensure that ACT teams and/or Housing Coordinator(s) also provide ongoing mental health and tenancy support services to Members.

4.11.5.7.2 In its contract with CMH Programs/CMH Providers, the MCO shall describe how it will provide appropriate oversight of CMH Program/CMH Provider responsibilities, including:

4.11.5.7.2.1. Identifying housing options for Members at risk for experiencing homelessness;

4.11.5.7.2.2. Assisting Members in filing applications for housing and gathering necessary documentation;

4.11.5.7.2.3. Coordinating the provision of supportive housing; and

4.11.5.7.2.4. Coordinating housing-related services amongst CMH Programs/CMH Providers, the MCO and NH's Housing Bridge Subsidy Program.

4.11.5.7.3 The contract with CMH Programs/CMH Providers shall require the quarterly assessments and documentation of housing status and homelessness for all Members.

4.11.5.7.4 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.10.10 (Coordination and Integration with Social Services and Continuity of Care) within twenty-four (24) hours upon release.

4.11.5.8 Supported Employment

4.11.5.8.1 In coordination with CMH Programs/CMH Providers, the MCO shall actively promote EBSE to eligible Members. The MCO shall obtain fidelity review reports from DHHS to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program/CMH Provider. In collaboration with DHHS, the MCO will support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the EBSE Quality Improvement Plan on file with DHHS to achieve full implementation of EBSE.

4.11.5.8.2 Based on data provided by DHHS, the MCO will support DHHS's goals to ensure that at least nineteen percent (19%) of adult Members are engaged in EBSE services and that employment status is updated by the CMH Program/CMH Provider on a quarterly basis. The MCO shall report the EBSE rate to DHHS in accordance with Exhibit O and provide updates

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as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.9 Illness Management and Recovery

4.11.5.9.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of and increased penetration rates of illness management and Recovery to Members with SMI and SPMI. The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.10 Dialectical Behavioral Therapy

4.11.5.10.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder. The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.11 Peer Recovery Support Services

4.11.5.11.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of PRSS provided by Peer Recovery Programs in a variety of settings such as CMH Programs, New Hampshire Hospital, primary care clinics, and EDs. The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.12 Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

4.11.5.12.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems³⁷ for children and youth Members experiencing anxiety, depression, trauma and conduct issues. The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.13 First Episode Psychosis

4.11.5.13.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis. The MCO

³⁷Available at: http://www.practicewise.com/portals/0/match_public/index.html

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shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.14 Child Parent Psychotherapy

4.11.5.14.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children. The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.15 Implementation of New Hampshire's 10-Year Mental Health Plan

4.11.5.15.1 In accordance with Exhibit O, the MCO shall actively support the implementation of NH's 10-Year Mental Health Plan, updated periodically, to reinforce implementation of priorities outlined in the plan.

4.11.5.16 Changes in Healthy Behavior

4.11.5.16.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities. Efforts could encompass interventions (e.g., tobacco cessation, "InShape") or other efforts designed to improve health. The MCO shall gather smoking status data on all Members and report to DHHS in accordance with Exhibit O. The MCO will support CMH Programs/CMH Providers to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.11.5.17 Reducing Psychiatric Boarding

4.11.5.17.1 For each hospital in its network, the MCO must have on its own staff or contract with clinical Providers who are credentialed by the hospital (i.e., "hospital-credentialed Providers") to provide services to reduce Psychiatric Boarding stays. In meeting this requirement, the MCO cannot use CMH Programs and CMH Providers and must ensure that its hospital-credentialed Providers are in addition to any capacity provided by CMH Programs and CMH Providers. The MCO must supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to or at risk for Psychiatric Boarding. The number of such hospital-credentialed Providers must be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed. The initial on-site assistance provided within these required timelines must include a beneficiary-specific plan for discharge,

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treatment, admittance or transfer to New Hampshire Hospital. Each such hospital-credentialed Provider must have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required. At the request of DHHS, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.11.5.17.2 For any day during which the Member is subject to Psychiatric Boarding, the MCO shall pay to the New Hampshire Hospital's administrative day rate inclusive of both the State and federal share of the payment, and pay all other hospitals at no less than the rate paid by the NH Medicaid FFS program for all inpatient and outpatient services categories.

4.11.5.17.3 The MCOs' capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital.

4.11.5.17.4 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O. At minimum, the plan must address how the MCO identifies when its Members are in the ED awaiting psychiatric placement or in a hospital setting awaiting an inpatient psychiatric bed; policies for ensuring a prompt crisis team consultation and face-to-face evaluation; strategies for identifying placement options or alternatives to hospitalization; and coordination with the CMH Programs/CMH Providers serving Members.

4.11.5.17.5 In accordance with Exhibit O, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.11.5.18 New Hampshire Hospital

4.11.5.18.1 New Hampshire Hospital Agreement

4.11.5.18.1.1. The MCO shall maintain a collaborative agreement with New Hampshire Hospital, NH's State operated inpatient psychiatric facility. This collaborative

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agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program/CMH Provider to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.

4.11.5.18.1.2. The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital.

4.11.5.18.1.3. Prior to admission to New Hampshire Hospital, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to New Hampshire Hospital and determine whether all available less restrictive alternative services and supports are unsuitable.

4.11.5.18.2 Discharge Planning

4.11.5.18.2.1. It is the policy of DHHS to avoid discharges from inpatient care at New Hampshire Hospital to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning from New Hampshire Hospital. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

4.11.5.18.2.2. Also included in Section 3.15.2 (Other MCO Required Staff), the MCO shall designate an on-site liaison with privileges, as required by New Hampshire Hospital, to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital. Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least

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restrictive environment complying with the ADA and other applicable State and federal regulations.

4.11.5.18.2.3. The liaison shall actively participate, and assist New Hampshire Hospital staff in the development of a written discharge plan within twenty-four (24) hours of admission. The MCO shall ensure that the final New Hampshire Hospital discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight percent (98%) of Members discharged. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged. For ACT team service recipients, the MCO must ensure that the discharge progress note is provided to the Provider within twenty-four (24) hours of Member discharge. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.11.5.18.2.4. The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from New Hampshire Hospital in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have. The performance metric shall be that at least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days. For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member on an expedited basis.

4.11.5.18.2.5. The MCO shall ensure an appointment with a CMH Program/CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member. Such appointment shall occur within seven (7) calendar days after discharge. ACT team service recipients must be seen within twenty-four (24) hours of discharge. For persons discharged from psychiatric hospitalization who are not a current client of the applicable CMH

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Program/CMH Provider, the Member must have an intake appointment that is scheduled to occur within seven (7) calendar days after discharge. The MCO shall work with DHHS and the applicable CMH Program/CMH Provider to review cases of Members that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

4.11.5.18.3 Administrative Days and Post Stabilization Care Services

4.11.5.18.3.1. The MCO shall perform in-reach activities to New Hampshire Hospital designed to accomplish transitions to the community. Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in the hospital. The MCO must pay New Hampshire Hospital for services delivered under the inpatient and outpatient service categories at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate community-based care and services.

4.11.5.18.4 Reduction in Behavioral Health Readmissions

4.11.5.18.4.1. The MCO shall describe a reduction in readmissions plan in its annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O, subject to approval by DHHS, to monitor the thirty (30)-day and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs/CMH Providers, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day and one hundred and eighty (180)-day readmission. Avoiding readmission is associated with the delivery of a full array of Medically Necessary outpatient medication and Behavioral Health Services in the ninety (90) days after discharge from New Hampshire Hospital; the MCO shall ensure provision of appropriate service delivery in the ninety (90) days after discharge.

4.11.5.18.4.2. For Members with readmissions within thirty (30) days and one hundred and eighty (180) days, the MCO will report on the mental health and related service

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utilization that directly proceeded readmission in accordance with Exhibit O. This data will be shared with the Member's CMH Program/CMH Provider, if applicable, and DHHS in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.11.6 Substance Use Disorder

4.11.6.1 The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including Chapter 420-J, Section J:17 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.11.6.2 In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.11.6.3 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.4 Contracting for Substance Use Disorder

4.11.6.4.1 The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.³⁸

4.11.6.4.2 The contract between the MCO and the Substance Use Disorder programs and Participating Providers must be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors). The contract must, at minimum, address the scope of services to be covered; compliance with the requirements of this Agreement; the role of the MCO versus the Substance Use Disorder program and/or Provider; procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider; other Providers serving the same Member, and DHHS as applicable; approach to payment, including enhanced payment for ACT services; data sharing on Members; data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and oversight, enforcement, and remedies for contract disputes. The contract shall provide for monitoring of Substance

³⁸ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.11.6.4.3 When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the state through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract. The MCO must reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.4.4 When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.11.6.5 Payment to Substance Use Disorder Providers

4.11.6.5.1 The MCO shall reimburse Substance Use Disorder Providers in accordance with rates that are no less than the equivalent DHHS FFS rates. The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements: (1) is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or (2) falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval are further described in Section 4.14 (Alternative Payment Models). DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

4.11.6.5.2 In accordance with Exhibit O, the MCO shall develop and submit to DHHS no later than sixty (60) calendar days prior to the Program Start Date and annually thereafter a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT.³⁹ The plan shall indicate at least two (2) tiers of enhanced payments that the MCO will make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per year (i.e., tier two (2) Providers). The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.

³⁹ SAMHSA, "Opioid Prescribing Courses for Health Care Providers," available at: <https://www.samhsa.gov/medication-assisted-treatment/training-resources/opioid-courses>

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4.11.6.5.3 The MCO is required to develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

4.11.6.6 Provision of Substance Use Disorder Services

4.11.6.6.1 The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513. This includes, but is not limited to, ensuring that the full continuum of care is appropriately provided to eligible Members; eligible Members are provided with Recovery support services; and that eligible Members are provided with coordinated care when entering or leaving a treatment program. The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513.

4.11.6.6.2 The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes. This can include but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.11.6.6.3 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513. This includes, but is not limited to: (1) ensuring that Members at risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and (2) providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether Peer Recovery Support is an aspect of an additional service provided to the Member. The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services. The provision of services to recipients enrolled in an MCO must not be subject to more stringent service coverage limits than specified under this Agreement or state Medicaid policies.

4.11.6.7 Substance Use Disorder Clinical Evaluations and Treatment Plans

4.11.6.7.1 The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use

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Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

4.11.6.7.2 A Clinical Evaluation is a biopsychosocial evaluation completed in accordance with Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.⁴⁰ The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013⁴¹ or as revised by ASAM. The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission. For a Member being transferred from or otherwise referred by another Provider, the Provider must use the clinical evaluation completed by a licensed behavioral health professional from the referring agency.

4.11.6.7.3 The Provider must complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation, that address problems in all ASAM 2013 domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART). The treatment plan must include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.11.6.7.4 Treatment plans must be updated based on any changes in any ASAM domain and no less frequently than every four (4) sessions or every four (4) weeks, whichever is less frequent. Treatment plan updates much include:

4.11.6.7.4.1. Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.11.6.7.4.2. Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives;

⁴⁰ Substance Abuse and Mental Health Services Administration, TAP 21: Addiction Counseling Competencies," available at <http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171>

⁴¹ The American Society of Addiction Medicine, "The ASAM Criteria," available at <https://www.asam.org/resources/the-asam-criteria>

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4.11.6.7.4.3. The counselor's assessment of whether or not the Member needs to move to a different level of care based on ASAM continuing care, transfer and discharge criteria; and

4.11.6.7.4.4. The signature of the Member and the counselor agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.11.6.8 Substance Use Disorder Performance Improvement Project

4.11.6.8.1 In compliance with the requirements outlined in Section 4.12.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.11.6.9 Reporting

4.11.6.9.1 The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O, including but not limited to measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment completion, safety monitoring, and service utilization.

4.11.6.9.2 The MCO shall additionally provide, in accordance with Exhibit O, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3 On a monthly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members. The MCO shall also provide annual training to Participating Providers.

4.11.6.10 Services for Members Who are Homeless or At-Risk of Homelessness

4.11.6.10.1 In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.11.5.7 (Services for the Homeless).

4.11.6.11 Peer Recovery Support Services

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4.11.6.11.1 In coordination with Peer Recovery Programs as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.11.6.12 Naloxone Availability

4.11.6.12.1 The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.11.6.13 Prescription Drug Monitoring Program

4.11.6.13.1 The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines. The Provider agreements must require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members. The MCO shall monitor harmful prescribing rates and, at the discretion of DHHS, may be required to provide ongoing updates on those Participating Providers who have been identified as overprescribing.

4.11.6.14 Response After Overdose

4.11.6.14.1 Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO must work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital. The MCO shall ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.11.6.15 Limitations on Prior Authorization Requirements

4.11.6.15.1 To the extent permitted under State and federal law, the MCO shall cover MAT. Methadone received at a methadone clinic shall not require Prior Authorization. However, methadone used to treat pain shall require Prior Authorization. Any Prior Authorization for office based MAT shall comply with NH RSA 420-J:18.

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4.11.6.15.2 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDS per month per treated Member. In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.11.6.15.3 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.11.6.15.4 The MCO must cover without Prior Authorization or other Utilization Management restrictions any treatments identified as necessary by a clinician trained in the use and application of the ASAM Criteria. Should the MCO have concerns about the appropriateness of a course of treatment after the treatment has commenced, the MCO shall contact the Provider to request additional information and/or recommend a change, but must continue to pay for the treatment unless and until the Provider determines an alternative type of treatment or setting is appropriate. DHHS will monitor utilization of Substance Use Disorder treatment services identify, prevent, and correct potential occurrences of fraud, waste and abuse, in accordance with 42 CFR 455 and 42 CFR 456 and He-W 520. DHHS will grant exceptions to this provision in instances where it is necessary to prevent fraud, waste and abuse.

4.11.6.15.5 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.3 (Clinical Policies and Prior Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.11.6.16 Opioid Prescribing Requirements

4.11.6.16.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members. As required under the NH Board Administrative Rule MED 502 Opioid Prescribing,⁴² the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.11.6.16.1.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

4.11.6.16.1.2. Random and periodic UDS; and

⁴² New Hampshire Medical Society, "New Hampshire Opioid Prescribing Resources", available at <https://www.nhms.org/resources/opioid>

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4.11.6.16.1.3. Utilizing written, informed consent.

4.11.6.16.2 The MCO must also ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED daily for longer than ninety (90) days. If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.11.6.17 Neonatal Abstinence Syndrome

4.11.6.17.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2. Substance Use Disorder Care Management features shall include conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose), ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services, scheduling Substance Use Disorder treatment appointments and following up to ensure appointments are attended, and coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies. The MCO must make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.11.6.17.2 The MCO will work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed. The MCO will work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.11.6.17.3 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment

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protocol for infants at risk of NAS. The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.11.6.17.3.1. Opportunities for the primary care giver(s) to room-in;

4.11.6.17.3.2. Transportation and childcare for the primary care giver(s);

4.11.6.17.3.3. Priority given to non-pharmaceutical approaches (e.g., quiet environment, swaddling);

4.11.6.17.3.4. Education for primary care giver(s) on caring for newborns;

4.11.6.17.3.5. Coordination with social service agencies providing supports, including coordinated case meetings and appropriate developmental services for the infant;

4.11.6.17.3.6. Information on family planning options; and

4.11.6.17.3.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.11.6.17.4 The MCO shall work with DHHS and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network standards.

4.11.6.18 Discharge Planning

4.11.6.18.1 The MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan for any Member who has an ED visit or is hospitalized for an overdose or Substance Use Disorder. The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged. The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.11.6.18.2 It is the expectation of DHHS that Members treated in the ED or inpatient setting for an overdose are not to be released

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to the community without outreach from the MCO or provided with referrals for an evaluation and treatment. The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

4.11.6.18.3 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have. At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days. For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member on an expedited basis.

4.11.6.18.4 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.11.6.18.5 In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been seen for more than three (3) overdose events within a thirty (30) day period or those that have had a difficulty engaging in treatment services following referral and Care Coordination provided by the MCO. The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.12 Quality Management

4.12.1 General Provisions

4.12.1.1 The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO shall work in collaboration with Members and Providers to actively improve the quality of care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the

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Agreement. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.12.1.2 The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.12.1.3 The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.12.1.3.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.12.1.3.2 Foster data-driven decision-making;

4.12.1.3.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities

4.12.1.3.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.12.1.3.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

4.12.1.3.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.12.2 Health Plan Accreditation

4.12.2.1 The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module. If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.12.2.2 If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date. To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.12.2.2.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify DHHS of the initiation of the process to obtain NCQA Health Plan Accreditation; and

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4.12.2.2.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, notify DHHS of the date of the scheduled on-site review.

4.12.2.3 The MCO shall inform DHHS of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation. The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review, including [42 CFR 438.332(a)]:

4.12.2.3.1 Accreditation status, survey type, and level (as applicable);

4.12.2.3.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.12.2.3.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1)-(3)]

4.12.2.4 To avoid duplication of mandatory activities with accreditation reviews, DHHS shall indicate in its quality strategy the accreditation review standards that are comparable to the standards established through federal EQR protocols and that DHHS will consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.12.3 Quality Assessment and Performance Improvement Program

4.12.3.1 The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]. The MCO's QAPI program must be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to DHHS for its review and approval annually. In accordance with Exhibit O, the QAPI Plan shall contain the following elements:

4.12.3.1.1 A description of the MCO's organization-wide QAPI program structure;

4.12.3.1.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.12.3.1.3 DHHS-required PIPs,

4.12.3.1.4 DHHS-required quality performance data,

4.12.3.1.5 DHHS-required quality reports, and

4.12.3.1.6 Implementation of EQRO recommendations from annual technical reports;

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4.12.3.1.7 Mechanisms to detect both underutilization and overutilization of services [42 CFR 438.330(b)(3)];

4.12.3.1.8 Mechanisms to assess the quality and appropriateness of care for Members with special health care needs (as defined by DHHS in the quality strategy) [42 CFR 438.330(b)(4)] in order to identify any Ongoing Special Conditions of a Member that require a course of treatment or regular care monitoring;

4.12.3.1.9 Mechanisms to assess and address disparities in the quality of and access to health care, based on age, race, ethnicity, sex, primary language, and disability status (defined as whether the individual qualified for Medicaid on the basis of a disability) [42 CFR 438.340(b)(6)]; and

4.12.3.1.10 The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.12.3.2 The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.12.3.2.1 Is organization-wide, with clear lines of accountability within the organization;

4.12.3.2.2 Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, clinicians, and non-clinicians;

4.12.3.2.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.12.3.2.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

4.12.3.3 If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by DHHS or its designee upon request, and a summary of any functions that have been delegated to Subcontractor(s) shall be indicated within the MCO's QAPI Plan submitted to DHHS annually.

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4.12.3.4 Additional detail regarding the elements of the QAPI program and the format in which it should be submitted to DHHS is provided in Exhibit O.

4.12.3.5 Performance Improvement Projects

4.12.3.5.1 The MCO shall conduct any PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.12.3.5.2 Annually, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

4.12.3.5.2.1. At least one (1) clinical PIP must have a focus on reducing Psychiatric Boarding in the ED for Medicaid enrollees (regardless of whether they are Medicaid-Medicare dual individuals), as defined in Section 4.11.5 (Mental Health);

4.12.3.5.2.2. At least one (1) clinical PIP must have a focus on Substance Use Disorder, as defined in Section 4.11.6 (Substance Use Disorder);

4.12.3.5.2.3. At least (1) clinical PIP must focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by DHHS. If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the fiftieth (50th) percentile. Should no quality measure have a lower than fiftieth (50th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.12.3.5.3 Annually, the MCO shall conduct at least one (1) non-clinical PIP, which must be related to one (1) of the following topic areas and approved by DHHS:

4.12.3.5.3.1. Addressing social determinants of health;

4.12.3.5.3.2. Integrating physical and behavioral health.

4.12.3.5.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

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4.12.3.5.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and must include the following elements:

4.12.3.5.5.1. Measurement of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.12.3.5.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.12.3.5.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.12.3.5.5.4. Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.12.3.5.6 Each PIP shall be approved by DHHS and must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

4.12.3.5.7 In accordance with Exhibit O, the MCO shall include in its QAPI Plan to be submitted to DHHS annually the status and results of each PIP conducted in the preceding twelve (12) months and any changes it plans to make to PIPs or other MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.12.3.6 Member Experience of Care Survey

4.12.3.6.1 The MCO shall be responsible for administering the CAHPS survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.12.3.6.1.1. CAHPS Health Plan Survey 5.0H, Adult Version or later version as specified by DHHS;

4.12.3.6.1.2. CAHPS Health Plan Survey 5.0H, Child Version with Children with Chronic Conditions Supplement or later version as specified by DHHS.

4.12.3.6.2 Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by DHHS and indicated in Exhibit O. Supplemental questions, including the number, are subject to NCQA approval.

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4.12.3.6.3 The MCO shall obtain DHHS approval of instruments prior to fielding the CAHPS surveys.

4.12.3.7 Quality Measures

4.12.3.7.1 The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with Exhibit O [42 CFR 438.330(b)(2); 42 CFR 438.330(c)(1) and (2); 42 CFR 438.330(a)(2)]:

4.12.3.7.1.1. CMS Child Core Set of Health Care Quality Measures for Medicaid and CHIP, as specified by DHHS;

4.12.3.7.1.2. CMS Adult Core Set of Health Care Quality Measures for Medicaid, as specified by DHHS;

4.12.3.7.1.3. NCQA Medicaid Accreditation measures, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA;

4.12.3.7.1.4. All available CAHPS measures and sections and additional supplemental questions defined by DHHS;

4.12.3.7.1.5. Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)];

4.12.3.7.1.6. Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts;

4.12.3.7.1.7. Select measures specified by DHHS as priority measures for use in assessing and addressing local challenges to high-quality care and access; and

4.12.3.7.1.8. Measures indicated by DHHS as a requirement for fulfilling CMS waiver requirements.

4.12.3.7.2 Utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information, the MCO shall collaborate in data collection with the NH Building Capacity for Transformation waiver IDNs for clinical data collected for quality and performance measures common between the MCM program and the DSRIP program to reduce duplication of effort in collection of data.

4.12.3.7.3 The MCO shall report all quality measures in accordance with Exhibit O, regardless of whether the MCO has achieved accreditation from NCQA. The MCO shall submit all quality measures in the formats and schedule in Exhibit O or otherwise identified by DHHS. This includes that the MCO shall, as determined by DHHS:

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4.12.3.7.3.1. Gain access to and utilize the NH Medicaid Quality Information System, including participating in any DHHS-required training necessary;

4.12.3.7.3.2. Attend all meetings with the relevant MCO subject matter experts to discuss specifications for data indicated in Exhibit O; and

4.12.3.7.3.3. Communicate and distribute all specifications and templates provided by DHHS for measures in Exhibit O to all MCO subject matter experts involved in the production of data in Exhibit O.

4.12.3.7.4 If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to DHHS. For measures that are no longer part of the measure sets, DHHS may at its option continue to require those measures; any changes to MCO quality measure reporting requirements will be communicated to MCOs and documented within a format similar to Exhibit O. DHHS shall provide the MCO with ninety (90) calendar days of notice of any additions or modifications to the measures and quality measure specifications.

4.12.3.7.5 At such time as DHHS provides access to Medicare data sets to the MCO, the MCO shall integrate expanded Medicare data sets into its QAPI Plan and Care Coordination and Quality Programs, and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual Members. The MCO shall:

4.12.3.7.5.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes and psycho-social outcomes resulting from Care Coordination of the dual Members;

4.12.3.7.5.2. Include Medicare data in DHHS quality reporting; and

4.12.3.7.5.3. Sign data use Agreements and submit data management plans as required by CMS.

4.12.3.7.6 For failure to submit required reports and quality data to DHHS, NCQA, the EQRO, and/or other DHHS-identified entities, the MCO shall be subject to liquidated damages as further described in Section 5.5.2 (Liquidated Damages).

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4.12.4.1 DHHS will collect the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.12.4.1.1 Performance on required quality measures; and

4.12.4.1.2 The MCO's QAPI Plan.

4.12.4.2 Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.12.4.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.12.4.2.2 Performance trends on QAPI measures to assess performance in quality of care and quality of service (QOS) for all activities identified in the QAPI Plan;

4.12.4.2.3 An analysis of whether there have been any demonstrated improvements in the quality of care or service for all activities identified in the QAPI Plan;

4.12.4.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.12.4.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.12.4.3 The annual evaluation report, developed in accordance with Exhibit O, shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)]. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as posted on the web.

4.12.4.4 In accordance with Exhibit O, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

4.12.5 Accountability for Quality Improvement

4.12.5.1 External Quality Review

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4.12.5.1.1 The MCO shall collaborate and cooperate fully with DHHS's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.12.5.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services to Members [42 CFR 438.350]. To facilitate this process, the MCO shall supply information, including but not limited to claims data, medical records, operational process details, and source code used to calculate performance measures to the EQRO as specified by DHHS.

4.12.5.2 Auto-Assignment Algorithm

4.12.5.2.1 As indicated in Section 4.3.6 (Auto-Assignment), the auto-assignment algorithm will, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members. The measures used to determine auto-assignment will be aligned with the priority measures assigned to the MCO withhold program, as determined by DHHS.

4.12.5.3 Quality Performance Withhold

4.12.5.3.1 As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by DHHS and indicated to the MCO in annual guidance.

4.12.5.3.2 Key areas of DHHS focus in the selection of measures will include, but are not limited to:

4.12.5.3.2.1. Utilization measures, including appropriate use of the ED, reduction in preventable admissions, and/or 30-day hospital readmission for all causes;

4.12.5.3.2.2. Measures related to the timeliness of prenatal and postpartum care, and in improved outcomes related to NAS births;

4.12.5.3.2.3. Successful integration of physical and behavioral health, including timeliness of a follow-up after a mental illness or Substance Use Disorder inpatient or residential admission;

4.12.5.3.2.4. Reduction in polypharmacy resulting in drug interaction harm; and

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4.12.5.3.2.5. Certain clinical and non-clinical quality measures for which there is ample opportunity for improved MCO performance.

4.13 Network Management

4.13.1 Network Requirements

4.13.1.1 The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.13.1.1.1 Supported by written agreements; and

4.13.1.1.2 Sufficient to provide adequate access to all services covered under this Agreement for all Members, including those with LEP or disabilities. [42 CFR 438.206(b)(1)]

4.13.1.2 In developing its network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.13.1.3 The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1)]. The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.13.1.4 The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.13.1.5 All Participating Providers shall be licensed and or certified in accordance with the laws of NH and not be under sanction or exclusion from any Medicare or Medicaid program. Participating Providers shall have a NH Medicaid identification number and unique National Provider Identifier (NPI) for every Provider type in accordance with 45 CFR 162, Subpart D.

4.13.1.6 The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions. The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(1); 42 CFR 438.3(q)(3)]

4.13.1.7 The MCO must permit Non-Participating Indian Health Care Providers to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

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4.13.1.8 The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.13.2 Provider Enrollment

4.13.2.1 The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.13.2.2 The MCO shall prepare and submit a Participating Provider report during the first readiness review in a format prescribed by DHHS for determination of the MCO's network adequacy. The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers. Prospective Participating Providers shall have executed letters of intent to contract with the MCO. The MCO shall confirm its provider network with DHHS and post to its website no later than thirty (30) calendar days prior to the Member enrollment period.

4.13.2.3 The MCO shall not discriminate relative to the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.13.2.4 The requirements in 42 CFR 438.12(a) shall not be construed to:

4.13.2.4.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.13.2.4.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.13.2.4.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)-(3)]

4.13.2.5 The MCO shall ensure that Participating Providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with Provider disclosure, screening and enrollment requirements. [438.608(b); 42 CFR 455.100-106; 42 CFR 455.400 – 470]

4.13.3 Provider Screening, Credentialing and Re-Credentialing

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4.13.3.1 DHHS will screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

4.13.3.2 The MCO shall rely on DHHS's NH Medicaid providers' affirmative screening in accordance with federal requirements and the current NCQA Standards and Guidelines for the credentialing and re-credentialing of licensed independent Providers and Provider groups with whom it contracts or employs and who fall within its scope of authority and action. [42 CFR 455.410; 42 CFR 438.206(b)(6)]

4.13.3.3 The MCO must demonstrate that its Participating Providers are credentialed, and must comply with any additional Provider selection requirements established by DHHS. [42 CFR 438.12(a)(2); 42 CFR 438.214(b)(1); 42 CFR 438.214(c); 42 CFR 438.214(e); 42 CFR 438.206(b)(6)]

4.13.3.4 The MCO's Provider selection policies and procedures must include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)] The MCO shall submit for DHHS approval at the first readiness review, policies and procedures for onboarding Participating Providers, which shall include its subcontracted entity's policies and procedures.

4.13.3.5 For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.13.3.5.1 Make reasonable efforts to streamline the credentialing process in collaboration with DHHS;

4.13.3.5.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.13.3.5.3 Concurrently work through MCO and DHHS contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.13.3.5.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.13.3.5.4.1. Authorization of out-of-network services;

4.13.3.5.4.2. Single case agreements for an individual Member; and

4.13.3.5.4.3. If agreed upon by the prospective Participating Provider, an opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for the prospective

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Participating Provider's compliance with network requirements and practices.

4.13.3.6 The MCO shall process credentialing applications from all types of Providers within prescribed timeframes:

4.13.3.6.1 For PCPs, within thirty (30) calendar days of receipt of clean and complete credentialing applications; and

4.13.3.6.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications.

4.13.3.7 The start time begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.13.3.8 A "clean and complete" application is a claim that is signed and appropriately dated by the Provider, and includes:

4.13.3.8.1 Evidence of the Provider's NH Medicaid ID; and

4.13.3.8.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.13.3.9 In the event the MCO does not process a Provider's credentialing application within the timeframes set forth in this Section 4.13.3 of the Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in 4.13.3.6 above.

4.13.3.10 For each day an application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by DHHS or its designate, the MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix).

4.13.3.11 Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.13.4 Provider Engagement

4.13.4.1 Provider Support Services

4.13.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

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4.13.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.13.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision.

4.13.4.1.1.3. Ability for Providers to contact MCO regarding contracting, billing, and service provisions;

4.13.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, social determinants of health, and quality;

4.13.4.1.1.5. Training curriculum, to be developed, in coordination with DHHS, that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.13.4.1.1.6. Training on billing and required documentation;

4.13.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.13.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as noted in Section 4.5.1 (General Requirements); and

4.13.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

4.13.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries. As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of DHHS-approved holidays.

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The Provider call center shall meet the following minimum standards, which may be modified by DHHS as necessary:

4.13.4.1.2.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

4.13.4.1.2.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds;

4.13.4.1.2.3. Average speed of voicemail response: ninety percent (90%) of voicemail messages shall be responded to no later than the next business day (defined as Monday through Friday, with the exception of DHHS-approved holidays).

4.13.4.1.3 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member. The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.13.4.1.4 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs. DHHS will provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

4.13.4.1.5 The MCO shall track and trend Provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate in Exhibit O.

4.13.4.2 Provider Advisory Board

4.13.4.2.1 The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback on the MCM program, and shall include representation from at least one (1) Federally Qualified Health Center (FQHC), at least one (1) CMH Program, and at least one Integrated Delivery Network (IDN). The

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Provider Advisory Board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.13.5 Provider Contract Requirements

4.13.5.1 General Provisions

4.13.5.1.1 The MCO's agreement with health care Providers shall be in writing, shall be in compliance with applicable State and federal laws and regulations, and shall include the requirements in this Agreement.

4.13.5.1.2 The MCO shall submit all model Provider contracts to DHHS for review before execution of the Provider contracts with NH Medicaid Providers. The MCO shall re-submit the model Provider contracts any time it makes substantive modifications to such Agreements. DHHS retains the right to reject or require changes to any Provider Agreement.

4.13.5.1.3 In all contracts with health care professionals, the MCO shall comply with requirements in 42 CFR 438.214 and RSA 420-J:4, which includes selection and retention of Participating Providers, credentialing and re-credentialing requirements, and non-discrimination. In all contracts with Participating Providers, the MCO must follow a documented process for credentialing and re-credentialing of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(b)(2)]

4.13.5.1.4 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, the ADA of 1990, 42 U.S.C. Section 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

4.13.5.1.5 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.13.5.1.6 The MCO shall keep participating physicians and other Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.12.3

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(Quality Assessment and Performance Improvement Program). The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.13.5.1.7 The MCO may execute Participating Provider agreements, pending the outcome of screening and enrollment in NH Medicaid, of up to one hundred and twenty (120) calendar days but must terminate a Participating Provider immediately upon notification from DHHS that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.13.5.1.8 The MCO shall maintain a Provider relations presence in NH, as approved by DHHS.

4.13.5.1.9 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and all Participating Providers, including any necessary specialty manuals (e.g., behavioral health). The Provider manual shall be available and easily accessible on the web and updated no less than annually.

4.13.5.1.10 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by DHHS.

4.13.5.1.11 Provider materials shall comply with State and federal laws and DHHS and NHID requirements. The MCO shall submit any Provider Manual(s) and Provider training materials to DHHS for review and approval during the readiness period and sixty (60) calendar days prior to any substantive revisions. Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days. The MCO Provider Manual shall consist of, at a minimum:

4.13.5.1.11.1. A description of the MCO's enrollment and credentialing process;

4.13.5.1.11.2. How to access MCO Provider relations assistance;

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4.13.5.1.11.3. A description of the MCO's medical management and Case Management programs;

4.13.5.1.11.4. Detail on the MCO's Prior Authorization processes;

4.13.5.1.11.5. A description of the Covered Services and Benefits for Members, including EPSDT and pharmacy;

4.13.5.1.11.6. A description of Emergency Services coverage;

4.13.5.1.11.7. Member parity;

4.13.5.1.11.8. The MCO Payment policies and processes; and

4.13.5.1.11.9. The MCO Member and Provider Grievance System.

4.13.5.1.12 The MCO shall require that Providers not bill Members, for Covered Services, any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1)-(2)]

4.13.5.2 Compliance with MCO Policies and Procedures

4.13.5.2.1 The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.13.5.2.2 The MCO's DRA policy;

4.13.5.2.3 Provider Manual;

4.13.5.2.4 The MCO's Compliance Program;

4.13.5.2.5 The MCO's Grievance and Appeals and Provider Appeal Processes;

4.13.5.2.6 Clean Claims and Prompt Payment requirements;

4.13.5.2.7 ADA requirements;

4.13.5.2.8 Clinical Practice Guidelines; and

4.13.5.2.9 Prior Authorization requirements.

4.13.5.3 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO about the following requirements, as described in Section 4.5 (Member Grievances and Appeals), of:

4.13.5.3.1 Member grievance, appeal, and fair hearing procedures and timeframes;

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4.13.5.3.2 The Member's right to file grievances and appeals and the requirements and timeframe for filing;

4.13.5.3.3 The availability of assistance to the Member with filing grievances and appeals; [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A)-(C)]

4.13.5.3.4 The Member's right to request a state fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]

4.13.5.3.5 The Member's right to request continuation of benefits that the MCO seeks to reduce or terminate during an appeal of state fair hearing filing, if filed within the allowable timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the Member. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)]

4.13.5.4 Member Hold Harmless

4.13.5.4.1 The Provider shall agree to hold the Member harmless for the costs of Medically Necessary Covered Services except for applicable cost sharing and patient liability amounts indicated by DHHS in this Agreement.

4.13.5.5 Requirement to Return Overpayment

4.13.5.5.1 The Provider shall comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the overpayment. [42 CFR 438.608(d)(2)]

4.13.5.5.2 Overpayments that are not returned within sixty (60) calendar days from the date the Overpayment was identified may be a violation of State or federal law.

4.13.5.6 Background Screening

4.13.5.6.1 The Provider shall screen its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning of that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the Agreement with the MCO.

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4.13.5.7 Books and Records Access

4.13.5.7.1 The Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the Members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements. The Provider shall make available, for the purposes of an audit, evaluation, or inspection by the MCO, DHHS, MFCU, DOJ, the OIG, and the Comptroller General or their respective designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members. These records, books, documents, etc., shall be available for any authorized State or federal agency, including but not limited to the MCO, DHHS, MFCU, DOJ, and the OIG or their respective designees, ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

4.13.5.8 Continuity of Care

4.13.5.8.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by DHHS and included in the DHHS model Member Handbook.

4.13.5.9 Anti-Gag Clause

4.13.5.9.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

4.13.5.9.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.13.5.9.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.13.5.9.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.13.5.9.1.4. For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [Section 1923(b)(3)(D) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98].

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4.13.5.9.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Appeal). [42 CFR 438.410(b)]

4.13.5.10 Anti-Discrimination

4.13.5.10.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including Providers only to the extent necessary to meet the needs of the organization's Members, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

4.13.5.10.2 In all contracts with Participating Providers, the MCO's Provider selection policies and procedures must not discriminate against particular Providers that service high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.12(a)(2); 42 CFR 438.214(c)]

4.13.5.11 Access and Availability

4.13.5.11.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.3.1 (Additional Provider Standards).

4.13.5.12 Payment Models

4.13.5.12.1 The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

4.13.5.12.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the Pharmacy Benefits Manager

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(PBM). The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.13.5.13 Non-Exclusivity

4.13.5.13.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.13.5.14 Proof of Membership

4.13.5.14.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.13.5.15 Other Provisions

4.13.5.15.1 The MCO's Provider contract shall also contain:

4.13.5.15.1.1. All required activities and obligations of the Provider and related reporting responsibilities.

4.13.5.15.1.2. Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement.

4.13.5.15.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.13.6 Reporting

4.13.6.1 The MCO shall comply with and complete all reporting in accordance with Exhibit O and as further specified by DHHS.

4.13.6.2 The MCO shall implement and maintain arrangements or procedures for notification to DHHS when it receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the MCO. [42 CFR 438.608(a)(4)]

4.13.6.3 The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the Participating Provider network. As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued Member access to needed service and how the MCO will maintain compliance with its contractual obligations for Member access to needed services. A significant change is defined as:

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4.13.6.3.1 A decrease in the total number of PCPs by more than five percent (5%);

4.13.6.3.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement;

4.13.6.3.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.13.6.3.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

4.13.6.4 The MCO shall provide to DHHS and/or its DHHS Subcontractors (e.g., the EQRO) Provider participation reports on an annual basis or as otherwise determined by DHHS in accordance with Exhibit O; these may include but are not limited to Provider participation by geographic location, categories of service, Provider type categories, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.14 Alternative Payment Models

4.14.1 As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community. In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to: (1) clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN; (2) encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and (3) provide an established framework for monitoring MCO performance on APMs.

4.14.2 Prior to and/or over the course of the Term of this Agreement, DHHS shall develop the DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement. Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14 of this Agreement) consistent with the DHHS Medicaid APM

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strategy. The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs, sharing data and analysis, and other activities as specified by DHHS.

4.14.3 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:

4.14.3.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.14.3.2 Uses a common set of performance measures across all the Providers;

4.14.3.3 Does not set the amount or frequency of the expenditures; and

4.14.3.4 Does not allow DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.14.4 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver

4.14.4.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions:

4.14.4.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and

4.14.4.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the 18 months and potential extension. For failure to meet this requirement, DHHS reserves the right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix).

4.14.4.2 MCO Incentives and Penalties for APM Implementation

4.14.4.2.1 Consistent with the requirements set forth in SB 313, the MCO shall include through APMs and other means provider

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alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.

4.14.4.2.2 MCOs shall be subject to incentives and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.14.5 Qualifying Alternative Payment Models

4.14.5.1 A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section 4.14.5 (Qualifying Alternative Payment Models) and the DHHS Medicaid APM Strategy.

4.14.5.2 At minimum, a Qualifying APM must meet the requirements of the HCP-LAN APM framework Category 2C, based on the refreshed 2017 framework released on July 11, 2017 and available at: <https://hcp-lan.org/groups/apm-refresh-white-paper/>. As indicated in the HCP-LAN APM framework white paper, Category 2C is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics. HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy. DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.4.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.14.5.3 Under no circumstances will DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

4.14.5.4 Standards for Large Providers and Provider Systems

4.14.5.4.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

4.14.5.5 Treatment of Payments to Community Mental Health Programs

4.14.5.5.1 The CMH Program payment model prescribed by DHHS in Section 4.11.5.1 (Contracting for Community Mental

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Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.5.5.2 At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.5.6 Accommodations for Small Providers

4.14.5.6.1 The MCO shall develop Qualifying APM models appropriate for small Providers, as further defined by the DHHS Medicaid APM Strategy. For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.14.5.7 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.14.5.7.1 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health. The MCO shall incorporate APM design elements into its Qualifying APMs that allow Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Additional information on Medicaid in the Quality Payment Program can be found here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Medicaid-in-the-Quality-Payment-Program.pdf>.

4.14.6 MCO Alternative Payment Model Implementation Plan

4.14.6.1 At least ninety (90) calendar days prior to the start of the program and annually at least sixty (60) days before July 1 of each year thereafter, the MCO shall submit to DHHS for review and approval an APM Implementation Plan. The APM Implementation Plan must meet the requirements of this section and of any subsequent guidance issued as part of the DHHS Medicaid APM Strategy. Additional details on the timing, format, and required contents of the MCO APM Implementation Plan will be specified by DHHS in Exhibit O and/or through additional guidance.

4.14.6.2 Alternative Payment Model Transparency

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4.14.6.2.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.14.4 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the model among the MCO, Providers, and Members.

4.14.6.3 Provider Engagement and Support

4.14.6.3.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO will use to assess and advance such readiness over time. The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy. The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs. MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.14.6.4 Implementation Approach

4.14.6.4.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO will take to advance its APM Implementation Plan: (1) in advance of the Program Start Date; (2) during the first year of this Agreement; and (3) into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

4.14.6.4.2 The APM Implementation Plan shall include the MCO's plan for providing the necessary data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations

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included in the APM, including how the MCO will ensure that the information received by Participating Providers is meaningful and actionable. The MCO shall provide data to Providers and IDNs, as appropriate, that describe the retrospective cost and utilization patterns for Members, which will inform the strategy and design of APMs. For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM. In addition, the MCO shall provide Member and Provider level data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions. The APM Implementation Plan shall describe in example form to DHHS the level of information that will be given to Providers that enter into APM Agreements with the MCO, including if the level of information will vary based on the Category and/or type of APM the Provider enters. The information provided shall be consistent with the requirements outlined under Section 4.14.4 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.14.7 Alternative Payment Model Transparency and Reporting Requirements

4.14.7.1 Transparency

4.14.7.1.1 In the MCO APM Implementation Plan, the MCO shall provide to DHHS for each APM, as applicable, the following information at a minimum:

4.14.7.1.1.1. The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.14.7.1.1.2. The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, the attachment points for cost targets, and risk adjustment methodology;

4.14.7.1.1.3. The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that will be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

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4.14.7.1.1.4. The frequency at which the MCO will regularly report cost and quality data related to APM performance to Providers, and the information that will be included in each report.

4.14.7.1.2 Additional information may be required by DHHS in supplemental guidance. All information provided to DHHS shall be made available to Providers eligible to participate in or already participating in the APM unless the MCO requests and receives DHHS approval for specified information not to be made available.

4.14.7.2 Standardized Assessment of Alternative Payment Model Usage

4.14.7.2.1 The MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment⁴³ within ninety (90) calendar days following the Program Start Date.

4.14.7.2.2 Thereafter, the MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment within one hundred and eighty (180) calendar days of the end of the contract year and annually thereafter in accordance with Exhibit O and/or the DHHS Medicaid APM Strategy.

4.14.7.2.3 If the MCO reaches agreement with DHHS that its implementation of the required APM model(s) may be delayed as described in Section 4.14.1, the MCO must comply with all terms set forth by DHHS for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.14.7.3 Additional Reporting on Alternative Payment Model Outcomes

4.14.7.3.1 The MCO shall provide additional information required by DHHS in Exhibit O or other DHHS guidance on the type, usage, effectiveness and outcomes of its APMs.

4.14.8 Development Period for MCO Implementation

4.14.8.1 Consistent with the requirements for new MCOs outlined in Section 4.14.2 (Qualifying Alternative Payment Models) above, DHHS acknowledges that MCOs will require time to advance their MCO Implementation Plan. DHHS will provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.14.9 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

⁴³ The HCP-LAN Assessment is available at: <https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf>; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).

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4.14.9.1 The MCO's APM Implementation Plan shall indicate the quantitative, measurable clinical outcomes the MCO seeks to improve through its APM initiative(s). At a minimum, the MCO shall address the priorities identified in this Section 4.14.6 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and any additional priorities identified by DHHS in the DHHS Medicaid APM Strategy.

4.14.9.2 State Priorities in Senate Bill 313

4.14.9.2.1 The MCO's APM Implementation Plan shall address the following priorities, as described in State law (Senate Bill 313 2018):

4.14.9.2.1.1. Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

4.14.9.2.1.2. Opportunities to reduce preventable admissions and 30-day hospital readmission for all causes;

4.14.9.2.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;

4.14.9.2.1.4. Opportunities to better integrate physical and behavioral health, particularly: efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;

4.14.9.2.1.5. Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

4.14.9.2.1.6. Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of this Agreement); and

4.14.9.2.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular

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to address “ED boarding,” in which Members that would be best treated in the community remain in the ED.

4.14.9.3 Alternative Payment Models for Substance Use Disorder Treatment

4.14.9.3.1 As is further described in Section 4.11.6.2 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:

4.14.9.3.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to infants born with NAS.

4.14.9.3.1.2. At least one (1) APM that promotes greater use of Medication-Assisted Treatment.

4.14.9.4 Emerging State Medicaid and Public Health Priorities

4.14.9.4.1 The MCO shall address any additional priorities identified by DHHS in the Medicaid APM Plan or related guidance. If DHHS adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of its APM Implementation Plan.

4.14.10 Physician Incentive Plans

4.14.10.1 The MCO shall submit all Physician Incentive Plans to DHHS for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO’s APM Implementation Plan. The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by DHHS.

4.14.10.2 Any Physician Incentive Plan, including those detailed within the MCO’s APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to “MA organization,” “CMS,” and “Medicare beneficiaries” should be read as references to “MCO,” “DHHS,” and “Members,” respectively. These include that:

4.14.10.2.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.14.10.2.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or

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Physician Group has adequate stop-loss protection [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.14.10.3 The MCO shall submit to DHHS annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously approved) Physician Incentive Plans, as described in Exhibit O. Annual Physician Incentive Plan reports must provide assurance satisfactory to DHHS that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any DHHS request to understand the terms of Provider payment arrangements.

4.14.10.4 The MCO shall provide to Members upon request the following information:

4.14.10.4.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.14.10.4.2 The type of incentive arrangement; and

4.14.10.4.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)]

4.15 Provider Payments

4.15.1 General Requirements

4.15.1.1 The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.15.1.2 The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) [Section 1903 of the Social Security Act]:

4.15.1.2.1 Furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

4.15.1.2.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act when the person knew or had any reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

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4.15.1.2.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

4.15.1.2.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4.15.1.2.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A) - (C) of the Social Security Act; section 1903(i)(16) - (17) of the Social Security Act]

4.15.1.3 No payment shall be made to a Participating Provider other than by the MCO for services covered under the contract between DHHS and the MCO, except when these payments are specifically required to be made by the state in Title XIX of the Social Security Act, in 42 CFR, or when DHHS makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan, or have been otherwise approved by CMS. [42 CFR 438.60]

4.15.1.4 The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by DHHS, the MCO shall contact DHHS and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.15.1.5 The MCO shall allow Providers up to one hundred and twenty (120) days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the 120 day timeframe. Good cause exceptions shall accommodate foreseeable and unforeseeable events such as a Member providing the wrong Medicaid identification number, natural disasters or failed information technology systems. The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim. Within the first one hundred and eighty (180) days of the Program Start Date, DHHS has discretion to direct MCOs to extend the one hundred and twenty (120) days on case by case basis.

4.15.1.6 The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

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4.15.1.7 The MCO shall collect data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and Care Coordination efforts. [42 CFR 438.242(b)(3)(iii)]

4.15.1.8 The MCO shall implement and maintain arrangements or procedures for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to DHHS. [42 CFR 438.608(a)(2)]

4.15.2 Hospital-Acquired Conditions and Provider-Preventable Conditions

4.15.2.1 The MCO must comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider-Preventable Conditions.

4.15.2.2 The MCO shall not make payments to a Provider for a Provider-Preventable Condition that meets the following criteria:

4.15.2.2.1 Is identified in the Medicaid State Plan;

4.15.2.2.2 Has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

4.15.2.2.3 Has a negative consequence for the Member;

4.15.2.2.4 Is auditable; and

4.15.2.2.5 Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.3(g); 42 CFR 438.6(a)(12)(i); 42 CFR 447.26(b)]

4.15.2.3 The MCO must require all Providers to report Provider-Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made, in accordance with Exhibit O. [42 CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.15.3 Federally Qualified Health Centers and Rural Health Clinics

4.15.3.1 FQHCs and RHCs shall be paid at minimum the encounter rate paid by DHHS at the time of service. FQHCs and RHCs shall also be paid for DHHS-specified CPT codes outside of the encounter rates.

4.15.3.2 The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make

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for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.15.3.3 The MCO shall enter into Alternative Payment Models with FQHCs, RHCs, and/or other health or family planning clinics or their designated contracting organizations as negotiated and agreed upon with DHHS in the MCO's APM Implementation Plan and as described by DHHS in the Medicaid APM Strategy.

4.15.4 Hospice Payment Rates

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

4.15.5 Community Mental Health Programs

4.15.5.1 The MCO shall, as described in Section 4.11.5.2 (Payment to Community Mental Health Programs and Community Mental Health Providers) meet the specific payment arrangement criteria in contracts with CMH Programs and CMH Providers for services provided to Members.

4.15.6 Payment Standards for Substance Use Disorder Providers

4.15.6.1 The MCO shall, as described in Section 4.11.6 (Substance Use Disorder), reimburse Substance Use Providers as directed by DHHS.

4.15.7 Payment Standards for Private Duty Nursing Services

4.15.7.1 The MCO shall reimburse private duty nursing agencies for private duty nursing services at least at the FFS rate established by DHHS.

4.15.8 Payment Standards for Indian Health Care Providers

4.15.8.1 The MCO must pay Indian Health Care Providers, whether Participating Providers or not, for Covered Services provided to American Indian Members who are eligible to receive services at a negotiated rate between the MCO and the Indian Health Care Provider, or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i) - (ii)]

4.15.8.2 For contracts involving Indian Health Care Providers, the MCO shall meet the requirements of FFS timely payment for all I/T/U Providers in its network, including the paying of ninety percent (95%) of all Clean Claims within thirty (30) days of the date of receipt; and paying ninety-nine percent (99%) of all Clean Claims within ninety (90) days of the date

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of receipt. [42 CFR 438.14(b)(2)(iii); ARRA 5006(d); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001)]

4.15.8.3 Indian Health Care Providers enrolled in Medicaid as FQHCs but not Participating Providers of the MCO must be paid an amount equal to the amount the MCO would pay an FQHC that is a Participating Provider but is not an Indian Health Care Provider, including any supplemental payment from DHHS to make up the difference between the amount the MCO pays and what the Indian Health Care Providers FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.15.8.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.15.8.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, DHHS shall make a supplemental payment to the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.16 Readiness Requirements Prior to Operations

4.16.1 General Requirements

4.16.1.1 Prior to the Program Start Date, the MCO shall demonstrate to DHHS's satisfaction its operational readiness and its ability to provide Covered Services to Members at the start of this Agreement in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 437.66(d)(1)(i).]

4.16.1.2 The Readiness Review requirements shall apply to all MCOs regardless of whether they have previously contracted with DHHS. [42 CFR 438.66((D(1)(II))] The Readiness Review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.16.1.3 In order to demonstrate its readiness, the MCO shall cooperate in the readiness review conducted by DHHS. If the MCO is unable to demonstrate its ability to meet the requirements of this Agreement, as determined solely by DHHS, within the timeframes determined solely by DHHS, then DHHS shall have the right to terminate this Agreement in accordance with Section 7.1 (Termination for Cause).

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4.16.1.4 The MCO shall participate in all DHHS trainings in preparation for implementation of the Agreement.

4.16.2 Emergency Response Plan

4.16.2.1 The MCO shall submit an Emergency Response Plan to DHHS for review and approval at least sixty (60) calendar days prior to the Program Start Date. The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.16.2.1.1 Staff and Provider training;

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

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

4.16.2.1.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.16.2.1.5 Plans to ensure continuity of services to Providers and Members;

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

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

4.16.2.2 On an annual basis, or as otherwise specified in Exhibit O, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.17 Managed Care Information System

4.17.1 System Functionality

4.17.1.1 The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.17.1.1.1 Collects, analyzes, integrates, and reports data [42 CFR 438.242(a)];

4.17.1.1.2 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.17.1.1.3 Collects and maintains data on Members and Providers, as specified in this Agreement and on all services

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furnished to Members, through an Encounter Data system [42 CFR 438.242(b)(2)];

4.17.1.1.4 Is capable of meeting the requirements listed below and throughout this Agreement; and

4.17.1.1.5 Is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

4.17.1.2 The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

4.17.1.2.1 Collection and maintenance of sufficient Member Encounter Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.17.1.2.2 Submission of Member Encounter Data to DHHS at the frequency and level of detail specified by CMS and by DHHS;

4.17.1.2.3 Submission of all Member Encounter Data that NH is required to report to CMS; and

4.17.1.2.4 Submission of Member Encounter Data to DHHS in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as specified in this Agreement. [42 CFR 438.242(c)(1) - (4); 42 CFR 438.818]

4.17.1.3 All Subcontractors shall meet the same standards, as described in this Section 4.17 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.17.1.4 The MCO MCIS shall include, but not be limited to:

4.17.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.17.1.4.2 Management of Provider Enrollment and Credentialing;

4.17.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.17.1.4.4 Eligibility Verification;

4.17.1.4.5 Encounter Data;

4.17.1.4.6 Reference File Updates;

4.17.1.4.7 Service Authorization Tracking, Support and Management;

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4.17.1.4.8 Third Party Coverage and Cost Avoidance Management;

4.17.1.4.9 Financial Transactions Management and Reporting;

4.17.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);

4.17.1.4.11 Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand);

4.17.1.4.12 Call Center Management;

4.17.1.4.13 Claims Adjudication;

4.17.1.4.14 Claims Payments; and

4.17.1.4.15 QOS metrics.

4.17.1.5 Specific functionality related to the above shall include, but is not limited to, the following:

4.17.1.5.1 The MCIS Membership management system must have the capability to receive, update, and maintain NH's Membership files consistent with information provided by DHHS;

4.17.1.5.2 The MCIS shall have the capability to provide daily updates of Membership information to sub-contractors or Providers with responsibility for processing claims or authorizing services based on Membership information;

4.17.1.5.3 The MCIS's Provider file must be maintained with detailed information on each Provider sufficient to support Provider enrollment and payment and also meet DHHS's reporting and Encounter Data requirements;

4.17.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal (Medicaid Management Information System) MMIS system;

4.17.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

4.17.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements;

4.17.1.5.7 The MCIS's credentialing system shall have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements, Quality Management, and Utilization Management Program Requirements;

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4.17.1.5.8 The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in Member, Provider, claims and authorization files, and in order to enable Encounter Data to be utilized for Member profiling, Provider profiling, claims validation, fraud, waste and abuse monitoring activities, and any other research and reporting purposes defined by DHHS; and

4.17.1.5.9 The Encounter Data system shall have a mechanism in place to receive, process, and store the required data.

4.17.1.6 The MCO system shall be compliant with the requirements of HIPAA and 42 CFR Part 2, including privacy, security, NPI, and transaction processing, including being able to process electronic data interchange (EDI) transactions in the ASC 5010 format. This also includes IRS Pub 1075 where applicable.

4.17.1.7 The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act. [42 CFR 438.242(b)(1)]

4.17.1.8 MCIS capability shall include, but not be limited to the following:

4.17.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.17.1.8.2 Documented scheduled down time and maintenance windows as agreed upon with DHHS for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

4.17.1.8.3 DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes, and procedures (approved by the State) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

4.17.1.8.4 DHHS access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals;

4.17.1.8.5 Documented instructions and user manuals for each component; and

4.17.1.8.6 Secure access.

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4.17.1.9 Managed Care Information System Up-Time

4.17.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by DHHS. The maintenance period shall not exceed four (4) consecutive hours without prior DHHS approval.

4.17.1.9.2 MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions will result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

4.17.2 Information System Data Transfer

4.17.2.1 Effective communication between the MCO and DHHS requires secure, accurate, complete, and auditable transfer of data to/from the MCO and DHHS data management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

4.17.2.1.1 DHHS read access to all MCM data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

4.17.2.1.2 Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

4.17.2.1.3 Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state;

4.17.2.1.4 Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.17.2.1.6 Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL

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processes, and provide for source to target or source to specification mappings;

4.17.2.1.7 Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

4.17.2.1.8 A given day's data transmissions, as specified in this Section 4.17.2 (Information System Data Transfer) of the Agreement, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions will be included in the next batch transmission.

4.17.2.2 The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

4.17.2.3 DHHS shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.17.2.4 Data transmissions from DHHS to the MCO will include, but not be limited to the following:

4.17.2.4.1 Provider Extract (Daily);

4.17.2.4.2 Recipient Eligibility Extract (Daily);

4.17.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.17.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.17.2.4.6 Claims History (Bi-Weekly); and

4.17.2.4.7 Capitation Payment data (Monthly).

4.17.2.5 Data transmissions from the MCO to DHHS shall include but not be limited to the following:

4.17.2.5.1 Member Demographic changes (Daily)

4.17.2.5.2 Member Primary Care Physician Selection (Daily)

4.17.2.5.3 MCO Provider Network Data (Daily)

4.17.2.5.4 Medical and Pharmacy Service Authorizations (Daily)

4.17.2.5.5 Member Encounter Data including paid, denied, adjustment transactions by pay period (Weekly)

4.17.2.5.6 Financial Transaction Data

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4.17.2.5.7 Updates to Third Party Coverage Data (Weekly)

4.17.2.5.8 Behavioral Health Certification Data (Monthly)

4.17.2.6 The MCO shall provide DHHS staff with access to timely and complete data and shall meet the following requirements:

4.17.2.6.1 All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS;

4.17.2.6.2 The MCO shall work collaboratively with DHHS, DHHS'S MMIS fiscal agent, the NH Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.17.2.6.4 The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data;

4.17.2.6.5 The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this Agreement;

4.17.2.6.6 Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable State and federal law; and

4.17.2.6.7 Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

4.17.3 Systems Operation and Support

4.17.3.1 Systems operations and support shall include, but not be limited to:

4.17.3.1.1 On-call procedures and contacts;

4.17.3.1.2 Job scheduling and failure notification documentation;

4.17.3.1.3 Secure (encrypted) data transmission and storage methodology;

4.17.3.1.4 Interface acknowledgements and error reporting;

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- 4.17.3.1.5 Technical issue escalation procedures;
- 4.17.3.1.6 Business and Member notification;
- 4.17.3.1.7 Change control management;
- 4.17.3.1.8 Assistance with UAT and implementation coordination;
- 4.17.3.1.9 Documented data interface specifications – data imported and extracts exported including database mapping specifications;
- 4.17.3.1.10 Disaster Recovery and Business Continuity Plan;
- 4.17.3.1.11 Journaling and internal backup procedures, for which facility for storage must be class 3 compliant; and
- 4.17.3.1.12 Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

4.17.3.2 The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

- 4.17.3.2.1 Network diagram that fully defines the topology of the MCO's network;
- 4.17.3.2.2 DHHS/MCO connectivity;
- 4.17.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and
- 4.17.3.2.4 Web access for DHHS staff, Providers and recipients.

4.17.4 Ownership and Access to Systems and Data

4.17.4.1 The MCO shall make available to DHHS and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.17.4.2 All data accumulated as part of the MCM program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

4.17.4.3 Systems enhancements developed specifically, and data accumulated, as part of the MCM program shall remain the property of the State of NH. Source code developed for the MCM program shall remain the property of the MCO but shall be held in escrow.

4.17.4.4 The MCO shall not destroy or purge DHHS's data unless directed to or agreed to in writing by DHHS. The MCO shall archive data

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only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be retrievable for review and or reporting by DHHS in the timeframe set forth by DHHS.

4.17.4.5 The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports, as well as the ability to execute ad-hoc queries to support DHHS data and information needs. DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

4.17.4.6 Records Retention

4.17.4.6.1 The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the data of termination of this Agreement. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

4.17.4.6.2 Upon expiration of the ten (10) year retention period and upon request, the subject records must be transferred to DHHS's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

4.17.5 Web Access and Use by Providers and Members

4.17.5.1 The MCIS shall include web access for use by and support to Participating Providers and Members. The services shall be provided at no cost to the Participating Provider or Members. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.17.5.2 The MCO shall create secure web access for Medicaid Providers and Members and authorized DHHS staff to access case-specific information; this web access shall fulfill the following requirements, and shall be available no later than the Program Start Date:

4.17.5.2.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

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4.17.5.2.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

4.17.5.2.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

4.17.5.2.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.17.5.2.5 Providers shall have access to drug information;

4.17.5.2.6 The website shall provide an e-mail link to the MCO to allow Providers and Members or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website;

4.17.5.2.7 The website shall be secure and HIPAA compliant in order to ensure the protection of PHI and Medicaid recipient confidentiality. Access shall be limited to verified users via passwords and any other available industry standards. Audit logs must be maintained reflecting access to the system and random audits will be conducted; and

4.17.5.2.8 The MCO shall ensure that any PHI, PI or other Confidential Information solicited on the website, shall not be stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.17.5.3 The MCO shall manage Provider and Member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist Providers and Members with gaining access and utilizing the web portal.

4.17.5.4 System Support Performance Standards shall include:

4.17.5.4.1 Email inquiries – one (1) business day response;

4.17.5.4.2 New information posted within one (1) business day of receipt, and up to two (2) business days of receipt for materials that must be made ADA compliant with Section 508 of the Rehabilitation Act;

4.17.5.4.3 Routine maintenance;

4.17.5.4.4 Standard reports regarding portal usage such as hits per month by Providers/Members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports; and

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4.17.5.4.5 Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO must redirect user to site to install appropriate browser.

4.17.6 Contingency Plans and Quality Assurance

4.17.6.1 Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

4.17.6.2 The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.17.6.3 The MCO shall ensure that the NH PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements.

4.17.6.4 The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction. Archiving processes shall not modify the data composition of DHHS's records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

4.17.6.5 The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, Provider billing agents/clearing houses, or DHHS and the MCO. Audit logs of activities will be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

4.17.6.6 In accordance with Exhibit O, the MCO shall submit the following documents and corresponding checklists for DHHS'S review and approval:

4.17.6.6.1 Disaster Recovery Plan;

4.17.6.6.2 Business Continuity Plan;

4.17.6.6.3 Security Plan;

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4.17.6.6.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redline documents and any corresponding checklists shall be submitted for DHHS review and approval:

4.17.6.6.4.1. Risk Management Plan,

4.17.6.6.4.2. Systems Quality Assurance Plan,

4.17.6.6.4.3. Confirmation of 5010 compliance and Companion Guides, and

4.17.6.6.4.4. Confirmation of compliance with IRS Publication 1075.

4.17.6.7 Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements shall be part of the MCO's change management process:

4.17.6.7.1 The complete system shall have proper configuration management/change management in place (to be reviewed and approved by DHHS). The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

4.17.6.7.2 The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to Subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent. DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.17.6.7.3 The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day. The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

4.17.6.7.4 A NH program centralized electronic repository shall be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

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4.17.6.7.5 The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any Member.

4.17.6.7.6 The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

4.17.6.8 DHHS, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

4.17.6.9 The System Readiness Review may include a desk review and/or an onsite review. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS. For purposes of this Section of the Agreement, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

4.17.6.10 If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a CAP and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency as described in Section 5.5 (Remedies) of this Agreement.

4.17.6.11 QOS metrics shall include:

4.17.6.11.1 System Integrity: The system shall ensure that both user and Provider portal design, and implementation is in accordance with federal standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

4.17.6.11.2 The security of the Care Management processing system must minimally provide the following three types of controls to maintain data integrity that directly impacts QOS. These controls shall be in place at all appropriate points of processing:

4.17.6.11.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

4.17.6.11.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

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4.17.6.11.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.17.6.11.3 System Administration: Ability to comply with HIPAA, ADA, and other State and federal regulations, and perform in accordance with Agreement terms and conditions, ability to provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of electronic health record, e-Prescribe) as well as new transactions at no additional cost.

4.18 Claims Quality Assurance Standards

4.18.1 Claims Payment Standards

4.18.1.1 For purposes of this Section 4.18 (Claims Quality Assurance Standards), DHHS has adopted the claims definitions established by CMS under the Medicare program, which are as follows:

4.18.1.1.1 "Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and

4.18.1.1.2 "Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.

4.18.1.2 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or EFT is issued to the service Provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.18.1.3 The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) days of receipt, or receipt of additional information. The MCO shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) days of receipt. [42 CFR 447.46; 42 CFR 447.45(d)(2)-(3) and (d)(5)-(6); Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act].

4.18.1.4 The MCO shall request all additional information necessary to process Incomplete Claims from the Provider within thirty (30) days from the date of original claim receipt.

4.18.2 Claims Quality Assurance Program

4.18.2.1 The MCO shall verify the accuracy and timeliness of data reported by Providers, including data from Participating Providers the

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MCO is compensating through a capitated payment arrangement. The MCO shall screen the data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

4.18.2.2 The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS, in accordance with Exhibit O. As indicated in Exhibit O, reporting to DHHS shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

4.18.2.3 The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

4.18.3 Claims Financial Accuracy

4.18.3.1 Claims financial accuracy measures the accuracy of dollars paid to Providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

4.18.4 Claims Payment Accuracy

4.18.4.1 Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.18.5 Claims Processing Accuracy

4.18.5.1 Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

5.1.1.1 As indicated throughout this Agreement, DHHS shall document ongoing MCO reporting requirements through Exhibit O and additional specifications provided by DHHS. The MCO shall provide data, reports, and plans in accordance with Exhibit O.

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5.1.1.2 The MCO shall comply with all NHID rules for data reporting, including those related to the NH CHIS.⁴⁴

5.1.1.3 The MCO shall make all collected data available to DHHS upon request and upon the request of CMS [42 CFR 438.242(b)(4)].

5.1.1.4 The MCO shall collect data on Member and Provider characteristics as specified by DHHS and on services furnished to Members through a MCIS system or other methods as may be specified by DHHS [42 CFR 438.242(b)(2)]

5.1.1.5 The MCO shall ensure that data received from Providers are accurate and complete by:

5.1.1.5.1 Verifying the accuracy and timeliness of reported data;

5.1.1.5.2 Screening the data for completeness, logic, and consistency; and

5.1.1.5.3 Collecting service information in standardized formats to the extent feasible and appropriate [42 CFR 438.242(b)(3)].

5.1.1.6 DHHS will collect the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.6.1 Enrollment and disenrollment data;

5.1.1.6.2 Member grievance and appeal logs;

5.1.1.6.3 Medical management committee reports and minutes;

5.1.1.6.4 Audited financial and encounter data;

5.1.1.6.5 The MLR summary reports;

5.1.1.6.6 Customer service performance data;

5.1.1.6.7 Performance on required quality measures; and

5.1.1.6.8 The MCO's QAPI Plan.

5.1.1.7 The MCO will be responsible for preparing, submitting, and presenting to the Governor, Legislature, and DHHS a report that includes the following information, or information otherwise indicated by the State:

5.1.1.7.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in SB 313, throughout this Agreement, and in other State statute, policies, and guidelines;

⁴⁴ For additional information, see the following laws and data collection rules: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-G/420-G-11-a.htm>; <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-G/420-G-11.htm>; http://www.gencourt.state.nh.us/rules/state_agencies/ins4000.html

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5.1.1.7.2 A description of the innovative programs the MCO has developed, and the outcomes associated with those programs;

5.1.1.7.3 A description of how the MCO is addressing social determinants of health, and the outcomes associated with MCO-implemented interventions;

5.1.1.7.4 A description of how the MCO is improving health outcomes in the state; and

5.1.1.7.5 Any other information indicated by the State for inclusion in the annual report.

5.1.2 Requirements for Waiver Programs

5.1.2.1 The MCO shall provide to DHHS the data and information required for its current CMS waiver programs and any waiver programs it enters during the Term of this Agreement that require data for Members covered by the MCO. These include but are not limited to:

5.1.2.1.1 NH's Building Capacity for Transformation 1115 waiver;

5.1.2.1.2 Substance Use Disorder Institute for Mental Disease 1115 waiver;

5.1.2.1.3 Mandatory managed care 1915b waiver; and

5.1.2.1.4 Granite Advantage 1115 waiver.

5.1.3 Encounter Data

5.1.3.1 The MCO shall submit Encounter Data in the format and content, timeliness, completeness, and accuracy as specified by DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS. [42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818]

5.1.3.2 All MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO may meet all DHHS reporting requirements.

5.1.3.3 The MCO shall submit to DHHS for approval during the first readiness review its policies and procedures that detail the MCO's encounter process. The MCO-submitted policies and procedures must at minimum include to DHHS's satisfaction:

5.1.3.3.1 An end-to-end description of the MCO's encounter process;

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5.1.3.3.2 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.3 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4 The MCO shall, as requested by DHHS, submit updates to and revise upon request its policies and procedures that detail the MCO's encounter process.

5.1.3.5 All Encounter Data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

5.1.3.6 The MCO shall submit Encounter Data to the EQRO and DHHS in accordance with this Section 5.1.3 (Encounter Data) of the Agreement and to DHHS's actuaries, as requested, according to the format and specification of the actuaries.

5.1.3.7 Submission of Encounter Data to DHHS does not eliminate the MCO's responsibility to comply with NHID rules, Chapter Ins 4000 Uniform Reporting System for Health Care Claims Data Sets.

5.1.3.8 The MCO shall ensure that encounter records are consistent with DHHS requirements and all applicable State and federal laws.

5.1.3.9 MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.10 The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

5.1.3.11 The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12 The MCO shall have a computer and data processing system, and staff, sufficient to accurately produce the data, reports, and encounter record set in formats and timelines as defined in this Agreement.

5.1.3.13 The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

5.1.3.14 The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS. The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

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5.1.3.15 The MCO's systems that are required to use or otherwise contain the applicable data type shall conform to current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards, including application of:

5.1.3.15.1 Health Care Common Procedure Coding System (HCPCS);

5.1.3.15.2 CPT codes;

5.1.3.15.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.15.4 National Drug Codes is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.15.5 Code on Dental Procedures and Nomenclature (CDT) is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA);

5.1.3.15.6 POS Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry;

5.1.3.15.7 Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the Provider or the patient when other insurance is involved; and

5.1.3.15.8 Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the MMIS using standard codes defined and maintained by CMS and the NCPDP.

5.1.3.16 All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) or at the discretion of DHHS the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional), and, for pharmacy services, in the NH file format , and other proprietary file layouts as defined by DHHS.

5.1.3.17 All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and, as applicable, the Medicare paid amount, other insurance paid amount and/or expected Member

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Copayment amount. The paid amount (or FFS equivalent) paid amount submitted with Encounter Data shall be the amount paid to Providers, not the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities. This requirement means that for pharmacy claims, the MCO paid amount shall include the amount paid to the pharmacy; the amount paid to the MCO's PBM is not acceptable.

5.1.3.18 The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.19 The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.20 The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Data for all Covered Services. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.21 The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.21.1 Batch and Online Transaction Types are as follows:

5.1.3.21.1.1. ASC X12N 820 Premium Payment Transaction

5.1.3.21.1.2. ASC X12N 834 Enrollment and Audit Transaction

5.1.3.21.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction

5.1.3.21.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction

5.1.3.21.1.5. ASC X12N 837P Professional Claim/Encounter Transaction

5.1.3.21.1.6. ASC X12N 837D Dental Claim/Encounter Transaction

5.1.3.21.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction

5.1.3.21.2 Online transaction types are as follows:

5.1.3.21.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

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5.1.3.21.2.2. ASC X12N 276 Claims Status Inquiry

5.1.3.21.2.3. ASC X12N 277 Claims Status Response

5.1.3.21.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response

5.1.3.21.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction

5.1.3.22 Submitted Encounter Data shall include all elements specified by DHHS, including but not limited to those specified in the DHHS Medicaid Encounter Submission Requirements Policy. The MCO shall submit summary reporting in accordance with Exhibit O, to be used to validate Encounter submissions.

5.1.3.23 The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee-for-service claims. Any exceptions will be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception.

5.1.3.24 The MCO shall also use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.25 The MCO shall provide as a supplement to the Encounter Data submission a Member file on a monthly basis, which shall contain appropriate Member Medicaid identification numbers, the PCP assignment of each Member, and the group affiliation and service location address of the PCP.

5.1.3.26 The MCO shall submit complete Encounter Data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

5.1.3.27 The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

5.1.3.28 The MCO shall provide complete and accurate encounters to DHHS. The MCO shall implement review procedures to validate Encounter Data submitted by Providers. The MCO shall meet the following standards:

5.1.3.28.1 Completeness:

5.1.3.28.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.28.2 Accuracy:

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5.1.3.28.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits.

5.1.3.28.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.28.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.28.2.4. Ninety-eight percent (98%) of billing Provider information will be accurate and valid.

5.1.3.28.2.5. Ninety-eight percent (98%) of servicing Provider information will be accurate and valid.

5.1.3.28.2.6. The MCO shall submit a monthly supplemental Provider file, to include data elements as defined by DHHS, for all Providers that were submitted on encounters in the prior month.

5.1.3.28.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.28.2.7.1 The end to end test shall include a review of the Provider claim to what data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.28.2.7.2 The MCO shall report a pass or fail to DHHS. If the result is a fail, the MCO shall also submit a root cause analysis that includes plans for remediation.

5.1.3.28.2.7.3 If DHHS or the MCO identifies a data defect, the MCO shall, for six (6) months post data defect identification, conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.28.2.7.4 If two (2) or more Encounter Data defects are identified within a rolling twelve (12) month period, DHHS may require the MCO to contract with an external vendor to independently

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assess the MCO Encounter Data process. The external vendor shall produce a report that will be shared with DHHS.

5.1.3.28.3 Timeliness:

5.1.3.28.3.1. Encounter Data shall be submitted weekly, within seven (7) calendar days of claim payment. All encounters shall be submitted, both paid and denied claims. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.28.4 Error Resolution:

5.1.3.28.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.28.4.2. For all ongoing claim encounters, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

5.1.3.28.4.3. If the MCO fails to comply with either error resolution timeline, DHHS will require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages). The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

5.1.3.28.5 Survival:

5.1.3.28.5.1. All Encounter Data accumulated as part of the MCM program shall remain the property of DHHS and, upon termination of the Agreement, the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS and as is further described in Section 7.7.2 (Data).

5.1.4 Data Certification

5.1.4.1 All data submitted to DHHS by the MCO shall be certified by one (1) of the following:

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5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CEO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

5.1.4.2 The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, Encounter Data, and other information contained in this Agreement or proposals. The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data. The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

5.1.4.3 The MCO shall submit the MCO Data Certification process policies and procedures for DHHS approval during the first readiness review.

5.1.5 Data System Support for Quality Assurance & Performance Improvement

5.1.5.1 The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.12.3 (Quality Assessment and Performance Improvement Program). The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of Participating Providers, Member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

5.2 Contract Oversight Program

5.2.1 The MCO shall have a formalized Contract Oversight Program to ensure that it complies with this Agreement, which at a minimum, should outline: the specific monitoring and auditing activities that the MCO shall undertake to ensure its and its Subcontractors' compliance with certain provisions and requirements of the Agreement; the frequency of those contract oversight activities; and the person(s) responsible for those contract oversight activities. The Contract Oversight Program shall specifically address how the MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.1.1 Section 3.12 (Privacy and Security of Members' Information);

5.2.1.2 Section 3.14 (Subcontractors);

5.2.1.3 Section 4 (Program Requirements); and

5.2.1.4 All data and reporting requirements.

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5.2.2 The Contract Oversight Program shall set forth how the MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board of Directors will be made aware of non-compliance identified through the Contract Oversight Program. The MCO shall present to DHHS for approval as part of the readiness review a copy of the Contract Oversight Program and any implementing policies. The MCO shall present to DHHS for review and approval redlined copies of proposed changes to the Contract Oversight Program and its implementing policies prior to adoption. This Contract Oversight Program is distinct from the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan discussed in Section 5.3 (Program Integrity).

5.2.3 The MCO shall promptly, but no later than thirty (30) days after the date of discovery, report any material non-compliance identified through the Contract Oversight Program and submit a Corrective Action Plan to DHHS to remediate such non-compliance. The MCO shall implement any changes to the Corrective Action Plan requested by DHHS.

5.3 **Program Integrity**

5.3.1 **General Requirements**

5.3.1.1 The MCO shall present to DHHS for review and approval as part of the readiness review a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan and shall comply with policies and procedures that guide and require the MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608] The MCO shall present to DHHS for review and approval redlined copies of proposed changes to the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan prior to adoption.

5.3.1.2 The MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and recredentialing processes.

5.3.1.3 The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

- 5.3.1.3.1** Section 1902(a)(68) of the Social Security Act;
- 5.3.1.3.2** 42 CFR Section 438;
- 5.3.1.3.3** 42 CFR Section 455;
- 5.3.1.3.4** 42 CFR Section 1000 through 1008; and
- 5.3.1.3.5** CMS Toolkits.

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5.3.1.4 The MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of fraud, waste and abuse and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to DHHS.

5.3.1.5 The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against fraud, waste and abuse. The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent and deter fraud, waste and abuse. The MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.6 The MCO shall work with DHHS on program integrity issues, and with MFCU as directed by DHHS, on fraud, waste or abuse investigations. This shall include the following:

5.3.1.6.1 Participation in MCO program integrity meetings with DHHS following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O. The frequency of the program integrity meetings shall be as often as monthly. Discussion at these meetings shall include, but not be limited to, case development and monitoring. The MCO shall ensure Subcontractors attend monthly meetings when requested by DHHS;

5.3.1.6.2 Participation in bi-annual MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned;

5.3.1.6.3 Quality control and review of encounter data submitted to DHHS; and

5.3.1.6.4 Participation in meetings with MFCU, as determined by MFCU and DHHS.

5.3.2 Fraud, Waste and Abuse

5.3.2.1 The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse. [42 CFR 438.608(a)]

5.3.2.2 The arrangements or procedures must include the following:

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5.3.2.2.1 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan that includes, at a minimum, all of the following elements:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii)];

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such provision of inducements;

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5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or fraud, waste and abuse to DHHS within thirty (30) business days;

5.3.2.2.4 A description of the MCO's specific controls to detect and prevent potential fraud, waste and abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any future changes in federal requirements for managed care billing;

5.3.2.2.4.4. At least three (3) data analytic algorithms for fraud detection specified by DHHS Program Integrity and three (3) additional data analytic algorithms as determined by the MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change at least annually;

5.3.2.2.4.5. A list of audits of post-processing review of claims planned;

5.3.2.2.4.6. A list of reports on Participating Provider and Non-Participating Provider profiling used to aid program integrity reviews;

5.3.2.2.4.7. The methods the MCO will use to identify high-risk claims and the MCO's definition of "high-risk claims";

5.3.2.2.4.8. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.9. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

5.3.2.2.4.10. A method to verify, by sampling or other method, whether services that have been represented to

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have been delivered by Participating Providers and were received by Members and the application of such verification processes on a regular basis. The MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.11. Provider and Member materials identifying the MCO's fraud and abuse reporting hotline number;

5.3.2.2.4.12. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.13. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.14. The ability to suspend a Participating Provider's or Non-Participating Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity;

5.3.2.2.4.15. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and or abusive incorrect billing trends with a particular Participating Provider or provider type, specific billing issue trends, or quality trends;

5.3.2.2.5 A provision for the prompt reporting of all overpayments identified and recovered, specifying the overpayments due to potential fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider fraud, waste and abuse that the MCO or Subcontractor identifies to DHHS Program Integrity and any potential fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO's suspension of payments to a Participating Provider for which DHHS determines there is credible allegation of fraud in accordance with this Agreement and 42 CFR 455.23; and

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5.3.2.2.8 A provision for notification to DHHS when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O.

5.3.2.3 The MCO and Subcontractors must implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4 The MCO, and if required by the MCO's Subcontractors, shall post and maintain DHHS-approved information related to fraud, waste and abuse on its website, including but not limited to, provider notices, current listing of Participating Providers, providers that have been excluded or sanctioned from the Medicaid Care Management Program, any updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

5.3.3 Identification and Recoveries of Overpayments

5.3.3.1 The MCO shall maintain an effective fraud, waste and abuse-related Provider overpayment identification, Recovery and tracking process. The MCO shall perform ongoing analysis of its authorization, utilization, claims, Provider's billing patterns, and encounter data to detect improper payments, and shall perform audits and investigations of Subcontractors, Providers and Provider entities. This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with Providers, and a system for managing and tracking of investigation findings, Recoveries, and underpayments related to fraud, waste and abuse investigations/audit/any other overpayment recovery process as described in the fraud, waste and abuse reports provided to DHHS in accordance with Exhibit O.

5.3.3.2 The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste and abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.3 When the MCO, Subcontractor or DHHS identifies an overpayment, the funds must be recovered by, and returned to DHHS or the MCO within sixty (60) calendar days from the date they were identified and known by the Provider. The MCO shall report to DHHS within sixty (60) calendar days when it has identified Capitation Payments

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or other payment amounts received are in excess to the amounts specified in this Agreement. [42 CFR 438.608(c)(3)].

5.3.3.4 To maintain compliance with regulations found in Section 1128J(d) of the Social Security Act, Overpayments that are not recovered by or returned to MCO within sixty (60) calendar days from the date they were identified and known by the Provider, Subcontractor or MCO, may be recovered by DHHS. [42 CFR 438.608(d)(1)(ii)-(iii)]

5.3.3.5 This Section of the Agreement does not apply to any amount of a recovery to be retained under False Claim Act cases or through other investigations.

5.3.3.6 DHHS will utilize the information and documentation collected under this Agreement, as well as nationally recognized information on average recovery amounts as reported by State MFCUs and commercial insurance plans for setting actuarially sound Capitation Payments for each MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.7 If the MCO does not meet the required metrics related to expected fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O, DHHS shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

5.3.4 Referrals of Credible Allegations of Fraud and Provider and Payment Suspensions

5.3.4.1 General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to DHHS Program Integrity Unit and the MFCU on credible allegations of fraud and for payment suspension when there is a credible allegation of fraud. [42 CFR 438.608(a)(8); 42 CFR 455.23].

5.3.4.1.2 When the MCO or its Subcontractor has concluded that a credible allegation of fraud or abuse exists, the MCO shall make a referral to DHHS Program Integrity Unit and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by DHHS. [42 CFR 438.608(a)(7)]

5.3.4.1.3 Unless and until prior written approval is obtained from DHHS, neither an MCO nor a Subcontractor shall take any administrative action or any of the following regarding the allegations of suspected fraud:

5.3.4.1.3.1. Suspend Provider payments;

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- 5.3.4.1.3.2. Contact the subject of the investigation about any matters related to the investigation;
 - 5.3.4.1.3.3. Continue the investigation into the matter;
 - 5.3.4.1.3.4. Enter into or attempt to negotiate any settlement or agreement regarding the matter; or
 - 5.3.4.1.3.5. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- 5.3.4.1.4 The MCO shall employ pre-payment review when directed by DHHS. In addition, the MCO may employ pre-payment review in the following circumstances without approval:
- 5.3.4.1.4.1. Upon new Participating Provider enrollment;
 - 5.3.4.1.4.2. For delayed payment during Provider education;
 - 5.3.4.1.4.3. For existing Providers with billing inaccuracies;
 - 5.3.4.1.4.4. Upon receipt of a credible allegation of fraud or abuse; or
 - 5.3.4.1.4.5. Upon identification from data analysis or other grounds.
- 5.3.4.1.5 If DHHS, MFCU or another law enforcement agency accepts the allegation for investigation, DHHS shall notify the MCO's Compliance Officer within two (2) business days of the acceptance notification, along with a directive to suspend payment to the affected Provider(s) if it is determined that suspension will not impair MFCU's or law enforcement's investigation. DHHS shall notify the MCO if the referral is declined for investigation. If DHHS, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this Section of the Agreement.
- 5.3.4.1.6 Upon receipt of notification from DHHS, the MCO shall send notice of the decision to suspend program payments to the Provider within the following timeframe:
- 5.3.4.1.6.1. Within five (5) calendar days of taking such action unless requested in writing by DHHS, the MFCU, or law enforcement to temporarily withhold such notice; or
 - 5.3.4.1.6.2. Within thirty (30) calendar days if requested by DHHS, MFCU, or law enforcement in writing to delay

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sending such notice. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.

5.3.4.1.7 The notice must include or address all of the following (42 CFR 455.23(2)):

5.3.4.1.7.1. That payments are being suspended in accordance with this provision;

5.3.4.1.7.2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

5.3.4.1.7.3. That the suspension is for a temporary period and cite the circumstances under which the suspension will be lifted;

5.3.4.1.7.4. Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

5.3.4.1.7.5. Where applicable and appropriate, inform the Provider of any appeal rights available to this Provider, along with the Provider's right to submit written evidence for consideration by MCO.

5.3.4.2 All suspension of payment actions under this Section of the Agreement will be temporary and will not continue after either of the following: (i) The MCO is notified by DHHS that there is insufficient evidence of fraud by the Provider; or (ii) The MCO is notified by DHHS that the legal proceedings related to the Provider's alleged fraud are completed. The MCO must document in writing the termination of a payment suspension and issue a notice of the termination to the Provider and to DHHS.

5.3.4.3 The DHHS Program Integrity Unit may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

5.3.4.3.1 MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;

5.3.4.3.2 Other available remedies are available to the MCO, after DHHS approves the remedies that more effectively or quickly protect Medicaid funds;

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5.3.4.3.3 The MCO determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed. The MCO shall review evidence submitted by the Provider and submit it with a recommendation to DHHS. DHHS shall direct the MCO to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence;

5.3.4.3.4 Member access to items or services would be jeopardized by a payment suspension because of either of the following: (i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or (ii) The individual or entity serves a large number of Members within a federal HRSA designated medically underserved area;

5.3.4.3.5 MFCU or law enforcement declines to certify that a matter continues to be under investigation; or

5.3.4.3.6 DHHS determines that payment suspension is not in the best interests of the Medicaid program.

5.3.4.4 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.4.1 Details of payment suspensions that were imposed in whole or in part; and

5.3.4.4.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.5 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and DHHS directed MCO to suspend payments, DHHS may impose liquidated damages.

5.3.4.6 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of NH, and the MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.7 Furthermore, the MCO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of NH for all criminal, civil and administrative action recoveries undertaken by any government entity, including but not limited to all claims the MCO or its Subcontractor(s) has or may have against any entity or individual that

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directly or indirectly receives funds under this Agreement, including but not limited to any health care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other Provider in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DME, or other health care related products or services. For the purposes of this Section of the Agreement, "subrogation" means the right of any state of NH government entity or local law enforcement to stand in the place of the MCO or client in the collection against a third party.

5.3.4.8 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

5.3.5 Investigations

5.3.5.1 The MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate fraud, waste and abuse. The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.2 The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (i.e., MFCU, DHHS, OIG, and CMS).

5.3.5.3 The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.4 The MCO and its Subcontractors shall maintain all records, documents and claim or encounter data for Members, Providers and Subcontractors who are under investigation by any State or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating State or federal agency. The MCO shall provide any data access or detail records upon written request from DHHS for any potential fraud, waste and abuse investigation, Provider or claim audit, or for MCO oversight review. The additional access shall be provided within three (3) business days of the request.

5.3.5.5 The MCO and its Subcontractors shall request a refund from a third-party payor, Provider or Subcontractor when an investigation indicates that such a refund is due. These refunds must be reported to DHHS as Overpayments.

5.3.5.6 DHHS shall conduct investigations related to suspected Provider fraud, waste and abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO does not have an active investigation.

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5.3.6 Reporting

5.3.6.1 Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity). The annual Fraud Prevention summary shall include, at a minimum, the following elements, in accordance with Exhibit O:

5.3.6.1.1.1. The name of the person and department responsible for submitting the Fraud Prevention Report;

5.3.6.1.1.2. The date the report was prepared;

5.3.6.1.1.3. The date the report is submitted;

5.3.6.1.1.4. A description of the SIU;

5.3.6.1.1.5. Cumulative Overpayments identified and recovered;

5.3.6.1.1.6. Investigations initiated, completed, and referred, and

5.3.6.1.1.7. Analysis of the effectiveness of the activities performed; and

5.3.6.1.1.8. Other information in accordance with Exhibit O.

5.3.6.1.2 As part of this report, the MCO shall submit to DHHS a report of the Overpayments it recovered, certified by its CFO that this information is accurate to the best of his or her information, knowledge, and belief, as required by Exhibit O. [42 CFR 438.606]

5.3.6.2 Reporting Member Fraud

5.3.6.2.1 The MCO shall notify DHHS of any cases in which the MCO believes there is a serious likelihood of Member fraud by sending a secure email to DHHS Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member fraud, waste and abuse and referring Member fraud to DHHS. The MCO shall provide initial allegations, investigations and resolutions of Member fraud to DHHS.

5.3.6.3 Termination Report

5.3.6.3.1 The MCO shall submit to DHHS a monthly Termination Report including Providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; Provider terminations for convenience; and Providers

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who self-terminated. The report must be completed using the DHHS template.

5.3.6.4 Other Reports

5.3.6.4.1 The MCO shall submit to DHHS demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 The MCO shall report at least annually to DHHS, and as otherwise required by this Agreement, on their recoveries of Overpayments. [42 CFR 38.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

5.3.7 Access to Records, On-Site Inspections and Periodic Audits

5.3.7.1 As an integral part of the MCO's program integrity function, and in accordance with 42 CFR 455, and 438, the MCO shall provide DHHS program integrity staff or its designee, to include DHHS third-party liability, real time access to all of the MCO electronic encounter and claims data from the MCO's current claims reporting system. The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in Section 4.18.2 (Claims Quality Assurance Program).

5.3.7.2 Upon request, the MCO and the MCO's Providers and Subcontractors shall allow DHHS, MFCU or any other authorized State or federal agency or duly authorized representative with access to the MCO's and the MCO's Providers and Subcontractors premises during normal business hours to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. The MCO and its Providers and Subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation. Copies of records and documents shall be made at no cost to the requesting agency. [42 CFR 438.3(h); 42 CFR 455.21(a)(2); 42 CFR 431.107(b)(2)]. A record includes but is not limited to:

5.3.7.2.1 Medical records;

5.3.7.2.2 Billing records;

5.3.7.2.3 Financial records;

5.3.7.2.4 Any record related to services rendered, quality, appropriateness, and timeliness of service;

5.3.7.2.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

5.3.7.2.6 Any record of an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

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5.3.7.3 Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate DHHS, MFCU or other State or federal agencies.

5.3.7.4 DHHS, CMS, MFCU, the OIG, the Comptroller General, or any other authorized State or federal agency or duly authorized representative shall be allowed to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time. [42 CFR 438.3(h)]

5.3.7.5 The MCO and its Subcontractors shall be subject to on-site or offsite reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests. Documents shall be furnished by the MCO or its Subcontractor at the MCO's expense.

5.3.7.6 The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.7 DHHS will conduct, or contract for the conducting of, periodic audits of the MCO no less frequently than once every three (3) years of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each Contractor. [42 CFR 438.602(e)] This shall include any records containing the ability of the MCO to bear the risk of financial losses or services performed or payable amounts under the Agreement.

5.3.8 Transparency

5.3.8.1 DHHS shall post on its website, as required by 42 CFR 438.10(c)(3), the following documents and reports:

5.3.8.1.1 The Agreement;

5.3.8.1.2 The data at 42 CFR 438.604(a)(5) which DHHS certifies that the MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 The name and title of individuals included in 42 CFR 438.604(a)(6) to confirm ownership and control of MCO, described in 42 CFR 455.104, and Subcontractors as governed by 42 CFR 438.230;

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5.3.8.1.4 The results of any audits, under 42 CFR 438.602(e), of the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by MCO; and

5.3.8.1.5 Performance metrics and outcomes.

5.4 **MCM Withhold and Incentive Program**

5.4.1 DHHS shall institute a withhold arrangement through which a portion of the MCO's Capitation Payment recouped from the MCO and distributed among MCOs participating in the MCM program on the basis of meeting targets specified in the DHHS Withhold and Incentive Program Policy.

5.4.2 DHHS will, as often as annually, issue MCM Withhold and Incentive Program Guidance within ninety (90) calendar days of the start of the Plan Year.

5.4.3 This withhold arrangement shall [42 CFR 438.6(b)(3)]:

5.4.3.1.1 Be for a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied (the "Agreement");

5.4.3.1.2 Not be renewed automatically;

5.4.3.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.1.4 Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.3.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.3.2 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.3.3 This incentive arrangement shall [42 CFR 438.6(b)(2)]:

5.4.3.3.1 Be for a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied (the "Agreement");

5.4.3.3.2 Not be renewed automatically;

5.4.3.3.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.3.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

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5.4.3.3.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.5 Remedies

5.5.1 **Reservation of Rights and Remedies**

5.5.1.1 The parties acknowledge and agree that a material default or breach in this Agreement will cause irreparable injury to DHHS.

5.5.1.2 The MCO acknowledges that failure to comply with provisions of this Agreement may result in the assessment of liquidated damages, termination of the Agreement, in whole or in part, and/or imposition of other sanctions as set forth in this Agreement.

5.5.1.3 In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State of NH to any existing or future right or remedy available by law. Failure of the state of NH to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release the MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State of NH to insist upon the strict performance of this Agreement.

5.5.1.4 In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, DHHS may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages. DHHS reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

5.5.1.5 The remedies specified in this Section of the Agreement shall apply until the failure is cured or a resulting dispute is resolved in the MCO's favor.

5.5.2 **Liquidated Damages**

5.5.2.1 DHHS may perform an annual review to assess if the liquidated damages set forth in Exhibit N (Liquidated Damages Matrix) align with DHHS's strategic aims and areas of identified non-compliance and update Exhibit N (Liquidated Damages Matrix) as needed.

5.5.2.2 DHHS and the MCO agree that it will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance

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standards indicated below during this Agreement. Any breach by the MCO will delay and disrupt DHHS's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in this Agreement are reasonable.

5.5.2.3 Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies that may be available to DHHS. Except and to the extent expressly provided herein, DHHS shall be entitled to recover liquidated damages for each day, incidence or occurrence, as applicable, of a violation or failure.

5.5.2.4 The liquidated damages shall be assessed based on the categorization of the violation or non-compliance and are set forth on Exhibit N (Liquidated Damages Matrix).

5.5.2.5 The MCO will be subject to liquidated damages for failure to comply in a timely manner with all reporting requirements in accordance with Exhibit O.

5.5.3 Suspension of Payment

5.5.3.1 Payment of Capitation Payments may be suspended when the MCO fails:

5.5.3.1.1 To cure a default under this Agreement within thirty (30) days of notification;

5.5.3.1.2 To implement CAP addressing violations or non-compliance; and

5.5.3.1.3 To implement approved Program Management Plans.

5.5.3.2 Upon correction of the deficiency or omission, Capitation Payments shall be reinstated.

5.5.4 Intermediate Sanctions

5.5.4.1 DHHS shall have the right to impose intermediate sanctions as set forth in 42 CFR Section 438.702(a), which include:

5.5.4.1.1 Civil monetary penalties (DHHS shall not impose any civil monetary penalty against an MCO in excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 Allowing Members to terminate enrollment without cause;

5.5.4.1.4 Suspending all new enrollment;

5.5.4.1.5 Suspending payments for new enrollment; and

5.5.4.1.6 Agreement termination.

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5.5.4.2 DHHS must impose intermediate sanctions if DHHS finds that an MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide under law or under its contract with DHHS, DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to provide services. DHHS may also:

5.5.4.2.1.1. Appoint temporary management to the MCO,

5.5.4.2.1.2. Grant Members the right to disenroll without cause,

5.5.4.2.1.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.1.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.2 Imposes premiums or charges on Members that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to \$25,000 or double the amount of the excess charges (whichever is greater). The state may also:

5.5.4.2.2.1. Appoint temporary management to the MCO,

5.5.4.2.2.2. Grant Members the right to disenroll without cause,

5.5.4.2.2.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.2.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; [42 CFR 438.700(b)(2); 42 CFR 438.702(a); 42 CFR 438.704(c); sections 1903(m)(5)(A)(ii);

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1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Social Security Act]

5.5.4.2.3 Discriminates among Members on the basis of their health status or need for health services, DHHS may impose a civil monetary penalty of up to one hundred thousand dollars (\$100,000) for each determination of discrimination. DHHS may impose a civil monetary penalty of up to fifteen thousand dollars (\$15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar (\$100,000) maximum. DHHS may also:

5.5.4.2.3.1. Appoint temporary management to the MCO,

5.5.4.2.3.2. Grant Members the right to disenroll without cause,

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Social Security Act]

5.5.4.2.4 Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider, DHHS may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation. DHHS may also:

5.5.4.2.4.1. Appoint temporary management to the MCO,

5.5.4.2.4.2. Grant Members the right to disenroll without case,

5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason

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for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.5 Misrepresents or falsifies information that it furnishes to CMS or to DHHS, DHHS may impose a civil monetary penalty of up to one hundred thousand dollars (\$100,000) for each instance of misrepresentation. DHHS may also:

5.5.4.2.5.1. Appoint temporary management to the MCO,

5.5.4.2.5.2. Grant Members the right to disenroll without cause,

5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.5.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.6 Fails to comply with the Medicare Physician Incentive Plan requirements, DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply. DHHS may also:

5.5.4.2.6.1. Appoint temporary management to the MCO,

5.5.4.2.6.2. Grant Members the right to disenroll without cause,

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5);

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42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3 DHHS shall have the right to impose civil monetary penalty of up to \$25,000 for each distribution if DHHS determines that the MCO has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by DHHS or that contain false or materially misleading information. [42 CFR 438.700(c); 42 CFR 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.4 DHHS shall have the right to terminate this Agreement and enroll that MCO's Members in other MCOs if DHHS determines that the MCO has failed to either carry out the substantive terms of this Agreement or meet applicable requirements in Sections 1905(t), 1903(m), and 1905(t) 1932 of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

5.5.4.5 DHHS shall grant Members the right to terminate MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6 DHHS shall only have the right to impose the following intermediate sanctions when DHHS determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of DHHS's intent to terminate the Agreement;

5.5.4.6.3 Suspend all new enrollment, including default enrollment, after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5.5.4.6.5 [42 CFR 438.700; 42 CFR 438.702(a); 42 CFR 438.704; 42 CFR 438.706(b); 42 CFR 438.722(a)-(b); Sections 1903(m)(5); 1932(e) of the Social Security Act]

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5.5.5 Administrative and Other Remedies

5.5.5.1 DHHS may, in addition to the other Remedies described within this Section 5.5 (Remedies), also impose the following remedies:

- 5.5.5.1.1 Requiring immediate remediation of the deficiency as determined by DHHS;
- 5.5.5.1.2 Requiring the submission of a CAP;
- 5.5.5.1.3 Suspending part of new enrollments;
- 5.5.5.1.4 Suspending part of the Agreement;
- 5.5.5.1.5 Requiring mandated trainings; and/or
- 5.5.5.1.6 Suspending all or part of Marketing activities for varying lengths of time.

5.5.5.2 Temporary Management

5.5.5.2.1 DHHS will impose optional temporary management when DHHS finds, through onsite surveys, Member or other complaints, financial status, or any other source:

- 5.5.5.2.1.1. There is continued egregious behavior by the MCO;
- 5.5.5.2.1.2. There is substantial risk to Members' health;
- 5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.2 DHHS shall impose mandatory temporary management when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. DHHS will not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the MCO can ensure the sanctioned behavior will not reoccur. [42 CFR 438.706(b)-(d); Section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.6 Corrective Action Plan

5.5.6.1 If requested by DHHS, the MCO shall submit a CAP within five (5) business days of DHHS's request, unless DHHS grants an extension to such timeframe. DHHS shall review and approve the CAP within five (5) days of receipt. MCO shall implement the CAP in accordance with the

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timeframes specified in the CAP. DHHS shall validate the implementation of the CAP and impose liquidated damages if it determines that the MCO failed to implement the CAP or a provision thereof as required.

5.5.7 Publication

5.5.7.1 DHHS may publish on its website on a quarterly basis a list of MCOs that had remedies imposed on them by DHHS during the prior quarter, the reasons for the imposition, and the type of remedy(ies) imposed. MCOs that had their remedies reversed pursuant to the dispute resolution process will not be listed.

5.5.8 Notice of Remedies

5.5.8.1 Prior to the imposition of remedies under this Agreement, except in the instance of required temporary management, DHHS will issue written notice of remedies that will include, as applicable, the following:

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

5.5.8.1.2 The remedies to be applied and the date the remedies shall be imposed;

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

5.5.8.1.4 The appeal rights provided by DHHS;

5.5.8.1.5 Whether a CAP is being requested;

5.5.8.1.6 The timeframe and procedure for the MCO to dispute DHHS's determination. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.1.7 If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor. [42 CFR 438.710(a)(1)-(2)]

5.6 State Audit Rights

5.6.1 DHHS, CMS, NHID, NH Attorney General, the OIG, the Comptroller General and their designees have the right to audit records or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

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5.6.2 HHS, the HHS Secretary, (or any person or organization designated by either), and DHHS, have the right to audit and inspect any books or records of the MCO or its Subcontractors pertaining to:

5.6.2.1 The ability of the MCO to bear the risk of financial losses.

5.6.2.2 Services performed or payable amounts under the contract.
[Section 1903(m)(2)(A)(iv) of the Social Security Act]

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

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

5.6.3.2 Written assertion by the MCO's management about whether:

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

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

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

5.6.3.3 Report of the MCO's auditor, which:

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

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

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

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

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

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

5.6.8 The MCO shall file annual and interim financial statements in accordance with the standards set forth below.

5.6.9 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)] Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

5.6.10 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.

5.6.11 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

5.7.1.1 In connection with any action taken or decision made by DHHS with respect to this Agreement, within thirty (30) calendar days following the action or decision, the MCO may protest such action or decision by the delivery of a notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director"). The MCO shall provide DHHS with a written explanation of its legal basis for the protest and its position on the action or decision. The Director will determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s). It is understood that the presentation and discussion of the disputed issue(s) will be informal in nature. The Director will provide written notice of the time, format and location of the presentations. At the conclusion of the presentations, the Director will consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation. The Director may appoint a designee to hear and determine the matter.

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5.7.2 Hearing

5.7.2.1 In the event of a termination by DHHS pursuant to 42 CFR Section 438.708, DHHS shall provide the MCO with notice and a pre-termination hearing in accordance with 42 CFR Section 438.710. DHHS shall provide written notice of the decision from the hearing. In the event of an affirming decision at the hearing, DHHS shall provide the effective date of the Agreement termination.

5.7.2.2 In the event of an affirming decision at the hearing, DHHS must give the Members of the MCO notice of the termination, and must inform Members of their options for receiving Medicaid services following the effective date of termination. [42 CFR 438.710(b); 42 CFR 438.710(b)(2)(i) - (iii); 42 CFR 438.10]

5.7.3 No Waiver

5.7.3.1 The MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A or any applicable provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written Agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

6.1.3.1 Risk-based capital ratio was less than two (2.0) for the most recent year filing, per R.S.A. 404- F:14 (III); and

6.1.3.2 MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO shall notify DHHS within ten (10) calendar days when its Agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

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6.1.5 The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

6.1.6 The MCO shall submit data on the basis of which DHHS determines that the MCO has made adequate provision against the risk of insolvency.

6.1.7 The MCO shall inform DHHS and NHID staff by phone and by email within five (5) business days of when any key personnel learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement with DHHS.

6.2 Capitation Payments

6.2.1 Capitation payments made by DHHS and retained by the MCO shall be for Medicaid-eligible Members. [42 CFR 438.3(c)(2)]

6.2.2 Capitation rates for the Term through June 30, 2020 are shown in Exhibit B (Capitation Rates). For each of the subsequent years of the Agreement actuarially sound per Member, per month capitated rates will be calculated and certified by DHHS's actuary. Any rate adjustments shall be subject to the availability of state appropriations.

6.2.3 In the event the MCO incurs costs that exceed the capitation payments, the state of NH and its agencies are not responsible for those costs and will not provide additional payments to cover such costs.

6.2.4 The MCO shall report to DHHS within seven (7) business days upon identifying any capitation or other payments in excess of amounts provided in this Agreement [42 CFR 438.608(c)(3)].

6.2.5 The MCO and DHHS agree that the capitation rates in Exhibit B (Capitation Rates) may be adjusted periodically to maintain actuarial soundness as determined by DHHS's actuary. The MCO shall submit data on the basis of which the state certifies the actuarial soundness of capitation rates to an MCO, including base data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.6 When requested by DHHS, the MCO shall submit Encounter Data, financial data, and other data to DHHS to ensure actuarial soundness in development of the capitated rates, or any other actuarial analysis required by DHHS or State law.

6.2.7 The MCO's CFO shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate. [42 CFR 438.606]

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6.2.8 The MCO has responsibility for implementing systems and protocols to maximize the collection of third-party liability (TPL) recoveries and subrogation activities. The capitation rates are calculated net of expected MCO recoveries.

6.2.9 DHHS will make a monthly payment to the MCO for each Member enrolled in the MCO's plan as DHHS currently structures its capitation payments. Specifically, the monthly capitation payments for standard Medicaid will be made retrospectively with a three (3) month plus five (5) business day lag (for example coverage for July 1, 2019 will be paid by the 5th business day in October, 2019). Capitation payments for all Granite Advantage Members will be made before the end of each month of coverage.

6.2.10 Capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment during the month. Capitation payments will be made once per month prorated to the number of days the Member is enrolled in the plan during the month.

6.2.11 The capitation rates will be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis and certified by DHHS's actuary.

6.2.12 DHHS reserves the right to terminate or implement the use of a risk adjustment process for all or specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates or as a result of credibility considerations of a population's size as determined by DHHS's actuary.

6.2.13 Capitation adjustments are processed systematically each month by DHHS's MMIS. DHHS will make systematic adjustments based on factors that affect rate cell assignment or plan enrollment. If a Member is deceased, DHHS shall recoup any and all capitation payments after the Member's date of death including any prorated share of a capitation payment intended to cover dates of services after the Member's date of death. DHHS will also make manual adjustments as needed, including manual adjustments for kick payments. DHHS has sole discretion over the settlement process. The MCO shall follow policies and procedures for the settlement process as developed by DHHS. Based on the provisions herein, DHHS shall not make any further retroactive adjustments other than those described herein or elsewhere in this agreement. DHHS and the contractor agree that there is a nine (9) month limitation from the date of the capitation payment and is applicable only to retroactive capitation rate payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO. DHHS shall have the discretion to recoup payments retroactively up to twenty-four (24) months for Members whom DHHS later determines were not eligible for Medicaid during the enrollment month for which capitation payment was made.

6.2.14 For each live birth, DHHS will make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB. This payment is a global fee to cover all delivery care. In the event of a multiple birth

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DHHS will only make only one (1) maternity kick payment. A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.15 For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2019 and August 2019 for a baby born any time in July 2019. Enrolled babies will be covered under the MCO capitated rates thereafter.

6.2.16 Different rates of newborn kick payments may be employed by DHHS to increase actuarial soundness. For the period beginning July 1, 2019, two (2) newborn kick payments will be employed, one (1) for newborns with NAS and one (1) for all other newborns. Each type of payment is distinct and only one payment is made per newborn.

6.2.17 The MCO shall submit information on maternity and newborn events to DHHS. The MCO shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.18 Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to DHHS's MMIS by the MCO. The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months. Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.

6.2.19 Beginning July 1, 2019, an actuarially sound portion of each Member's capitation payment to the MCO will be withheld via a recoupment after the completion of the contract year and may be repaid in full or in part to the MCO on the basis of the MCO's performance in DHHS's MCM Withhold and Incentive Program. Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by DHHS as indicated in Section 5.4 (MCM Withhold and Incentive Payment Program).

6.2.20 DHHS will inform the MCO of any required program revisions or additions in a timely manner. DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.21 In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member. The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services

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authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.22 DHHS shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment, or as has been otherwise permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.23 Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the NH Insurance Administrative Fund (Fund) pursuant to R.S.A. 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

6.2.24 For any Member with claims exceeding five hundred thousand dollars (\$500,000) for the fiscal year, after applying any third party insurance offset, DHHS will reimburse fifty percent (50%) of the amount over five hundred thousand dollars (\$500,000) after all claims have been recalculated based on the DHHS fee schedule for the services. For a Member whose services may be projected to exceed five hundred thousand dollars (\$500,000) in MCO claims, the MCO shall advise DHHS. Prior approval from the Medicaid Director is required for subsequent services provided to the Member.

6.3 Medical Loss Ratio

6.3.1 Minimum Medical Loss Ratio Performance and Rebate Requirements

6.3.1.1 The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher. In the event the MCO's MLR for any single reporting year does not meet or exceed the eighty-five percent (85%) requirement, the MCO shall provide to DHHS a rebate that amounts to the difference between the total amount of Capitation Payments received by the MCO from DHHS multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR. [42 CFR 438.8(j); 42 CFR 438.8(c)]

6.3.1.2 If the MCO fails to pay any rebate owed to DHHS in accordance with the time periods set forth by DHHS, in addition to providing the required rebate to DHHS, the MCO shall pay DHHS interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate.

6.3.2 Calculation of the Medical Loss Ratio

6.3.2.1 The MCO shall calculate and report to DHHS the MLR for each MLR reporting year, in accordance with 42 CFR 438.8 and the standards described within this Agreement. [42 CFR 438.8(a)]

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6.3.2.2 The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). [42 CFR 438.8 (d)-(f)].

6.3.2.3 Each MCO expense must be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between the two types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. [42 CFR 438.8(g)(1)(i)-(ii)]

6.3.2.4 Expense allocation must be based on a generally accepted accounting method that is extended to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities. [42 CFR 438.8(g)(2)(i)-(iii)]

6.3.2.5 The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment, if included, must be added to the reported MLR calculation prior to calculating any remittances. The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 Medical Loss Ratio Reporting

6.3.3.1 The MCO shall submit MLR summary reports quarterly to DHHS in accordance with Exhibit O [42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)]. The MLR summary reports shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year, including:

6.3.3.1.1 Total incurred claims;

6.3.3.1.2 Expenditures on quality improvement activities;

6.3.3.1.3 Expenditures related to activities compliant with the program integrity requirements;

6.3.3.1.4 Non-claims costs;

6.3.3.1.5 Premium revenue;

6.3.3.1.6 Taxes;

6.3.3.1.7 Licensing fees;

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- 6.3.3.1.8 Regulatory fees;
- 6.3.3.1.9 Methodology(ies) for allocation of expenditures;
- 6.3.3.1.10 Any credibility adjustment applied;
- 6.3.3.1.11 The calculated MLR;
- 6.3.3.1.12 Any remittance owed to NH, if applicable;
- 6.3.3.1.13 A comparison of the information reported with the audited financial report;
- 6.3.3.1.14 A description of the aggregate method used to calculate total incurred claims; and
- 6.3.3.1.15 The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)]

6.3.3.2 The MCO must attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS [42 CFR 438.8(n); 42 CFR 438.8(k)]. Such summary reports shall be based on a template provided and developed by DHHS within sixty (60) calendar days of the Program Start Date. [42 CFR 438.8(a)]

6.3.3.3 The MCO shall in its MLR summary reports aggregate data for all Medicaid eligibility groups covered under this Agreement unless otherwise required by DHHS. [42 CFR 438.8(i)]

6.3.3.4 The MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) days or the end of the MLR reporting year or within thirty (30) days of a request by the MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.5 In any instance in which DHHS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHHS, the MCO shall:

6.3.3.5.1 Re-calculate the MLR for all MLR reporting years affected by the change; and

6.3.3.5.2 Submit a new MLR report meeting the applicable requirements. [42 CFR 438.8(m); 42 CFR 438.8(k)]

6.3.3.6 The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

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6.4 Financial Responsibility for Dual-Eligible Members

6.4.1 For Medicare Part A crossover claims, and for Medicare Part B crossover claims billed on the UB-04, the MCO will pay the patient responsibility amount (deductible and coinsurance). For Part B crossover claims billed on the CMS-1500, the MCO will pay the lesser of 1) the patient responsibility amount (deductible and coinsurance), or 2) the difference between the amount paid by the primary payer and the Medicaid allowed amount. For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO will make no payment.

6.5 Medical Cost Accruals

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The MCO shall allow DHHS and/or the NHID to inspect and audit any of the financial records of the MCO and its Subcontractors. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.2 The MCO shall file annual and interim financial statements in accordance with the standards set forth in this Section of the Agreement. This Section shall supersede any conflicting requirements in Exhibit C (Special Provisions) of this Agreement.

6.6.3 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant. Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

6.6.4 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.5 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

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6.7 Member Liability

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1 The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2 The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3 The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4 Payments for Covered Services furnished under an Agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c); section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to DHHS that its provision against the risk of insolvency is adequate to ensure that Medicaid Members will not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly [Section 1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMDL 12/30/97].

6.7.4 The MCO shall cover continuation of services to Members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency [SMM 2086.6B].

6.7.5 The MCO must meet DHHS's solvency standards for private health maintenance organizations, or be licensed or certified by DHHS as a risk-bearing entity. [Section 1903(m)(1) of the Social Security Act; 42 CFR 438.116(b)]

6.8 Denial of Payment

6.8.1 Payments provided for under the Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS. CMS may deny payment to the state for new Members if its determination is not timely contested by the MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)].

6.9 Federal Matching Funds

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and

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Section 1903(i)(2) of the SSA; SMDL 12/30/97]. Payments made to such Providers are subject to recoupment from the MCO by DHHS.

6.10 Health Insurance Providers Fee

6.10.1 The Affordable Care Act imposed an annual fee on health insurance Providers beginning in 2014 ("Annual Fee"). The MCO is responsible for a percentage of the Annual Fee for all health insurance Providers as determined by the ratio of MCO's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year. To the extent such fees exist and DHHS is legally obligated to pay such fees under Federal law:

6.10.1.1 The State shall reimburse the MCO for the amount of the Annual Fee specifically allocable to the premiums paid during the Term of this Agreement for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The MCO's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount MCO or MCO's parent receives from the United States Internal Revenue Service. The State will provide reimbursement no later than 120 days following its review and acceptance of the MCO's Adjusted Fee.

6.10.1.2 To claim reimbursement for the MCO's Adjusted Fee, the MCO must submit a certified copy of its full Annual Fee assessment within 60 days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Agreement. The MCO must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or CEO/Executive Director, certifying the accuracy, truthfulness and completeness of the data provided.

6.11 Third Party Liability

6.11.1 NH Medicaid shall be the payor of last resort for all Covered Services in accordance with federal regulations. The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.2 DHHS and the MCO will cooperate in implementing cost avoidance and cost recovery activities.

6.11.3 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

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6.11.4 DHHS shall conduct two (2) TPL policy and procedure audits of the MCO and its Subcontractors per Agreement year. Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

6.11.5 The MCO shall have one (1) dedicated contact person for DHHS for TPL. DHHS and its actuary will identify a market-expected median TPL percentage amount and deduct an appropriate amount from the gross medical costs included in the DHHS Capitation Payment rate setting process. All cost recovery amounts, even those greater than identified in the rate cells, shall be retained by the MCO.

6.11.6 The MCO and its Subcontractors shall comply with all regulations and state laws related to Third-Party Liability, including but not limited to:

6.11.6.1 42 CFR 433.138

6.11.6.2 42 CFR 433.139

6.11.6.3 RSA 167:14-a

6.11.7 Cost Avoidance

6.11.7.1 The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans and workers compensation.

6.11.7.2 The MCO must establish claims edits and deny payment of claims when active Medicare or active private insurance exists at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.11.7.3 The MCO shall deny payment on a claim that has been denied by Medicare or private insurance when the reason for denial is the Provider or Member's failure to follow prescribed procedures, including but not limited to failure to obtain Prior Authorization or timely claim filing. The MCO shall establish claim edits to ensure claims with Medicare or private insurance denials are properly denied by the MCO.

6.11.7.4 The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance or Medicare if either:

6.11.7.4.1 The primary payor does not cover the services and the MCO does; or

6.11.7.4.2 The service was denied as not Medically Necessary and the Provider followed the dispute resolution and/or Appeal

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Process of the private insurance or Medicare and the denial was upheld.

6.11.7.5 If a claim is denied by the MCO based on active Medicare or active private insurance, the MCO shall provide the Medicare or private insurance information to the Provider.

6.11.7.6 To ensure the MCO is cost avoiding, the MCO must implement a file transfer protocol between DHHS MMIS and the MCO's MCIS to receive and send Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138.

6.11.7.7 The MCO must implement a nightly file transfer protocol with its Subcontractors to ensure Medicare, private health insurance, ERISA, 29 U.S.C. 1396a(a)(25) plans, and workers compensation policy information is updated and utilized to ensure claims are properly denied for Medicare or private insurance.

6.11.7.8 The MCO shall establish, at a minimum, monthly electronic data matches with private insurance companies (Medical and pharmacy) that sell insurance in NH to obtain current and accurate private insurance for their Members. The MCO shall maintain the following private insurance data within their system for all insurance policies that a Member may have and include for each policy:

6.11.7.8.1 Member's first and last name;

6.11.7.8.2 Member's policy number;

6.11.7.8.3 Member's group number, if available;

6.11.7.8.4 Policyholder's first and last name;

6.11.7.8.5 Policy coverage type to include at a minimum:

6.11.7.8.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below).

6.11.7.8.5.2. Hospital coverage,

6.11.7.8.5.3. Pharmacy coverage,

6.11.7.8.5.4. Dental coverage, and

6.11.7.8.5.5. Vision Coverage;

6.11.7.8.6 Begin date of insurance; and

6.11.7.8.7 End date of insurance (when terminated).

6.11.7.9 The MCO shall submit any new, changed, or terminated private insurance data to DHHS through file transfer on a weekly basis.

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6.11.7.10 The MCO shall not cost avoid claims for preventive pediatric services (including EPSDT), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3). The MCO shall pay all preventive pediatric services and collect reimbursement from private insurance after the claim adjudicates.

6.11.7.11 The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable.

6.11.7.12 On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O. This report will reflect the number of claims and dollar amount avoided by private insurance and Medicare for all types of coverage:

6.11.7.12.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.11.7.12.2 Hospital coverage;

6.11.7.12.3 Pharmacy coverage;

6.11.7.12.4 Dental coverage; and

6.11.7.12.5 Vision coverage.

6.11.8 Post Payment Recovery

6.11.8.1 Definitions

6.11.8.1.1 Pay and Chase means recovery of claims paid in which Medicare or private insurance was not known at the time the claim was adjudicated.

6.11.8.1.2 Subrogation means personal injury, liability insurance, automobile/home insurance, or accident indemnity insurance.

6.11.8.2 Pay and Chase Private Insurance

6.11.8.2.1 If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company.

6.11.8.2.2 The MCO shall submit quarterly recovery reports, in accordance with Exhibit O. These reports will reflect detail and summary information of the MCOs collection efforts and recovery from Medicare and private insurance for all types of coverage:

6.11.8.2.2.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

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- 6.11.8.2.2.2. Hospital coverage;
- 6.11.8.2.2.3. Pharmacy coverage;
- 6.11.8.2.2.4. Dental coverage; and
- 6.11.8.2.2.5. Vision Coverage.

6.11.8.2.3 The MCO shall have eight (8) months from last date of service to recover funds from private insurance. If funds have not been recovered by that date, DHHS has the sole and exclusive right to pursue, collect, and retain funds from private insurance.

6.11.8.2.4 The MCO shall treat funds recovered from private insurance as offsets to the claims payments by posting within the claim system. The MCO shall post all payments to claim level detail by Member. Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member. Amounts beyond a Member's outstanding claims shall be returned to the Member.

6.11.8.2.5 The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.8.3 Subrogation Recoveries

6.11.8.3.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.11.8.3.2 The MCO shall establish detailed policies and procedures for determining, processing, and recovering funds based on accident and trauma Subrogation cases. The MCO shall submit its policies and procedures to DHHS for approval during the first Readiness Review. The MCO shall have in its policies and procedures, at a minimum, the following:

- 6.11.8.3.2.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party. The claims required to be identified, at a minimum, should include ICD-10

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diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y". The MCO shall present a list of ICD-10 diagnostic codes to DHHS for approval in identifying claims for review. DHHS reserves the right to require specific codes be reviewed by MCO.

6.11.8.3.2.2. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members. The MCO shall submit a report of letters generated and sent as described in Exhibit O.

6.11.8.3.2.3. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indicators.

6.11.8.3.2.4. The MCO shall respond to accident referrals and lien request within 21 days of the notice per RSA 167:14-a.

6.11.8.3.3 The MCO shall establish a case tracking system to monitor and manage Subrogation cases. This system will allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

6.11.8.3.3.1. Date inquiry letter sent to Member, if applicable;

6.11.8.3.3.2. Date inquiry letter received back from Member, if applicable;

6.11.8.3.3.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;

6.11.8.3.3.4. Date case is established;

6.11.8.3.3.5. Date of incident;

6.11.8.3.3.6. Reason for incident;

6.11.8.3.3.7. Claims associated with incident;

6.11.8.3.3.8. All correspondence and dates;

6.11.8.3.3.9. Case comments by date;

6.11.8.3.3.10. Lien amount and date updated;

6.11.8.3.3.11. Settlement amount;

6.11.8.3.3.12. Date settlement funds received; and

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6.11.8.3.3.13. Date case closed.

6.11.8.3.4 The MCO shall submit Subrogation reports in accordance with Exhibit O. [42 CFR 433 Sub D; 42 CFR 447.20] DHHS will inform the MCO of any claims related to an MCO Subrogation cases. The MCO is required to submit to DHHS any and all information regarding the case if DHHS also has a Subrogation lien. DHHS claims shall be paid first in any dual Subrogation settlement.

6.11.8.3.5 The MCO shall submit to DHHS for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement. DHHS will have twenty (20) business days to review the case once the MCO provides all relevant information as determined by DHHS to approve the settlement from date received from MCO. If DHHS does not respond within twenty (20) business days, the MCO may proceed with settlement. If DHHS does not approve of the settlement agreement, then DHHS will work with the MCO and other parties on the settlement.

6.11.8.3.6 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign DHHS all rights to such cases to complete and collect on those Subrogation settlements. DHHS will retain all recoveries after Agreement termination.

6.11.8.3.7 The MCO shall treat funds recovered due to Subrogation, if not processed as part of claims, outside of the claims processing system as offsets to medical expenses for the purpose of reporting.

6.11.8.4 Medicare

6.11.8.4.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable. The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process [42 CFR 438.3(t)]. A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.11.8.4.2 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.11.8.4.2.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

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6.11.8.4.2.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.11.8.4.2.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and will establish claims edits and deny part D for those part C Members.

6.11.8.4.3 If Medicare was not known or active at the time a claim was adjudicated but was determined active or retroactive at a later date, the MCO shall recoup funds from the Provider and require the Provider to pursue Medicare payment for all claim types except Medicare part D. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.8.4.4 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the timely filing requirements. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.8.4.5 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.11.8.4.6 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4 (Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment.

6.11.8.4.7 The MCO shall pay any wrap around services not covered by Medicare that are services under the Medicaid State Plan Amendment and this Agreement.

6.11.8.5 Estate Recoveries

6.11.8.5.1 DHHS shall be solely responsible for estate recovery activities and shall retain all funds recovered through these activities.

7 TERMINATION OF AGREEMENT

7.1 Termination for Cause

7.1.1 DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part if the MCO:

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- 7.1.1.1 Takes any action or fails to prevent an action that threatens the health, safety or welfare of any Member, including significant Marketing abuses;
- 7.1.1.2 Takes any action that threatens the fiscal integrity of the Medicaid program;
- 7.1.1.3 Has its certification suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non- procurement Agreement;
- 7.1.1.4 Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;
- 7.1.1.5 Violates State or federal law or regulation;
- 7.1.1.6 Fails to carry out the substantive terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;
- 7.1.1.7 Becomes insolvent;
- 7.1.1.8 Fails to meet applicable requirements in Sections 1932, 1903 (m) and 1905(t) of the Social Security Act.; [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]
- 7.1.1.9 Received a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency;
- 7.1.1.10 Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily under Title 11 of the U.S. Code.

7.2 Termination for Other Reasons

7.2.1 The MCO shall have the right to terminate this Agreement if DHHS fails to make agreed-upon payments in a timely manner; or fails to comply with any material term or condition of this Agreement; provided that, DHHS has not cured such deficiency within sixty (60) days of its receipt of notice of such deficiency.

7.2.2 This Agreement may be terminated by either MCO or DHHS as of the last day of any month upon no less than one-hundred twenty (120) days prior written notice to the other Party.

7.2.3 This Agreement may terminate immediately if federal financial participation in the costs hereof becomes unavailable or if state funds sufficient to fulfill its obligations of DHHS hereunder are not appropriated by the Legislature. In either event, DHHS shall give MCO prompt written notice of such termination.

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7.2.4 Notwithstanding the above, the MCO shall not be relieved of liability to DHHS or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.5 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to DHHS immediately on demand.

7.3 Transition Assistance

7.3.1 DHHS may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if DHHS determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act] In such event, Section 4.7.9 (Access to Providers During Transition of Care) shall apply.

7.4 Claims Responsibilities

7.4.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.4.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.7.3 (Service Authorization/Continuity of Care) below, or if the service is provided through the date of discharge.

7.5 Final Obligations

7.5.1 DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Amounts due to MCO for unpaid premiums, risk settlement, High Dollar Stop Loss, shall be paid to MCO within one (1) year of date of termination.

7.6 Survival of Terms

7.6.1 Termination or expiration of this Agreement for any reason will not release either the MCO or DHHS from any liabilities or obligations set forth in this Agreement that:

7.6.1.1 The parties have expressly agreed shall survive any such termination or expiration; or

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

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7.7 Agreement Closeout

7.7.1 Period

7.7.1.1 DHHS shall have the right to define the close out period in each event of termination, and such period shall take into consideration factors such as the reason for the termination and the timeframe necessary to transfer Members. During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS. Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

7.7.2 Data

7.7.2.1 The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including but not limited to Encounter Data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new MCO and/or DHHS shall define the information required during this period and the time frames for submission.

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

7.7.2.3 The MCO shall be responsible for continued submission of data to the CHIS during and after the transition in accordance with NHID regulations.

7.7.3 Service Authorization/Continuity of Care

7.7.3.1 Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received. Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS.

7.7.3.2 The MCO shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

7.7.3.3 The Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for the period referenced in Section 4.7.9 (Access to Providers

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During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.7.3.4 The Member is referred to appropriate Participating Providers.

7.7.3.5 The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization data from the new MCO in compliance with State and federal law.

7.7.3.6 Consistent with State and federal law, the Member's new Provider(s) are able to obtain copies of the Member's medical records, as appropriate.

7.7.3.7 Any other necessary procedures as specified by the HHS Secretary to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

7.7.3.8 DHHS shall make any other transition of care requirements publically available.

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Exhibit B – Methods and Conditions Precedent to Payment



Method and Conditions Precedent to Payment

Placeholder, defined at contract phase

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Exhibit L – MCOs Implementation Plan



MCOs Implementation Plan

Placeholder, defined at contract phase and as approved by DHHS

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Exhibit M - Reserved



RESERVED FOR FUTURE USE



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Exhibit N

Liquidated Damages Matrix

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
1. LEVEL 1 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	\$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	\$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	\$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	\$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing failure to meet minimum care management, care coordination and transition of care policy requirements	\$25,000 per week of violation
	1.6 Continuing failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including regarding the full continuum of care for members with substance use disorders	\$25,000 per week of violation
	1.7 Continuing failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7.5.	\$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan \$100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	\$25,000 per violation
	1.9 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	\$10,000 per month of violation (for each month that DHHS determines that the MCO is not substantially in compliance)
	1.10 Continuing failure to resolve member appeals and grievances within specified timeframes	\$25,000 per violation
	1.11 Failure to submit timely, accurate, and/or complete encounter data submission in the required file format <i>(For submissions more than 30 calendar days late, DHHS reserves the right</i>	\$5,000 per day the submission is late



Appendix C – Medicaid Care Management Services Model Contract **Exhibit N** **Liquidated Damages Matrix**

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	<i>to withhold 5% of the aggregate capitation payments made to the MCO in that month until such time as the required submission is made)</i>	
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	\$25,000 per violation
	1.13 Failure to adhere to the Preferred Drug List requirements	\$25,000 per violation
	1.14 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 2 violation	\$25,000 per violation
	1.15 Continued failure to comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder	\$50,000 per violation for continuing failure
	1.16 Continued failure to meet the requirements for minimizing psychiatric boarding	\$5,000 per day for continuing failure
	1.17 In-network provider not enrolled with NH Medicaid	\$1,000 per provider not enrolled, \$500 per additional day provider is not suspended once MCO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.18 Failure to notify a member of DHHS senior management within eight (8) hours of a Member reporting an allegation of a serious criminal offense against the Member by any employee or Subcontractor of the MCO	\$50,000 per violation
	1.19 Two or more Level 1 violations within a contract year	\$75,000 per occurrence
2. LEVEL 2 MCO action(s) or inaction(s) that jeopardize the integrity of the	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	\$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified)

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Liquidated Damages Matrix

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
managed care program, but does not necessarily jeopardize member(s) health, safety, and welfare or access to care.	2.2 Failure to maintain the privacy and/or security of data containing protected health information (PII) which results in a breach of the security of such information and/or timely report violations in the access, use, and disclosure of PII	\$100,000 per violation
	2.3 Failure to meet prompt payment requirements and standards	\$25,000 per violation
	2.4 Failure to cost recover at least 1% of claims in the first year of the contract, 1.2% in the second year, and 1.5% in contract years 3, 4, and 5	\$50,000 per violation
	2.5 Failure to cost avoid claims of known third party liability (TPL)	\$250 per member and total claim amount paid that should have been cost avoided
	2.6 Failure to collect overpayments for fraud, waste, and abuse in the amount of 0.10% of claims in the first year of the contract, 0.12% in the second year, and 0.15% in years 3, 4, and 5	\$50,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud, waste, or abuse to DHHS annually	\$10,000 unless good cause determined by Program Integrity
	2.8 EQR or other program audit reports with substantial findings	\$10,000 per violation
	2.9 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	\$5,000 per violation
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	\$5,000 per day of violation
	2.11 Member in pharmacy “lock-in” program not locked into a pharmacy and no documentation as to waiver or other excuse for not being locked in	\$500 per member per occurrence and total pharmacy claims amount paid while not locked-in
	2.12 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 3 violation	\$25,000 per week of violation
	2.13 Failure to suspend or terminate providers in which it has been determined that the provider has committed a violation or is under fraud	\$500 per day of violation



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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	investigation	
	2.14 Failure to process a provider credentialing application timely	\$5,000 per delayed application and \$1,000 per each day the application is delayed
	2.15 Failure to meet performance standards in the contract which include case management measures (Section 4.10.2.6, 4.10.6.2, 4.10.8.2), claims processing (Section 4.15.8.2, 4.18.1.3, 4.18.2.2, 4.18.3-4.18.5), call center performance (Section 4.4.4.2.3.1 & 4.13.4.1.2), transportation rides (Section 4.1.9.3 & 4.1.9.7), and service authorization processing (Section 4.2.3.7.1 & 4.8.4.1)	\$1,000 per violation
	2.16 Two or more Level 2 violations within a contract year	\$50,000 per occurrence
3. LEVEL 3 MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring DHHS review and/or approval	\$10,000 per violation
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	\$10,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	\$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	\$10,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (50% of the lien amount)	\$10,000 per violation
	3.6 Failure to enforce provisions under its agreements with Subcontractor	\$25,000 per violation
	3.7 Failure to submit and obtain DHHS review and approval for applicable Subcontracts	\$25,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	\$10,000 per violation



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Liquidated Damages Matrix

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 4 violation	\$25,000 per week of violation
	3.10 Failure to meet minimum social services and community care requirements, as described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of the contract, with respect to unmet resource needs of members	\$10,000 per violation
	3.11 Failure to ensure that clinicians conducting or contributing to a comprehensive assessment are certified in the use of New Hampshire's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within the specified timeframe	\$10,000 per violation
	3.12 Two or more Level 3 violations within a contract year	\$100,000 per occurrence
4. LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports)	\$500 per day of violation
	4.2 Failure to comply with timeframes for distributing (or providing access to) beneficiary handbooks, identification cards, provider directories, and educational materials to beneficiaries (or potential members)	\$5,000 per violation
	4.3 Failure to meet minimum requirements requiring coordination and cooperation with external entities (e.g., the New Hampshire Medicaid Fraud Control Unit, Office of the Inspector General) as described in the contract	\$5,000 per violation
	4.4 EQR or other program audit reports with non-significant findings	\$5,000 per occurrence
	4.5 Failure to meet staffing requirements	\$5,000 per violation
	4.6 Failure to ensure provider agreements include all required provisions	\$10,000 per violation



EXHIBIT O – Quality and Oversight Reporting Requirements

1. General

- 1.1. The list of deliverables in Exhibit O provides a high level summary of what each deliverable will entail.
Please note all information is subject to revision and refinement as NH DHHS finalizes the specifications for each deliverable.
- 1.2. The Exhibit O measures/measure sets, logs, and narrative reports shall be submitted according to the specified schedule. Submission formats shall be either the standard HEDIS submission format for HEDIS measures or as specified by NH DHHS for other measures, data tables and reports.
- 1.3. NH DHHS utilizes measures from several measure stewards, including NCQA and the Pharmacy Quality Alliance (PQA). The MCOs are responsible for contracting with these entities or associated vendors as appropriate for producing deliverables.
- 1.4. To help insure the successful generation of consistent Exhibit O deliverables (both over time for each MCO and also across all MCOs), the following processes will be in place:
 - 1.4.1. NH DHHS shall:
 - 1.4.1.1. Identify specifications for each deliverable;
 - 1.4.1.2. Engage the MCOs in the development of measures as appropriate;
 - 1.4.1.3. Schedule “Exhibit O” meetings (webinars, typically held on Friday afternoons) with the MCOs to:
 - 1.4.1.3.1. Review all deliverable specifications;
 - 1.4.1.3.2. Provide clarifications as needed by the MCOs;
 - 1.4.1.3.3. Establish initial due dates for all deliverables;
 - 1.4.1.4. Provide training for use of the NH Medicaid Quality Information System (MQIS) and the DHHS SFTP site;
 - 1.4.1.5. Contact MCO compliance staff to validate suspected reporting discrepancies.
 - 1.4.2. MCO compliance staff and appropriate subject matter experts (SMEs) shall:
 - 1.4.2.1. Review all specifications for clarity and request more information as needed;
 - 1.4.2.2. Participate in measure development activities as appropriate;
 - 1.4.2.3. Participate in the “Exhibit O” meetings;
 - 1.4.2.4. Follow the finalized specifications for submission of deliverables;
 - 1.4.2.5. Gain access to and utilize the MQIS, including participation in any DHHS-required training necessary;
 - 1.4.2.6. Submit all data as required to MQIS using MQIS specified formats;
 - 1.4.2.7. Submit deliverables as required to the DHHS SFTP site;
 - 1.4.2.8. Respond to system generated error reports;
 - 1.4.2.9. Respond to requests from DHHS staff to validate suspected reporting discrepancies.
- 1.5. The Department reserves the right to develop and require alternative methodologies to submit data.

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EXHIBIT O – Quality and Oversight Reporting Requirements

2. Key Definitions

2.1. The following terms include some of the unique or new terms found in Exhibit O. Please reference the model contract for more details.

Term	Definition
2.1.1. Community Hospital	Any hospital other than New Hampshire Hospital
2.1.2. Community Mental Health Program or CMHP	<p>A program established and administered by the state, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, case management, and psychotherapy services [RSA 135-C:2, IV]. A CMHP is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.</p> <p><i>Formerly referred to as Community Mental Health Center or CMHC.</i></p>
2.1.3. High Risk / High Need	<i>See Section 4.10.6 of the model contract.</i>
2.1.4. Local Care Management	<p>Local Care Management shall mean that the MCO will provide real time, high touch, in-person Care Management and consistent follow up with Providers and Members to assure that selected Members are making progress with their Care Plans.</p> <p><i>See Section 4.10.8 of the model contract.</i></p>
2.1.5. Priority Populations	<p>Populations that are most likely to have Care Management needs and are most able to benefit from Care Management.</p> <p><i>See Section 4.10.3 of the model contract.</i></p>
2.1.6. Subpopulations	<p>Subpopulations are made up of components used together to classify a member. Subpopulation methodology will vary depending on the measure. Subpopulations are used for selected measures as indicated in the NH Medicaid Care Management Quality and Oversight Reporting Deliverables table below. Note: some measures use more than one subpopulation method. The following subpopulations are used:</p> <ul style="list-style-type: none">• General• Granite Advantage Waiver• SUD IMD Waiver <p><u>General:</u></p> <ul style="list-style-type: none">• The General subpopulation is made up of the following components: Age Group, Member Type, LTSS Type, and Payer Type. Measures use specific components in conjunction based on the measurement intent.• Each component is broken down into categories that have standardized

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	<p>definitions used consistently across all measures. The categories for the components are:</p> <ul style="list-style-type: none">○ Age Group (<i>Children, Adults, Older Adults</i>),○ Member Type (<i>DCYF Involved Child, Child with Severe Disabilities (HC-CSD, SSI, SMS), Other Special Needs Child, Other Child, Special Needs Adult, All Other Adults, All Older Adults</i>),○ LTSS Type (<i>Receiving LTC Services (Waiver or Nursing Home), Eligible for CMHC Services and Not Also Waiver/Nursing Home, Not Receiving Waiver, CMHC, or Nursing Home</i>), and○ Payer Type (<i>Medicaid Primary, Medicare Primary, Other Primary</i>) <p><u>Granite Advantage Waiver:</u></p> <ul style="list-style-type: none">• The Granite Advantage Waiver subpopulation components are those necessary to meet Centers for Medicare and Medicaid Services (CMS) waiver requirements for monitoring and evaluation. <p><u>SUD IMD Waiver:</u></p> <ul style="list-style-type: none">• The SUD IMD Waiver subpopulation components are those necessary to meet Centers for Medicare and Medicaid Services (CMS) waiver requirements for monitoring and evaluation.
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NH Medicaid Care Management Quality and Oversight Reporting Deliverables

Note: Table is Sorted by Domain and Reporting Reference ID; purpose of monitoring is the primary purpose for monitoring; in addition all measures are monitored by DHHS for its general monitoring of managed care plans.

Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PDN.04	Access	Private Duty Nursing: RN-Level Hours Delivered and Billed	The number of RN level private duty nursing hours delivered and billed by day/weekend/night, and intensive (ventilator dependent) modifiers (S9123, S9123 U1, S9123 U2). The hours will be reported out by adult (age 21+) and pediatric (age 0-20) beneficiary categories on a quarterly basis to ensure that private duty nursing payments are achieving their intended purpose of increasing access to private duty nursing services.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PDN.05	Access	Private Duty Nursing: LPN-Level Hours Delivered and Billed	The number of LPN level private duty nursing hours delivered and billed by day/weekend/night, and intensive (ventilator dependent) modifiers (S9124, S9124 U1). The hours will be reported out by adult (age 21+) and pediatric (age 0-20) beneficiary categories on a quarterly basis to ensure that private duty nursing payments are achieving their intended purpose of increasing access to private duty nursing services.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
PDN.07	Access	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X
ANNUALRPT.01	Care Management	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's report on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other	Agreement Year	Narrative and Analytic Report		Annually	August 30th								X		X

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Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
			stakeholders. From the health plan’s perspective, the report will connect outcomes and opportunities for both clinical and operational improvement. While the health plans have flexibility on the detailed specific content, the report must cover the following topics in the order of the table of contents provided in the specification. When applicable, the health plan will assess each topic’s impact on members, providers, program quality, and cost. Text and graphics will be used to produce a report that is engaging and informative to a public audience in plain language. The report should be between 20 and 80 pages and will be posted on the New Hampshire Medicaid Quality and health plan website.															
CARECOORD.03	Care Management	Case Management: Neonatal Abstinence Syndrome Referrals	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter referred to case management within 30 calendar days of diagnosis.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period										X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CARECOORD.04	Care Management	Case Management: Neonatal Abstinence Syndrome Engagement	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter who enrolled with the MCO care management program within 30 days of the referral.	Quarter	Measure		Quarterly	5 Months after end of Measurement Period										X
CAREMGT.01	Care Management	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Overview of the MCO comprehensive care management and an assessment of MCO care management, with comprehensive care coordination across its health plan, other payers, fee-for-service Medicaid, community services and other health and social service providers; promoting and assuring service accessibility; centered on individual member and care giver needs with member and family involvement; community centered; culturally appropriate care. The plan will also include the MCO's local care management plan describing the structure, the percentage of high-risk/high-need members serviced, the list of designated local care management entities that will conduct the local care management, and description	N/A	Plan		Annually	May 1st										X



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Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
			of the geography and priority populations the designated local entities will serve. The plan will also include the MCO's risk scoring and stratification methodology which shall include but not be limited to: information and data to be utilized; description of the methodology; methodology for identifying high risk/ high need Members who are not Priority Populations; number of risk strata; criteria for each risk stratum; and approximate expected population in each stratum. In the second agreement year, the MCO shall include an appendix to the plan that includes the number of members broken out by each of the risk stratum as well as referrals for social services and community care provided to members.															
CAREMGT.22	Care Management	Care Management: Comprehensive Assessments Completed for Priority Populations	Count and percent of members newly identified as being in one or more priority population during the quarter, who have a completed comprehensive assessment.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.23	Care Management	Care Management: Comprehensive Assessments Completed for Priority Populations by Subcontractors	Count and percent of members newly identified as being in one or more priority population during the quarter, who have a completed comprehensive assessment by a subcontractor (e.g. Independent Delivery Networks, Community Mental Health Programs, Special Medical Services, HCBS case managers, and Area Agencies.)	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.24	Care Management	Care Management: Comprehensive Assessments Completed for Priority Populations Within 30 Calendar Days	Count and percent of members newly identified as being in one or more priority population during the quarter, have a completed comprehensive assessment within 30 calendar days of identification.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.25	Care Management	Care Management: Care Plans Disseminated within 14 Calendar Days	Count and percent of members with a new care plan established during the quarter, in which the plan was distributed in writing to members of the local based care team within 14 calendar days. The local care team includes but is not limited to the member's PCP, specialist, behavioral health provider, and local community based care team.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.26	Care Management	Care Management: Local Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.27	Care Management	Care Management: Members Identified as High Risk Receiving Care Management	Count and percent of members identified as "high-risk"/"high-need" through the comprehensive assessment during the quarter, who are enrolled in care management. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.28	Care Management	Care Management: Members Receiving Care Management by Priority Population	Standard template capturing quarterly counts of members enrolled in care management, including local and plan administered, during the quarter broken out by priority populations outlined in the Care Coordination and Care Management section of the MCM Model Contract. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.29	Care Management	Care Management Outreach: High Risk Members	Count and percent of members identified as "high-risk"/"high-need" through the comprehensive assessment, who receive outreach to enroll in care management.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.30	Care Management	Care Management: Members Receiving Local Care Management	Count and percent of members who are enrolled in care management and receiving local care management. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.31	Care Management	Care Management: Median Days Members Enrolled by Local Care Management and Plan Care Management	Median number of days enrolled in care management for members who were discharged from care management during the quarter. The measure will include enrollment in local care management and plan care management. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.32	Care Management	Care Management: Members Enrolled in Local Care Management Who Receive a Face-to-Face Care Management	Count and percent of members enrolled in local care management during the quarter, who had at least one face to face meeting with their local case manager during the quarter. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.33	Care Management	Care Management - Members Receiving Local Care Management who are High Risk Members	Count and percent of member receiving local care management who were identified as "high-risk"/"high-need" by the comprehensive assessment. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
CAREMGT.34	Care Management	Care Management: Members Enrolled in Care Management by Subpopulation	Count and percent of members enrolled in care management during the quarter by subpopulation breakouts. Enrollment in care management is defined as the member having a completed plan of care.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			X

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Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.35	Care Management	Care Management: Member Referrals to DHHS's Tobacco Cessation Programs	Count of the number of member referrals made to the NH DHHS Tobacco Cessation Programs (e.g. Quit Line, Cessation Coaching / Counseling) during the quarter. The total should include referrals made by the MCO member call centers, case managers, and other MCO staff and contractors that are able to make referrals.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
HRA.04	Care Management	Health Risk Assessment: Best Effort to Have New Member Conduct MCO's Health Needs Self-Assessment	Count and percent of new members in the quarter in which the MCO made at least three attempts, by phone, to complete the Health Risk Assessment within 90 calendar days of the member's enrollment. The rate also includes all members who complete the health risk assessment within 90 calendar days, regardless of the number of MCO attempts to contact the member.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								X		X
HRA.05	Care Management	Health Risk Assessment: New Member Successfully Completed MCO's Health Needs Self-Assessment	Count and percent of new members in the quarter who successfully complete the Health Risk Assessment within 90 calendar days of the enrollment.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								X		X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
APPEALS.01	Grievances & Appeals	Appeals Resolution: Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals received during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								x		x
APPEALS.02	Grievances & Appeals	Appeals Resolution: Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								x		x
APPEALS.03	Grievances & Appeals	Appeals Resolution: Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								x		x
APPEALS.04	Grievances & Appeals	Appeals Resolution: Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								x		x
APPEALS.05	Grievances & Appeals	Appeals Resolution: Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								x		x

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
APPEALS.16	Grievances & Appeals	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Quarter	Table		Quarterly	2 Months after end of Measurement Period						X	X	X		
APPEALS.17	Grievances & Appeals	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Standard template providing counts of MCO appeals resolutions by resolution type and category of pharmacy class	Quarter	Table		Quarterly	2 Months after end of Measurement Period						X	X	X		
APPEALS.18	Grievances & Appeals	Appeals Reversed: Service Authorized Within 72 Hours Following Reversed Appeal	Count and percent of services authorized within 72 hours following a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								x		X
APPEALS.19	Grievances & Appeals	Appeals Received: Member Initiated	Count and percent of Member appeals filed during the measurement data period, per 1,000 member months.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								X		x
GRIEVANCE.01	Grievances & Appeals	Grievances: Dispositions Made Within 45 Calendar Days	Count and percent of grievance dispositions made within 45 calendar days of receipt of the grievance for grievances made within the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period	X							X		

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
GRIEVANCE.02	Grievances & Appeals	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Quarter	Table		Quarterly	15 Calendar Days after end of Measurement Period						X	X	X		
GRIEVANCE.03	Grievances & Appeals	Grievances: Received from Member	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								X		
ACCIDENT.01	MCO Operations	Accident and Trauma Claim Log	Standard template of MCO monthly detailed paid claim history log related to cases identified by DHHS as possible accident and trauma. This report will provide DHHS with a monthly detailed paid/void/adjusted claim history log related to cases identified by DHHS as possible accident and trauma through the monthly "MCO recovery cases" request provided to the MCOs by DHHS.	Month	Table		Monthly	15 Calendar Days after end of Measurement Period								X		X
ACCRED.01	MCO Operations	NCQA Accreditation Submission Overview Report	The NCQA Submission Overview Report provides detailed information about NCQA accreditation results and areas for improvement. NCQA makes this report available via the Interactive Review Tool.	Per NCQA Accreditation Schedule	Narrative Report		Per NCQA Accreditation Schedule	15 Calendar Days after MCO Receives Final Accreditation Results from NCQA.							x	x		

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APM.01	MCO Operations	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Varies	Plan		Annually	May 1st				X						X
APM.02	MCO Operations	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Varies	Table		Quarterly	January 31st				X						X
APM.03	MCO Operations	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf ; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Varies	Narrative Report		Annually	May 1st				X						X
CLAIM.05	MCO Operations	Claims: Processing Accuracy	Sampled percent of professional and facility clean claims that are accurately processed in their entirety from both a financial and non-financial perspective. Note: Claims include both Medical and Behavioral Health claims.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period							X	X		X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CLAIM.06	MCO Operations	Claims: Payment Accuracy	Sampled percent of clean professional and facility claims correctly paid. Note: Claims include both Medical and Behavioral Health claims.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period							X	X		X
CLAIM.07	MCO Operations	Claims: Financial Accuracy	Sampled percent of dollars accurately paid to providers for professional and facility claims. Note: Claims include both Medical and Behavioral Health claims.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period							X	X		X
CLAIM.08	MCO Operations	Claims: Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period								X		X
CLAIM.09	MCO Operations	Claims: Timely Processing: Sixty Days of Receipt for Professional and Facility Medical Claims	Count and percent of clean professional and facility claims processed (paid or denied) within 60 calendar days of receipt. Note: Claims include both Medical and Behavioral Health claims.	Day	Measure		Monthly	80 Calendar Days after end of Measurement Period								X		X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CLAIM.11	MCO Operations	Claims: Processing Results for Professional and Facility Medical Claims - Paid, Suspended, Denied	Count and percent of professional and facility medical claims received in the prior month, with processing status on the last day of the previous month of: A: Paid, B: Suspended, C: Denied. Note: Claims include both Medical and Behavioral Health claims.	Day	Measure		Monthly	50 Calendar Days after end of Measurement Period								X		X
CLAIM.17	MCO Operations	Claims: Timely Processing for Pharmacy Claims	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period								X		X
CLAIM.21	MCO Operations	Claims: Timely Processing for Electronic Professional and Facility Medical Claims	Count and percent of clean electronic professional and facility claims processed (paid or denied) within 15 calendar days of receipt, for those claims received in the measure data source time period.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period							X	X		X

Appendix C – Medicaid Care Management Services Model Contract



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EXHIBIT O – Quality and Oversight Reporting Requirements

Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CLAIM.22	MCO Operations	Claims: Timely Processing for Non-Electronic Professional and Facility Medical Claims	Count and percent of clean non-electronic professional and facility claims processed (paid or denied) within 30 calendar days of receipt, for those claims received in the measure data source time period.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period							X	X		X
CLAIM.23	MCO Operations	Claims: Timely Processing for All Professional and Facility Medical Claims	Count and percent of all professional and facility claims processed (paid or denied) within 30 calendar days after first submittal of the claim, for those claims received in the measure data source time period. All claims include clean claims, non-clean claims, electronic claims and non-electronic claims.	Month	Measure		Monthly	50 Calendar Days after end of Measurement Period							X	X		X
CULTURALCOMP.01	MCO Operations	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	N/A	Plan		Annually	September 30th										X



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DSH.01	MCO Operations	Disproportionate Hospital Claims Report	Standard template aggregating results generated for eligible hospitals from MCO claims data. Information included is used to confirm hospital submitted charge amounts, paid amounts, and paid days that will be used as part of the DSH calculation.	Hospital Fiscal Year	Table		Annually	December 10th								X		X
DUR.01	MCO Operations	Drug Utilization Review (DUR) Annual Report	This annual report includes information on the operation of your MCO's Medicaid DUR Program and meets the federal regulation with respect to providing pharmacy data to the Centers for Medicare and Medicaid Services (CMS).	Federal Fiscal Year	Narrative Report		Annually	June 15th								X		X

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EMERGENCY RESPONSE.01	MCO Operations	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	N/A	Plan		Annually	May 1st										X
EPSDT.01-EPSDT-0X	MCO Operations	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	TBD	Quarter	Measure		Quarterly	4 Months after end of Measurement Period										X

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EPSDT.20	MCO Operations	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The plan shall emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population.	N/A	Plan		Annually	May 1st										X
FINANCIALSTMT.01	MCO Operations	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	MCO Financial Period	Narrative Report		Annually	August 10th										X
FWA.02	MCO Operations	Fraud Waste and Abuse Log: FWA Related to Providers	Standard template log of all Fraud Waste and Abuse related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Month	Table		Monthly	30 Calendar Days after end of Measurement Period								X		X

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FWA.04	MCO Operations	Fraud Waste and Abuse Log: Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Month	Table		Monthly	30 Calendar Days after end of Measurement Period								X		X
FWA.05	MCO Operations	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Quarter	Table		Quarterly	30 Calendar Days after end of Measurement Period								X		X
FWA.20	MCO Operations	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	The MCO shall provide a summary report on MCO Fraud, Waste and Abuse investigations. This should include a description of the MCO's special investigation's unit. The MCO shall describe cumulative overpayments identified and recovered, investigations initiated, completed, and referred, and an analysis of the effectiveness of activities performed. The MCO's Chief Financial Officer will certify that the information in the report is accurate to the best of his or her information, knowledge, and belief.	Agreement Year	Narrative Report		Annually	September 30th								X		X

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FWA.22	MCO Operations	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Month	Table		Monthly	15 Calendar Days after end of Measurement Period								X		X
INLIEUOF.01	MCO Operations	In Lieu of Services Report	A narrative report describing the cost effectiveness of each approved In Lieu of Service by evaluating utilization and expenditures.	Agreement Year	Narrative Report		Annually	November 1st								X		X
INTEGRITY.01	MCO Operations	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	N/A	Plan		Other	May 1 st , Upon Revision								X		
MCISPLANS.01	MCO Operations	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	N/A	Plan		Annually	June 1st										X



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MLR.01	MCO Operations	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information, including, but not limited to: <ul style="list-style-type: none">• Total incurred claims;• Expenditures on quality improvement activities;• Expenditures related to activities compliant with the program integrity requirements;• Non-claims costs;• Premium revenue;• Taxes;• Licensing fees;• Regulatory fees;• Methodology for allocation of expenditures;• Any credibility adjustment applied;• The calculated MLR;• Any remittance owed to New Hampshire, if applicable;• A comparison of the information reported with the audited financial report;• A description of the aggregate method used to calculate total	Quarter	Table		Quarterly	9 Months after end of Measurement Period									X	

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			incurred claims; and • The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)]															
MONTHLYOPS.01	MCO Operations	Monthly Operations Report	This report will include monthly operational data for member services, provider services, claims processing, grievances and appeals. Data will be collected as specified for the quarterly versions of these deliverables, but utilizing a measurement period of one month rather than one quarter. Data will be submitted utilizing a template loaded to the DHHS SFTP site.	Month	Table		Monthly	30 Calendar Days after end of Measurement Period										X
MSQ.01	MCO Operations	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Month	Table		Monthly	30 Days After End of Reporting Month								X		X

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NETWORK.01	MCO Operations	Comprehensive Provider Network and Equal and Timely Access Semi-Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Semi-Annual	Narrative Report		Semi-Annually	45 Calendar Days after end of Measurement Period						X	X	X		
NETWORK.03	MCO Operations	Plan to Recruit and Maintain Sufficient Networks of SUD Service Providers and Member Access	Plan for recruiting and maintaining a sufficient network of providers offering SUD services to meet the time and distance standards required by the MCM contract.	Agreement Year	Plan		Annually	TBD						X	X	X		
NETWORK.10	MCO Operations	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Point-in-time	Plan		Semi-Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period						X	X	X		
NETWORK.11	MCO OPERATIONS	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Agreement Year	Table		Annually	45 Calendar Days after end of Measurement Period						X	X	X		
PMP.01	MCO Operations	Program Management Plan	The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and	N/A	Plan		Annually	TBD										X

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			associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan. Table of Contents I. Executive Summary II. Organizational structure a. Staffing and contingency plans; b. Corporation Relationships and Structure III. Business Operations a. Overview; b. Hours of operation; c. Holidays and emergency closing notification IV. Committees and workgroups a. General; b. Member Advisory Board; c. Provider Advisory Board V. Communication a. General; b. Vendor relationships; c. Member management; d. Providers VI. Systems a. Software and information management; b. Process improvement methods; c. Project management; d. Evaluation methods VII. Providers																

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			a. Management and communication; b. Relationships VIII. Services a. Pharmacy; b. Behavioral Health; c. Substance Use Disorder; d. Durable medical equipment; e. Special populations; f. Transportation; g. Other Benefits IX. Program Operations a. Utilization management; b. Grievance and Appeals; c. Care Management X. Community Engagement															
TIMELYCRED.01	MCO Operations	Timely Provider Credentialing	Mean time lag from the date a provider application is submitted to the MCO or subcontractor to the date the MCO or subcontractor credentials the provider.	Quarterly	Measure		Quarterly	20 Calendar Days after end of Measurement Period										X
TIMELYNOTICE.05	MCO Operations	Service Authorizations: Timeliness of Notice Delivery for Adverse Decisions	Count and percent of notices delivered to members within 3 calendar days of adverse decision.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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TIMELYNOTICE.06	MCO Operations	Service Authorizations: Timeliness of Notice Delivery for Termination, Suspension or Reduction of Services	Count and percent of notices delivered to members at least 10 calendar days prior to termination, suspension, or reduction of previously authorized Medicaid covered services	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
TPLCOB.01	MCO Operations	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other to other benefit coverage by insurance type for the measure data period.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X
TPLCOB.02	MCO Operations	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X
TPLCOB.03	MCO Operations	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X



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UMSUMMARY.03	MCO Operations	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Agreement Year	Narrative Report		Annually	2 Months after end of Measurement Period								X		
AMBCARE.10	Medical Utilization	Physician/APRN/Clinic Visits by Subpopulation	Count and percent of physician/APRN/clinic visits per 1,000 member months by subpopulation.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period					X		X	X		
AMBCARE.11	Medical Utilization	Emergency Department Visits for Medical Health Conditions by Subpopulation	Count and percent of ambulatory emergency department (ED) visits per 1,000 member months by subpopulation. This measure excludes ED visits for mental health and substance use disorder/substance misuse conditions.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period					X		X	X		
AMBCARE.12	Medical Utilization	Emergency Department Visits Potentially Treatable in Primary Care by Subpopulation	Count and percent of ambulatory emergency department (ED) visits for conditions potentially treatable in primary care per 1,000 member months by subpopulation.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period				X	X		X	X		

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AMBCARE.13	Medical Utilization	Emergency Department Visits for Mental Health Conditions by Subpopulation	Count and percent of ambulatory emergency department (ED) visits for mental health conditions per 1,000 member months by subpopulation. This measure excludes ED visits for substance use disorder/substance misuse conditions.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period					X		X	X	X	
AMBCARE.14	Medical Utilization	Emergency Department Visits for Substance Use Related (Chronic or Acute) Conditions by Subpopulation	Count and percent of ambulatory emergency department (ED) visits for substance use disorder and substance misuse related conditions (chronic or acute) per 1,000 member months, by subpopulation. This measure excludes ED visits for mental health conditions.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period					X		X	X		
AMBCARE.18	Medical Utilization	Frequent (4+ per year) Emergency Department Use by Subpopulation	Count and percent of members with frequent emergency department (ED) use in the previous 12 months, by subpopulation. Frequent ED use is defined as 4+ visits in a 12 month period. This measure includes ED visits for physical health, mental health and substance use disorder/substance misuse conditions.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period				X	X		X	X		



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AMBCARE.20	Medical Utilization	Emergency Department Visits for Any Condition by Subpopulation	Count and percent of all Ambulatory emergency department (ED) visits for Medical Health, Behavioral Health and Substance Use Related (Chronic or Acute) Conditions (Total counts, not broken out by condition group).	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period					X		X	X	X	
INPASC.04	Medical Utilization	Inpatient Hospital Utilization: Ambulatory Care Sensitive Conditions by Adult Subpopulation	Count and percent of inpatient hospital utilization for ambulatory care sensitive conditions per 1,000 member months, by adult subpopulation breakouts. This measure includes the following ambulatory care sensitive conditions, as defined for the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Overall Composite (PQI 90): Diabetes Short-Term Complications (PQI #1); Diabetes Long-Term Complications (PQI #3); Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (PQI #5); Hypertension (PQI #7); Heart Failure (PQI #8); Dehydration (PQI #10); Bacterial Pneumonia (PQI #11); Urinary Tract Infection (PQI #12); Uncontrolled Diabetes (PQI #14); Asthma in	Agreement Year	Measure	General and Granite Advantage	Annually	4 Months after end of Measurement Period							X	X		

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			Younger Adults (PQI #15); and Lower-Extremity Amputation among Patients with Diabetes (PQI #16).															
INPUTIL.02	Medical Utilization	Inpatient Hospital Utilization: All Conditions Excluding Maternity/Newborns by Subpopulation	Count and percent of inpatient hospital utilization for all conditions, excluding maternity and newborns, per 1,000 member months, by subpopulation.	Quarter	Measure	General and Granite Advantage	Quarterly	4 Months after end of Measurement Period							X	X		
GRNT_ADV.01	Member	Granite Advantage: Members who Received Outreach and Education	Count and percent of Granite Advantage members who received outreach and education in the past 12 months from the MCO, as related to Granite Advantage work and community engagement requirements.	Rolling Prior 12 Months	Measure		Quarterly	4 Months after end of Measurement Period					X					X
MEMCOMM.01	Member	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls answered by a live voice within 30 seconds, by health plan vendor.	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period							X	X		
MEMCOMM.03	Member	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue, by health plan vendor.	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period							X	X		



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MEMCOMM.06	Member	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period								X		X
MEMCOMM.21	Member	Behavioral Health Crisis Call Results	Count and percent of calls to the behavioral health member crisis line by disposition (i.e. educational, referral to care, no action)	Month to start, Shift to Quarter	Measure		Monthly to start, Shift to Quarterly	20 Calendar Days after end of Measurement Period										X
MEMCOMM.22	Member	Granite Advantage Outreach: Members who are Mandatory and Non-compliant with Work and Community Engagement Requirements	Count and percent of Granite Advantage members identified by the MCO as potentially exempt from work and community engagement requirements that receive outreach via telephone, mail, or electronic messaging.	Month to start, Shift to Quarter	Measure		Monthly to start, Shift to Quarterly	2 Months after end of Measurement Period					X					

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MEMCOMM.23	Member	Granite Advantage Outreach: Members Identified by DHHS as Mandatory and Non-compliant	Count and percent of Granite Advantage members identified by DHHS as mandatory and non-compliant with work and community engagement requirements that receive outreach via telephone, mail, or electronic messaging (combined total for telephone, mail, electronic).	Month to start, Shift to Quarter	Measure		Monthly to start, Shift to Quarterly	2 Months after end of Measurement Period					X					
MEMCOMM.24	Member	Member Communications: Messages Returned by the Next Business Day	Count and percent of calls received by the after-hours call center or call center voice mail that require a returned call and which the member receives a returned call by the next business day.	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period								X		X
MEMINCENTIVE.01	Member	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										x

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MEMINCENTIVE.02	Member	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Point-in-Time	Plan		Annually	May 1 st										x
BHDISCHARGE.01	Mental Health	Community Hospital Discharges for Mental Health Conditions: Member Had Visit With Mental Health Practitioner within 07 Calendar Days of Discharge by Subpopulation	Count and percent of member discharges from a community hospital with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			
BHDISCHARGE.02	Mental Health	Community Hospital Discharges for Mental Health Conditions: Member Had Visit With Mental Health Practitioner within 30 Calendar Days of Discharge by Subpopulation	Count and percent of member discharges from a community hospital with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			

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BHDRUG.01	Mental Health	Severe Mental Illness Drug Preauthorization Report	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Month	Table		Monthly	10 Calendar Days after end of Measurement Period										X
BHPARITY.01	Mental Health	Behavioral Health Parity Analysis Tool	Standard template that utilizes the BH Parity Analysis tool and MCO narrative to recertify compliance with Mental Health (MH) and Substance Use Disorder (SUD) Parity requirements. Recertification includes verifying changes in service limitations for all MH, SUD, or Medical Surgical (M/S) services.	Agreement Year	Table		Annually	4 Months after end of Measurement Period								X		X

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BHPARITY.02	Mental Health	Behavioral Health Parity Compliance Report	Standard template for providing a summary of behavioral health parity compliance. The report includes detail at the category and service level related to service utilization, denials, service authorization, appeals, and grievances.	Semi-Annual	Table		Semi-Annually	4 Months after end of Measurement Period								X		X
BHREADMIT.05	Mental Health	Community Hospital Readmissions for Mental Health Conditions: Within 30 Days by Subpopulation	Count and percent of community hospital admissions that were preceded by a discharge for a mental health-related condition from the same facility within 30 days, for continuously enrolled Medicaid members with a primary diagnosis for a mental health-related condition, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			
BHREADMIT.06	Mental Health	Community Hospital Readmissions for Mental Health Conditions: Within 180 Days by Subpopulation	Count and percent of community hospital admissions that were preceded by a discharge for a mental health-related condition from the same facility within 180 days, for continuously enrolled Medicaid members with a primary diagnosis for a mental health-related condition, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			
BHSTRATEGY.01	Mental Health	Behavioral Health Strategy Plan and Report	Annual plan describing the MCOs policies and procedures regarding the continuity and coordination of covered physical and Behavioral	Agreement Year	Plan		Annually	May 1st									X	X



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			Health Services and integration between physical health and behavioral health Providers. The plan should be comprehensive and shall address but not be limited to how the MCO will: <ul style="list-style-type: none">• Assure Participating Providers meet SAMHSA standards for co-located and Integrated Care;• Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;• Assure the promotion of integrated care;• Reduce Psychiatric Boarding described in 4.11.5.17;• Implement the payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT;• Reduce Behavioral Health Readmissions described in 4.11.5.18.4;• Support the New Hampshire 10-year plan outlined in 4.11.5.16;• Assure the appropriateness of psychopharmacological medication;															

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			<ul style="list-style-type: none">• Assure access to appropriate services;• Implement a training plan that includes but is not limited to trauma-informed care and Integrated Care; and• Other information in accordance with Exhibit O. The second year of the plan will include an effectiveness analysis of initial plan’s program, policies and procedures. The analysis will include MCO interventions which require improvement, including improvements in co-located and Integrated Care, continuity, coordination, and collaboration for physical health and Behavioral Health Services.															

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HOSP_INP.01	Mental Health	Risk Adjusted Readmission to Any Hospital for Any Cause by Adult Behavioral Health and Non-Behavioral Health Population within 30 Days	Percent of inpatient hospital stays (excluding maternity, cancer, transplant, and rehabilitation admissions) during the measurement period by members age 18 years and older whose inpatient stay was followed by an unplanned acute readmission within 30 Days, by behavioral health and non-behavioral health population groups. The behavioral health population group includes members indicated as 1) Bureau of Mental Health eligible recipients of Community Mental Health Center (CMHC) services during the measurement period, 2) having a behavioral health primary diagnosis code on one or more claims during the measurement period, or 3) having behavioral health prescriptions on one or more pharmacy claims during the measurement period. Based on CMS Adult Core Set.	Calendar Year	Measure		Annually	6 Months after end of Measurement Period				X						

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MHACT.01	Mental Health	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least one billed Assertive Community Treatment (ACT) service in each month of the measurement period.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period										X
MHACT.02	Mental Health	Adult CMHP Assertive Community Treatment (ACT) Service Recipients who had a Visit with a Community Mental Health Program (CMHP) within 24 Hours of Discharge from New Hampshire Hospital	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least one billed Assertive Community Treatment (ACT) service within 90 days of admission to New Hampshire Hospital who had a visit at a Community Mental Health Program within 24 hours of discharge from New Hampshire Hospital. This measure includes stays at New Hampshire Hospital that are not reimbursed by the MCO.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period										X
MHEBSE.01	Mental Health	Adult CMHP Eligible Members Engaged in Evidence Based Supportive Employment (EBSE) Services	Count and percent of adult members eligible for and receiving Community Mental Health Program (CMHP) services (at least one service in the prior 90 days) who received an Evidence Based Supportive Employment (EBSE) service within the prior year.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period									X	X



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MHEBSE.02	Mental Health	Adult CMHP Eligible Members with Updated Employment Status	Count and percent of adult members eligible for and receiving Community Mental Health Program (CMHP) services (at least one service in the prior 90 days) who had an employment status update in the last 3 months excluding updates with "unknown" status.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period									X	X
MHEDBRD.01	Mental Health	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaited placement within the prior 30, 60 and 90 days.	Month	Table		Monthly	1 Month after end of Measurement Period										X

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MHREADMIT.01	Mental Health	Readmissions for Mental Health Conditions: Within 30 Days by Subpopulation	Count and percent of admissions to either a community hospital or NH Hospital for a mental health-related condition that were preceded by a discharge for a mental health-related condition from either a community hospital or NH Hospital within 30 days, for continuously enrolled Medicaid members with a primary diagnosis for a mental health-related condition, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			
MHREADMIT.02	Mental Health	Readmissions for Mental Health Conditions: Within 180 Days by Subpopulation	Count and percent of admissions to either a community hospital or NH Hospital for a mental health-related condition that were preceded by a discharge for a mental health-related condition from either a community hospital or NH Hospital within 180 days, for continuously enrolled Medicaid members with a primary diagnosis for a mental health-related condition, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X			
MHSUICIDE.01	Mental Health	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	N/A	Plan		Annually	May 1st										X

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MHSURVEY.01	Mental Health	Mental Health Satisfaction Survey Annual Report	Annually the MCO shall conduct and submit to DHHS an analytic narrative report that interprets the results from a consumer satisfaction survey for members with behavioral health conditions.	Agreement Year	Narrative Report		Annually	June 30th	X									
MHTOBACCO.01	Mental Health	Adult and Youth CMHP Eligible Members: Smoking Status	Count and percent of Community Mental Health Program (CMHP) Eligible Adult and Youth Members 12-17 and 18 and older who are current tobacco users.	Agreement Year	Measure		Annually	4 Months after end of Measurement Period										X
NHHDISCHARGE.01	Mental Health	New Hampshire Hospital: Discharges Where Members Received Discharge Instruction Sheet	Count and percent of discharges from New Hampshire Hospital where the member received a discharge instruction sheet upon discharge.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period									X	X
NHHDISCHARGE.10	Mental Health	New Hampshire Hospital Discharges: Patient Had Visit With Mental Health Practitioner within 07 Calendar Days of Discharge by Subpopulation	Count and percent of member discharges from New Hampshire Hospital where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X		X	X

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NHHDISCHARGE.12	Mental Health	New Hampshire Hospital Discharges: Patient Had Visit With Mental Health Practitioner within 30 Calendar Days of Discharge by Subpopulation	Count and percent of member discharges from New Hampshire Hospital where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X		X	X
NHHDISCHARGE.13	Mental Health	New Hampshire Hospital Discharges: Discharge Plan Provided to Aftercare Provider within 07 Days of Member Discharge	Count and percent of members discharged from New Hampshire Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. The contract standard = at least ninety percent (90%) of members discharged.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period									X	X
NHHDISCHARGE.16	Mental Health	New Hampshire Hospital Discharges: New CMHP Patient Had CMHP Intake Appointment within 7 Calendar Days of Discharge	Count and percent of New Hampshire Hospital discharges where the patient had an intake appointment with a Community Mental Health Program (CMHP) within 7 calendar days of discharge AND who were new to the CMHP system.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period									X	X

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NHHDISCHARGE.17	Mental Health	New Hampshire Hospital Discharges: MCO Contacts and Contact Attempts	Count and percent of members discharged from New Hampshire Hospital during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period									X	X
NHHREADMIT.09	Mental Health	New Hampshire Hospital Readmissions: Service Utilization Prior to Readmission	For Members for the measurement month who represented a readmission within 180 days, the MCO will report on the mental health and related service utilization that directly proceeded readmission in accordance with Exhibit O.	Month	Table		Monthly	4 Months after end of Measurement Period							X			
NHHREADMIT.10	Mental Health	New Hampshire Hospital Readmissions: Within 30 Days by Subpopulation	Count and percent of New Hampshire Hospital admissions that were preceded by a New Hampshire Hospital discharge within 30 days, for continuously enrolled Medicaid members, by subpopulation.	Quarter	Measure	General	Quarterly	4 Months after end of Measurement Period							X		X	X
NHHREADMIT.11	Mental Health	New Hampshire Hospital Readmissions: Within 180 Days by Subpopulation	Count and percent of New Hampshire Hospital admissions that were preceded by a New Hampshire Hospital discharge within 180 days, for continuously enrolled Medicaid members by subpopulation.	Quarter	Measure	General	Quarterly	4 months after end of Measurement Period							X		X	X

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NEMT.12	NEMT	Non-Emergent Medical Transportation: Services Delivered by Mode of Transportation	Count and percent of Non-Emergent Medical Transportation (NEMT) requests delivered, by mode of transportation. Modes include: A: Contracted Transportation Provider (Non-Wheelchair Van) B: Volunteer Driver, C: Member, D: Public Transportation, E: Wheelchair Van, F: Other	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
NEMT.13	NEMT	Non-Emergent Medical Transportation: Request Authorization Approvals by Mode of Transportation	Count and percent of Non-Emergent Medical Transportation (NEMT) requests authorized, of those requested during the measure data period, by mode of transportation. Modes include: A: Contracted Transportation Provider (Non-Wheelchair Van) B: Volunteer Driver, C: Member, D: Public Transportation, E: Wheelchair Van, F: Other	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
NEMT.15	NEMT	Non-Emergent Medical Transportation: Services Delivered by Type of Medical Service	Count and percent of Non-Emergent Medical Transportation (NEMT) requests delivered, by type of medical service. Types include: A: Hospital, B: Medical Provider, C: Mental Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G. Other	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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NEMT.17	NEMT	Non-Emergent Medical Transportation: Member Cancellations for Scheduled Trips by Reason	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van scheduled trip member cancellations, by reason for member cancellation. Reasons include: A. Appointment changed or cancelled, B. Member found other transportation, C. Member illness, D. Other reason.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
NEMT.18	NEMT	Non-Emergent Medical Transportation: Contracted Transportation & Wheelchair Van Provider Scheduled Trip Results by Outcome	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests scheduled for all rides, including Methadone treatment rides, requested during the measure data period. Outcomes include: A: Member cancelled or rescheduled, B: Transportation provider cancelled or rescheduled, C: Member no show, D: Transportation provider no show, E: Other reason trip wasn't made, F: Delivered and G: Unknown if trip occurred.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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NEMT.21	NEMT	Non-Emergent Medical Transportation: Contracted Transportation & Wheelchair Van Provider Scheduled Trips Timeliness	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests scheduled and delivered during the measurement period, with an outcome of delivered on time or delivered late. The following exclusions apply: Exclude Methadone treatment rides. Exclude rides provided by Easter Seals. Outcomes include: A: On Time, B: Late.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
NEMT.22	NEMT	Non-Emergent Medical Transportation: Family and Friends Program Rides	Count and percent of NEMT one way rides provided by the MCO to member utilizing NEMT services that are delivered through the Family and Friends Mileage Program.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
ACCESSREQ.05	Network Adequacy	Member Requests for Assistance Accessing MCO Designated Primary Care Providers per Average Members by County	Count and percent of Member requests for assistance accessing MCO Designated Primary Care Providers per average 1,000 members by New Hampshire county.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								X		

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ACCESSREQ.06	Network Adequacy	Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers per Average Members by County	Count and percent of Member requests for assistance accessing Physician/APRN Specialists (Non-MCO Designated Primary Care) providers per average 1,000 members by New Hampshire county.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period								X		
LOCKIN.01	Pharmacy	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked in to a pharmacy for the measurement period.	Month	Table		Monthly	30 Calendar Days after end of Measurement Period										X
LOCKIN.03	Pharmacy	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Month	Table		Monthly	30 Calendar Days after end of Measurement Period										X

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PHARM_PDC	Pharmacy	Proportion of Days Covered (PDC):	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for: Beta-blockers, Renin Angiotensin System Antagonists, Calcium Channel Blockers, Biguanides, Sulfonylureas, Thiazolidinediones, Dipeptidyl Peptidase (DPP)-IV Inhibitors, Diabetes All Class, Statins, Antiretroviral Medications, Non-Warfarin Oral Anticoagulants, Long-Acting Inhaled Bronchodilator Agents in COPD Patients, and Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis.	Calendar Year	Measure		Annually	March 31st										X
PHARMQI.09	Pharmacy	Safety Monitoring: Prior Authorized Fills for Opioid Prescriptions with Dosage over 100 mg Morphine Equivalent Dosing (MED)	Count and percent of opioid prescription fills prior authorized for dosage over 100 mg Morphine Equivalent Dosing (MED), including members with cancer or other terminal illnesses.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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PHARMQI.10	Pharmacy	Child Psychotropic Medication Monitoring Report	Standard template of aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Quarter	Table		Quarterly	2 Months after end of Measurement Period										X
PHARMQI.17	Pharmacy	Annual Comprehensive Medication Review and Counseling: Completion Rate	Count and percent of eligible polypharmacy members who completed an annual comprehensive medication review and counseling in the prior twelve months by age group. Age Groups include: Age 0-17 Years, Age 18-64 Years, and Age 65 and Older.	Prior 12 months	Measure		Semi-Annually	March 31st and September 30th										X
PHARMQI.18	Pharmacy	Annual Comprehensive Medication Review and Counseling: Impact of Review	Percent of people who had medication review who changed medications within 30 days of the annual comprehensive medication review.	Prior 12 months	Measure		Semi-Annually	March 31st and September 30th										X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PHARMUTLMGT.02	Pharmacy	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
PHARMUTLMGT.03	Pharmacy	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
PHARMUTLMGT.04	Pharmacy	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
POLYPHARM.04	Pharmacy	Polypharmacy Monitoring: Children With 4 or More Prescriptions	Count and percent of child Medicaid members with four or more prescriptions filled in each month of the measurement quarter, regardless of member participation in a plan polypharmacy program, by age group. Age Groups include: A. Age 0-5 years, B. Age 6-17 years	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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POLYPHARM.06	Pharmacy	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members 5 or more prescriptions filled in any consecutive 60 day period during the measurement quarter and the month prior to the measurement quarter, regardless of member participation in a plan polypharmacy program, by age group. Age Groups include: A. Age 18-44 years, B. Age 45-64 years.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
PROVAPPEAL.01	Provider	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of provider appeals within 30 calendar days of receipt of appeal for appeals received during the measure data period.	Quarter	Measure		Quarterly	4 Months after end of Measurement Period								X		
PROVAPPEAL.02	Provider	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measure data period.	Quarter	Table		Quarterly	4 Months after end of Measurement Period								X		
PROVCOMM.01	Provider	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls answered by a live voice within 30 seconds by health plan vendor.	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period										X

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PROVCOMM.03	Provider	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned either while waiting in call queue by health plan vendor.	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period										X
PROVCOMM.06	Provider	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact Information, etc. E: Changing Service Mix Offered by Provider, F: Changing Panel Size, G: Voluntary Termination, H: Enrollment / Credentialing, I: Complaints About Health Plan, J: Other	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period										X
PROVCOMM.21	Provider	Provider Communications: Messages Returned by the Next Business Day	Count and percent of calls received by the afterhours call center or call center voice mail that require a returned call and which the provider receives a returned call by the next business day.	Month	Measure		Monthly	20 Calendar Days after end of Measurement Period										X
PROVCOMPLAINT.01	Provider	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Quarter	Table		Quarterly	4 Months after end of Measurement Period								X		



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PROVPREVENT.01	Provider	Hospital-Acquired and Provider-Preventable Condition Table	Standard template that identifies denials or reduced payment amounts for hospital-acquired conditions and provider preventable conditions. Table will include MCO claim identifier, provider, date of service, amount of denied payment or payment reduction and reason for payment denial or reduction.	Annual	Table		Annually	April 30th								X		
PROVPRIV.01	Provider	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Agreement Year	Narrative Report		Annually	4 Months after end of Measurement Period								X		X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PROVTERM.01	Provider	Provider Termination Log	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	As Needed or Weekly	Table		Other	TBD								X		X
PROVTERM.02	Provider	Provider Termination Report	Standard template reporting all providers terminated (after provider has exhausted all appeal rights, if applicable) based on Database Checks.	Month	Table		Monthly	30 Days After End of Reporting Month								X		X
CAHPS_A_ALL	Quality Monitoring	CAHPS 5.0H Core Survey - Adults	Includes 1) Survey Instrument Proofs created by Survey Vendor, 2) Validated Member Level Data File (VMLDF), 3) Validated Member Level Data File (VMLDF) - Layout, 4) Medicaid Adult Survey Results Report, and 5) CAHPS Survey Results with Confidence Intervals.	Standard HEDIS schedule	Reports, Files		Annually	June 30th	X		X					X		
CAHPS_A_SUP	Quality Monitoring	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Standard HEDIS schedule	Measure		Annually	July 15th	X							X		X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_CCC_ALL	Quality Monitoring	CAHPS 5.0H Survey - Children with Chronic Conditions	Includes 1) Survey Instrument Proofs created by Survey Vendor, 2) Validated Member Level Data File (VMLDF), 3) Validated Member Level Data File (VMLDF) - Layout, 4) Medicaid Child with CCC - CCC Population Survey Results Report, 5) CAHPS Survey Results with Confidence Intervals - Child with CCC, 6) Medicaid Child with CCC - General Population Survey Results Report, and 7) CAHPS Survey Results with Confidence Intervals - General Population	Standard HEDIS schedule	Reports, Files		Annually	June 30th	X	X						X		
CAHPS_CCC_SUP	Quality Monitoring	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Standard HEDIS schedule	Measure		Annually	July 15th	X							X		X
CMS_A_ABA	Quality Monitoring	Adult BMI Assessment	CMS Adult Core Set – Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_AMM	Quality Monitoring	Antidepressant Medication Management	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	May 1 of year prior to measurement year to Oct 31 of measurement year.	Measure	Granite Advantage	Annually	September 30th			X		X					

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_AMR	Quality Monitoring	Asthma Medication Ratio	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_BCS	Quality Monitoring	Breast Cancer Screening	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	2 Calendar Years	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_CBP	Quality Monitoring	Controlling High Blood Pressure	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_CCP	Quality Monitoring	Contraceptive Care – Postpartum Women	CMS Adult and Child Core Sets (member age determines in which set the member is reported) – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th		X	X		X					
CMS_A_CDF	Quality Monitoring	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported) – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_CHL	Quality Monitoring	Chlamydia Screening in Women	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_CUOB	Quality Monitoring	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X	X				

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_FUAFUM	Quality Monitoring	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X	X				
CMS_A_HA1C	Quality Monitoring	Comprehensive Diabetes Care: Hemoglobin A1c Testing	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_HPC	Quality Monitoring	Comprehensive Diabetes Care: Hemoglobin A1C Poor Control (>9.0%)	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_HPCMI	Quality Monitoring	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_IET	Quality Monitoring	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X	X				
CMS_A_INP_PQI01	Quality Monitoring	Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					

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CMS_A_INP_PQI05	Quality Monitoring	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_INP_PQI08	Quality Monitoring	Heart Failure Admission Rate per 100,000 Enrollee Months	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_INP_PQI15	Quality Monitoring	Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_MPM	Quality Monitoring	Annual Monitoring for Patients on Persistent Medications	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_MSC.01	Quality Monitoring	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	CMS Adult Core Set	Calendar Year	Measure		Annually	September 30th	X		X							

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_MSC.02	Quality Monitoring	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	CMS Adult Core Set	Calendar Year	Measure		Annually	September 30th			X							
CMS_A_MSC.03	Quality Monitoring	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	CMS Adult Core Set	Calendar Year	Measure		Annually	September 30th			X							
CMS_A_OHD	Quality Monitoring	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X	X				
CMS_A_PCR	Quality Monitoring	Plan All-Cause Readmissions	CMS Adult Core Set – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_A_SAA	Quality Monitoring	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					

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CMS_A_SSD	Quality Monitoring	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure.	Calendar Year	Measure	Granite Advantage	Annually	September 30th			X		X					
CMS_CCW.01	Quality Monitoring	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets (member age determines in which set the member is reported) – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th		X	X		X					
CMS_CCW.02	Quality Monitoring	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets (member age determines in which set the member is reported) – to include subpopulation breakout as indicated.	Calendar Year	Measure	Granite Advantage	Annually	September 30th		X	X		X					
CMS_CH_DEV	Quality Monitoring	Developmental Screening in the First Three Years of Life	CMS Child Core Set	Calendar Year	Measure		Annually	September 30th		X								
HEDIS_AAB	Quality Monitoring	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X		X							
HEDIS_ABA	Quality Monitoring	Adult BMI Assessment	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									

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HEDIS_ADD	Quality Monitoring	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure	One year starting March 1 of year prior to measurement year to February 28 of measurement year.	Measure		Annually	June 30th	X	X								
HEDIS_ADD_SUB	Quality Monitoring	Follow-Up Care for Children Prescribed ADHD Medication by Subpopulation	HEDIS Measure broken out by subpopulation.	One year starting March 1 of year prior to measurement year to February 28 of measurement year.	Measure	General	Annually	July 31st							X			
HEDIS_AMB	Quality Monitoring	Outpatient and Emergency Dept. Visits/1000 Member Months	HEDIS Measure	Calendar Year	Measure		Annually	June 30th		X								
HEDIS_AMM	Quality Monitoring	Antidepressant Medication Management	HEDIS Measure	May 1 of year prior to measurement year to Oct 31 of measurement year.	Measure		Annually	June 30th	X		X	X						

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HEDIS_AMM_SUB	Quality Monitoring	Antidepressant Medication Management by Subpopulation	HEDIS Measure broken out by subpopulation.	May 1 of year prior to measurement year to Oct 31 of measurement year.	Measure	General	Annually	July 31st							X			
HEDIS_AMR	Quality Monitoring	Asthma Medication Ratio	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X	X							
HEDIS_APC	Quality Monitoring	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	HEDIS Measure	Calendar Year	Measure		Annually	June 30th		X								
HEDIS_APM	Quality Monitoring	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X		X						
HEDIS_APP	Quality Monitoring	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X								
HEDIS_APP_SUB	Quality Monitoring	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics by Subpopulation	HEDIS Measure broken out by subpopulation.	Calendar Year	Measure	General	Annually	July 31st							X			

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HEDIS_ASF	Quality Monitoring	Unhealthy Alcohol Use Screening and Follow-Up	HEDIS Measure	Calendar Year	Measure		Annually	June 30th						X				
HEDIS_AWC	Quality Monitoring	Adolescent Well Care Visits	HEDIS Measure	Calendar Year	Measure		Annually	June 30th		X		X						
HEDIS_BCS	Quality Monitoring	Breast Cancer Screening	HEDIS Measure	2 Calendar Years	Measure		Annually	June 30th	X		X							
HEDIS_BCS_SUB	Quality Monitoring	Breast Cancer Screening - Age 50-74 by Subpopulation	HEDIS Measure broken out by subpopulation.	2 Calendar Years	Measure	General	Annually	July 31st							X			
HEDIS_CAP	Quality Monitoring	Children and Adolescents' Access To Primary Care Practitioners	HEDIS Measure	Calendar Year	Measure		Annually	June 30th		X								
HEDIS_CBP	Quality Monitoring	Controlling High Blood Pressure	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X		X							
HEDIS_CCS	Quality Monitoring	Cervical Cancer Screening	HEDIS Measure	3 Calendar Years	Measure		Annually	June 30th	X									
HEDIS_CDC	Quality Monitoring	Comprehensive Diabetes Care	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X		X							
HEDIS_CHL	Quality Monitoring	Chlamydia Screening in Women	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X	X							
HEDIS_CIS	Quality Monitoring	Childhood Immunization Status	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X								
HEDIS_COU	Quality Monitoring	Risk of Chronic Opioid Use (COU)	HEDIS Measure	Calendar Year	Measure		Annually	June 30th						X				

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HEDIS_CWP	Quality Monitoring	Appropriate Testing for Children With Pharyngitis	HEDIS Measure	One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Measure		Annually	June 30th	X									
HEDIS_Deliverables	Quality Monitoring	HEDIS Deliverables generated for submission to NCQA	HEDIS Deliverables generated for submission to NCQA: 1) HEDIS Roadmap, 2) HEDIS Data Filled Workbook, 3) HEDIS Comma Separated Values Workbook, and 4) NCQA HEDIS Compliance Audit™ Final Audit Report	Standard HEDIS schedule	Reports, Files		Annually	June 30th	X									
HEDIS_DSF	Quality Monitoring	Depression Screening and Follow-up for Adolescents and Adults	HEDIS Measure	Calendar Year	Measure		Annually	June 30th				X					X	
HEDIS_FMC	Quality Monitoring	Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	HEDIS Measure	January 1 to December 24 of measurement year	Measure		Annually	June 30th										

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
HEDIS_FUA	Quality Monitoring	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	HEDIS Measure	Calendar Year	Measure		Annually	June 30th			X			X				
HEDIS_FUH	Quality Monitoring	Follow-Up After Hospitalization For Mental Illness	HEDIS Measure	January 1 to December 1 of measurement year	Measure		Annually	June 30th	X		X	X						
HEDIS_FUM	Quality Monitoring	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure	Calendar Year	Measure		Annually	June 30th			X							
HEDIS_HFS	Quality Monitoring	Hospitalization Following Discharge from a Skilled Nursing Facility (within 30 Days of the ED visit)	HEDIS Measure	Calendar Year	Measure		Annually	June 30th										X
HEDIS_IET	Quality Monitoring	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X		X			X				
HEDIS_IET_SUB	Quality Monitoring	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment by Subpopulation	HEDIS Measure broken out by subpopulation.	Calendar Year	Measure	General	Annually	July 31st	X					X	X			

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
HEDIS_IMA	Quality Monitoring	Immunizations for Adolescents	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X								
HEDIS_LBP	Quality Monitoring	Use of Imaging Studies for Low Back Pain	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_LSC	Quality Monitoring	Lead Screening in Children	HEDIS Measure	Calendar Year	Measure		Annually	June 30th										X
HEDIS_MMA	Quality Monitoring	Medication Management for People with Asthma	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_MPM	Quality Monitoring	Annual Monitoring for Patients on Persistent Medications	HEDIS Measure	Calendar Year	Measure		Annually	June 30th			X							
HEDIS_MPM_SUB	Quality Monitoring	Annual Monitoring for Patients on Persistent Medications by Subpopulation	HEDIS Measure broken out by subpopulation.	Calendar Year	Measure	General	Annually	July 31st							X			
HEDIS_PCE	Quality Monitoring	Pharmacotherapy Management of COPD Exacerbation	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_PCE_SUB	Quality Monitoring	Pharmacotherapy Management of COPD Exacerbation by Subpopulation	HEDIS Measure broken out by subpopulation.	Calendar Year	Measure	General	Annually	July 31st							X			
HEDIS_PPC	Quality Monitoring	Prenatal and Postpartum Care	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X								

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
HEDIS_SAA	Quality Monitoring	Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_SMC	Quality Monitoring	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_SMD	Quality Monitoring	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_SPC	Quality Monitoring	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_SPD	Quality Monitoring	Statin Therapy for Patients with Diabetes	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_SSD	Quality Monitoring	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X									
HEDIS_UOD	Quality Monitoring	Use of Opioids at High Dosage	HEDIS Measure	Calendar Year	Measure		Annually	June 30th						X				

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
HEDIS_URI	Quality Monitoring	Appropriate Treatment for Children With Upper Respiratory Infection	HEDIS Measure	One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Measure		Annually	June 30th	X									
HEDIS_W15	Quality Monitoring	Well-Child Visits in the first 15 Months of Life	HEDIS Measure	Calendar Year	Measure		Annually	June 30th		X								
HEDIS_W34	Quality Monitoring	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	HEDIS Measure	Calendar Year	Measure		Annually	June 30th		X								
HEDIS_WCC	Quality Monitoring	Weight Assessment and Counseling	HEDIS Measure	Calendar Year	Measure		Annually	June 30th	X	X								
QAPI.01	Quality Monitoring	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of mechanisms to detect under and over utilization, assess quality and appropriateness of care for members with special health care needs and disparities in quality of and access to health care (e.g. age, race, ethnicity, sex, primary	Agreement Year	Narrative Report		Annually	2 Months after end of Measurement Period								X		

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
			language, and disability)); and process for monitoring, evaluating and improving quality of care for members receiving behavioral health services. In the second agreement year, the MCO will provide an appendix to the plan that will include a report. The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's technical report and other quality studies; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.															
SDH.XX	Quality Monitoring	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	TBD	Measure		TBD	TBD										X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SERVICEAUTH.01	Service Authorization	Service Authorizations: Timely Determinations for Urgent Medical Service, Equipment and Supply Requests	Count and percent of medical service, equipment, and supply service authorization determinations for urgent requests made within 72 hours after receipt of request for requests made during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										
SERVICEAUTH.03	Service Authorization	Service Authorizations: Timely (14 Day) Determinations for New Routine Medical Service, Equipment and Supply Requests (excludes NEMT and Complex Diagnostic Radiology)	Count and percent of medical service, equipment, and supply service, authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measure data period. Exclude authorization requests that extend beyond the 14 day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for non-emergency transportation from this measure.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SERVICEAUTH.04	Service Authorization	Service Authorizations: Timely Determinations for Pharmacy	Count and percent of pharmacy service authorization determinations made and noticed via telecommunications device within 24 hours after receipt of request for requests made during the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										
SERVICEAUTH.05	Service Authorization	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period.	Quarter	Table		Quarterly	2 Months after end of Measurement Period						X				
SERVICEAUTH.09	Service Authorization	Service Authorizations: Pharmacy Prior Authorizations Stratified by Behavioral Health and Other Drugs	Count and percent of pharmacy service authorization requests that were received and approved, denied or remain pending, by drug class, for the measure data period.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
SERVICEAUTH.13	Service Authorization	Service Authorizations: Post-Delivery Timely (30 Day) Determinations for Medical Service, Equipment and Supply Requests	Count and percent of post-delivery authorization determinations made within 30 calendar days of receipt of routine requests, for medical services, equipment, and supply services. Exclude requests for non-emergency transportation from this measure.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SERVICEAUTH.14	Service Authorization	Service Authorizations: Pharmacy Service Authorization Denials by Waiver and Non-Waiver Populations	Count and percent of pharmacy service authorizations denied during the measurement period per 1,000 member months, broken out by the following groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X
SERVICEAUTH.15	Service Authorization	Service Authorizations: Physical, Occupational and Speech Therapy Service Authorization Denials by Waiver and Non-Waiver Populations	Count and percent of physical, occupational and speech therapy service authorizations denied during the measurement period per 1,000 member months, broken out by the following groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Quarter	Measure		Quarterly	2 Months after end of Measurement Period										X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.25	Substance Use Disorder	Substance Use Disorder: Continuity of Pharmacotherapy for Opioid Use Disorder	Count and percent of members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for opioid use disorder without a gap for more than seven days by subpopulation. The standard measure is National Quality Forum endorsed measure #3175.	Calendar Year	Measure	SUD IMD Waiver	Annually	6 Months after end of Measurement Period						X				X
SUD.26	Substance Use Disorder	Substance Use Disorder: Member Access to SUD Services After Initial Positive Screening	Count and percent of members receiving any substance use disorder (SUD) service, other than evaluation, within ten days of screening for SUD services. The measure will be collected by a file review of a sample of members who received a positive screening for SUD services during the measurement period by subpopulation.	Calendar Year	Measure	SUD IMD Waiver	Annually	6 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.27	Substance Use Disorder	Substance Use Disorder: Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination	Count and percent of members receiving American Society of Addiction Medicine (ASAM) substance use disorder (SUD) services as identified by initial or subsequent ASAM level of care criteria determination within 30 days of the screening. The measure will be collected by a file review of a sample of members who received an ASAM SUD service during the measurement period by subpopulation.	Calendar Year	Measure	SUD IMD Waiver	Annually	6 Months after end of Measurement Period						X				X
SUD.28	Substance Use Disorder	Substance Use Disorder: Members Completing SUD Treatment	Count and percent of members with a substance use disorder (SUD) diagnosis who completed treatment. The measure will be collected by a file review of a sample of members who had a diagnosis for SUD and received SUD treatment during the measurement period by subpopulation.	Calendar Year	Measure	SUD IMD Waiver	Annually	6 Months after end of Measurement Period						X				X
SUD.29	Substance Use Disorder	Substance Use Disorder: Members with an SUD Diagnosis	Count of members enrolled in the measurement period with a substance use disorder (SUD) diagnosis or treatment service within the last 6 months by subpopulation. Measure is collected quarterly with monthly breakouts.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.30	Substance Use Disorder	Substance Use Disorder: Members with an Emergency Department visit for SUD	Members enrolled in the measurement period who had an Emergency Department visit claim for substance use disorder (SUD) during the measurement period, per 1,000 member months. Measure is collected quarterly with monthly breakouts.	Month	Measure		Quarterly	4 Months after end of Measurement Period						X				X
SUD.31	Substance Use Disorder	Substance Use Disorder: Members Receiving Early Intervention Services	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service claim for early intervention services in the measurement period by subpopulation. Early intervention services include procedure codes associated with Screening, Brief Intervention, and Referral to Treatment (SBIRT). Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.32	Substance Use Disorder	Substance Use Disorder: Members Receiving Outpatient Services (ASAM level 1)	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service claim for outpatient services in the measurement period by subpopulation. Outpatient services include outpatient recovery or motivational enhancement therapies, step down care, monitoring for stable patients. Measure is collected quarterly with monthly breakout. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.33	Substance Use Disorder	Substance Use Disorder: Members Receiving Intensive Outpatient and Partial Hospitalization Services	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service claim for intensive outpatient and/or partial hospitalization services in the measurement period by subpopulation. Intensive outpatient and/or partial hospitalization services include specialized outpatient SUD therapy and other clinical services. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X
SUD.34	Substance Use Disorder	Substance Use Disorder: Members Receiving Residential and Inpatient Services	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service claim for residential and/or inpatient services during the measurement period by subpopulation. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.35	Substance Use Disorder	Substance Use Disorder: Members Receiving Medically Managed Intensive Inpatient Services (ASAM Level 4)	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service claim for American Society of Addiction Medicine (ASAM) medically managed intensive inpatient services during the measurement period by subpopulation. Medically managed intensive inpatient services include 24 hour structures with physician care for severe unstable problems. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.36	Substance Use Disorder	Substance Use Disorder: Members Receiving Pharmacy-based or Opioid Treatment Program-based Medication Assisted Treatment	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a prescription claim for Medication Assisted Treatment (MAT) or an opioid treatment program service (e.g. Methadone clinic service) during the measurement period by subpopulation. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X
SUD.37	Substance Use Disorder	Substance Use Disorder: Members Receiving Pharmacy-based Medication Assisted Treatment and Other Treatment	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service and prescription claim for Medication Assisted Treatment (MAT) during the measurement period by subpopulation. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.38	Substance Use Disorder	Substance Use Disorder: Withdrawal Management	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had a service claim for any form of withdrawal management during the measurement period by subpopulation. Withdrawal management includes ambulatory with or without extended on-site monitoring; clinically managed residential, medically monitored inpatient, medically managed inpatient. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X



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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.39	Substance Use Disorder	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers with high opioid prescribing rates and efforts to follow up with providers. The report should include the MCO's operational definition of a provider with a high opioid prescribing rate, the process for identifying and following up with providers. The report should include aggregate data about the number of providers that are identified and the follow up.	Agreement Year	Narrative Report		Annually	2 Months after end of Measurement Period						X				X
SUD.40	Substance Use Disorder	Emergency Department Discharges for SUD: Members Received Discharge Instruction Sheet	Count and percent of discharges from an Emergency Department where the member received a discharge instruction sheet upon discharge by subpopulation. Denominators will be the same for SUD.40, SUD.41, SUD.42 and SUD.43.	Quarter	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X

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SUD.41	Substance Use Disorder	Emergency Department Discharges for SUD: Discharge Plan Submitted to Provider within 7 Calendar Days of Discharge	Count and percent of members discharged from an Emergency Department where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge by subpopulation. The contract standard = at least ninety percent (90%) of members discharged. Denominators will be the same for SUD.40, SUD.41, SUD.42 and SUD.43.	Quarter	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X
SUD.42	Substance Use Disorder	Emergency Department Discharges for SUD: MCO Contacts and Contact Attempts	Count and percent of members discharged from an Emergency Department with a substance use disorder (SUD) diagnosis during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge by subpopulation. Denominators will be the same for SUD.40, SUD.41, SUD.42 and SUD.43.	Quarter	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X

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SUD.43	Substance Use Disorder	Emergency Department Discharges for SUD: Patient Had Visit with Provider within 7 Calendar Days of Discharge	Count and percent of members discharged from Emergency Department with a substance use disorder (SUD) diagnosis during the measurement period, where the member had a visit with a provider within 7 calendar days of discharge by subpopulation. Denominators will be the same for SUD.40, SUD.41, SUD.42 and SUD.43.	Quarter	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				X
SUD.44	Substance Use Disorder	Substance Use Disorder: Any SUD Services	Count and percent of members enrolled in the measurement period who had any substance use disorder (SUD) service in the prior six months, who had any SUD service during the measurement period by subpopulation. Measure is collected quarterly with monthly breakouts. SUD.29 is the denominator.	Quarter	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				
SUD.45	Substance Use Disorder	Substance Use Disorder: SUD Diagnosis Treated in an IMD	Count and percent of members enrolled in the measurement period with a substance use disorder (SUD) diagnosis, who had SUD treatment in an Institute for Mental Disease (IMD) .	Agreement Year	Measure	SUD IMD Waiver	Annually	4 Months after end of Measurement Period						X				

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Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.46	Substance Use Disorder	Substance Use Disorder: Average Length of Stay in IMDs	Average length of stay in days for members who had substance use disorder (SUD) treatment in an Institute for Mental Disease (IMD) during the measurement year by subpopulation. The population for this measure is the numerator for SUD.45.	Agreement Year	Measure	SUD IMD Waiver	Annually	4 Months after end of Measurement Period						X				
SUD.47	Substance Use Disorder	Substance Use Disorder: Members with Inpatient Admission for SUD	Count and percent of members enrolled in the measurement period who had an inpatient admission for substance use disorder (SUD) during the measurement period per 1,000 member months by subpopulation. Measure is collected quarterly with monthly breakouts.	Month	Measure	SUD IMD Waiver	Quarterly	4 Months after end of Measurement Period						X				
SUD.48	Substance Use Disorder	Substance Use Disorder: Readmissions for SUD	Count and percent of members enrolled in the measurement period who had an inpatient admission for substance use disorder (SUD) during the measurement period followed by an acute readmission for SUD within 30 days by subpopulation.	Agreement Year	Measure	SUD IMD Waiver	Annually	4 Months after end of Measurement Period						X				



EXHIBIT O – Quality and Oversight Reporting Requirements

Deliverable Description							Data Submission		Purpose of Monitoring									
Reporting Reference ID	Domain	Name	Description / Notes	Measurement Period	Type	Required DHHS Sub population Breakout	MCO Submission Frequency	Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 DSRIP Waiver	1115 Granite Advantage	1115 SUD IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.49	Substance Use Disorder	Substance Use Disorder: Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD	Count and percent of members enrolled in the measurement period with a diagnosis for substance use disorder (SUD) who had an ambulatory or preventive care visit during the measurement period by subpopulation. (Based on HEDIS AMB)	Agreement Year	Measure	SUD IMD Waiver	Annually	4 Months after end of Measurement Period						X				

Appendix C – Medicaid Care Management Services Model Contract

New Hampshire Department of Health and Human Services

Medicaid Care Management Services

Exhibit P – MCOs Program Management Plan



The MCOs Program Management Plan

Placeholder,

Defined at contract phase and as approved by DHHS in accordance with Exhibit A Section 3.1.3 (Program Management Plan) of this Agreement.