64 MTT

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

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

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate
Commissioner

June 3, 2014

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

SOLE SOURCE

50% Fed funds / 75% Federal funds
50% Gen funds / 25% General funds

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Business and Policy, to exercise a **sole source** amendment to an agreement with Keystone Peer Review Organization, Inc., (KePRO). Vendor #166976, 777 East Park Drive, Harrisburg, PA 17111, by increasing the Price Limitation by $355,652.84 from $611,175.06 to $966,827.90 to provide benefits management, including but not limited to prior authorization, service limit override, and other Medicaid benefits determination services for New Hampshire's Medicaid Fee for Services (FFS) Program beneficiaries, effective the date of Governor and Council approval through June 30, 2016. This agreement was originally approved by Governor and Council on June 5, 2013, Item #88.

Funds are available in the following accounts for SFY 2014 and 2015, and are anticipated to be available in SFY 2016, upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts within the price limitation and amend the related terms of the contract without further approval from Governor and Executive Council.

05-95-47-470010-7937 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: OFC OF MEDICAID & BUS PLCY, OFFICE OF MEDICAID & BUSINESS POLICY, MEDICAID ADMINISTRATION

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY14	102-500731	Contracts for Prog Svc	47000501	480,018.18	95.000.00	575,018.18
SFY15	102-500731	Contracts for Prog Svc	47000102	65,578.44	254,652.84	320,231.28
SFY16	102-500731	Contracts for Prog Svc	47000102	65,578.44	6000.00	71,578.44
			Total	611,175.06	355,652.84	966,827.90

EXPLANATION

A **sole source** amendment is required in order to fund the continuation of utilization management services for Medicaid recipients remaining in fee for service arrangements. The contract was unfunded for the actual volume of services rendered in SFY 2014 and the volume of services anticipated in SFY 2015.

The purpose of this agreement is to provide for high quality and cost efficient benefits management including prior authorization, service limit override, and other benefits determination services for New Hampshire Medicaid Fee for Service Program beneficiaries. KePRO will provide benefits management services consistent with evidence-based clinical assessment and current federal and state regulations governing the Medicaid program. This agreement will ensure that the Department meets its responsibility for managing healthcare-related programs, maintaining beneficiary access to healthcare, containing healthcare costs, and ensuring the appropriateness and quality of care provided to New Hampshire Medicaid beneficiaries. Included in this agreement is a provision to conduct orthodontic review and related service authorizations.

The Department's Medicaid Program provided healthcare services coverage for more than 130,000 beneficiaries during State Fiscal Year (SFY) 2014 using a Fee for Service delivery model. With the advent of its Medicaid Care Management program on December 1, 2013, the Department's need for benefits management, although changed, will need to continue. The Department has anticipated and addressed these changes this amended contract.

This request is to add additional funding of $95,000 for SFY 2014 to cover higher than projected costs due to the number of medical reviews completed during this time-period. The estimate of the number of reviews conducted for SFY 2014 was based on the anticipated voluntarily enrollment during Step 1 into Medicaid Care Management. Since December 1, 2014, there have been a significant number of recipients opting out of care management, returning to fee for service and thereby increasing the number of KePRO medical reviews. Additional KePRO reviews were also required due to deferments in the rollout of Steps 2 and 3.

During Step One of Medicaid Care Management, KePRO will continue to provide benefits management services, including representation at any needed fair hearings, for an estimated 18,000 beneficiaries, which is expected to result in approximately 5,400 benefit decisions per year. Implementation of Step Two and Step Three will require KePRO to provide services for an estimated 5,000 beneficiaries per year, resulting in an estimated 200 benefit decisions. This agreement is based on an estimated number of covered lives, benefit decisions, and fair hearings addressing appeals of KePRO decisions. The costs associated with this agreement will be in accordance with the schedule set forth below:

Management of medical reviews of remaining Fee for Service beneficiaries during **Step 1** of the Medicaid Care Management Program will be in accordance with the schedule set forth below:

- Price Limit per Month: $16,685.94 (unchanged from original contract) for the first 250 reviews per month. All completed reviews above 250 per month will be billed at $50.00 per review

Upon commencement of Step 2 and 3, management of medical reviews of remaining Fee for Service beneficiaries of the Medicaid Care Management Program will be in accordance with the schedule set forth below:

- Price Limit per Month: $5,464.87(unchanged from original contract) for 200 medical reviews

The Department contractually reserves the right to unilaterally change the timing and pricing estimates at any time. Actual costs will not exceed the pricing limits provided above absent an amendment to this agreement.

Should the Governor and Executive Council withhold its approval of this request, the Department would be responsible for conducting prior authorization activities for services reimbursed on a fee for service basis. Existing Department staffing constraints make it highly unlikely that staff would be able to meet performance standards, contractually required of KePRO, including the timeliness of Medicaid benefits and authorization decisions. Untimely decisions on both routine and urgent medical service requests for authorization would potentially subject Medicaid beneficiaries to considerable delay and risk in accessing healthcare services. Delayed decision-making would also likely subject healthcare providers to additional administrative burden and further increase the Department's exposure to the risk of litigation.

This contract with KePRO will allow the Department to continue its stewardship of healthcare services in its Fee for Service Program. The Department will actively monitor the KePRO contract through ongoing performance measurement.

Competitive Bidding

The KePRO contract was the result of a competitive bidding process. The Department released a Request for Proposals for Medicaid Benefits Management for New Hampshire Medicaid Beneficiaries under Fee for Service Payment Arrangements on February 8, 2013. Two potential bidders sent Letters of Intent in response to the Request for Proposals to the Department, and then submitted their proposals on March 14, 2013. The Department appointed an evaluation team from Finance, Policy, and Clinical Administration to review, and score the two proposal submitted. Using a weighted evaluation tool, the team evaluated the proposals based on three broad criteria, Vendor Qualifications and Experience, Technical Approach, and Cost. The Technical Approach assessment included evaluation of the Bidders' proposal regarding thirteen programmatic criteria. KePRO achieved the highest score with a total score of 838 out of a possible 1025 total points. The proposal scoring-sheet is attached hereto. Based upon the evaluation team's findings, the Commissioner determined that KePRO is the best-qualified contractor to provide Medicaid benefits management services for the Department's Medicaid beneficiaries.

The evaluation team's final assessment reflected that, in particular, KePRO received the overall higher ranking on the service and programmatic attributes and proposed a reasonable financial structure for the Department as it transitions its Medicaid Fee for Service to a Medicaid Care Management Program. The evaluation team concluded that KePRO was more likely that the other bidder to be successful in implementing and managing cost-effective benefits management programs to improve the health status of the target population and was more likely to provide economic benefits to the State.

Geographic Area Served

The geographic area to be served is statewide.

Source of Funds

The source of funds is an enhanced federal match of 75% Federal Funds and 25% General Funds for prior authorization activities that are considered Quality Improvement Organization functions, and for any remaining funds is 50% Federal Funds and 50% General Funds.

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

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner and
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

[redacted]

13-OMBP-PA-02					Telligen		KePro
Vendor Qulaifications and Experience	**Points**	**Total Weight**	**Points**	**Initial Points**	**Final Points**	**Initial Points**	**Final Points**
Qualifications (section 4.1)	10	5	50	8	40	10	50
Experience (Section 4.1)	10	5	50	7	35	9	45
[redacted]							
Methodology Proposed/Technical Approach	**Possible Score**						
Call Center Operations (Section 3.1.1) 5	5	25	2	10	5	25	
Development of New Criteria (Section 3.1.2)	10	10	100	5	50	9	90
Review of Current Medicaid Clinical Criteria (Section 3.1.3)	5	5	25	3	15	5	25
Regulatory Development and Compliance (Section 3.1.4)	5	5	25	3	15	3	15
Coverage Determinaiton Process (Section 3.1.5)	10	10	100	6	60	9	90
Communications and Notice of Coverage Determinations (Section 3.1.6)	10	5	50	6	60	9	45
Appeals (Section 3.1.7)	10	7.5	75	7	52.5	10	75
Redirection of Site of Service (Section 3.1.8)	5	5	25	2	10	3	15
Qualtiy Assurance and Inter-rater Reliability (Section 3.1.9)	5	5	25	2	10	3	15
Physician Staffing (Section 3.1.10)	5	5	25	2	10	3	15
Accreditation (Section 3.1.11)	5	5	25	2	10	4	20
Provider Network Education and Support	5	5	25	3	15	5	25
Program Implementation	10	10	100	7	70	9	90
Sub Total	90	82.5	625	50	387.5	77	545
[redacted]							
Cost 300 Points	**Possible Score**				Telligen		KePRO
Cost Total	300	1	300		300		198
Summary	**Points**	**Total Weight**	**Points**	**Initial Points**	**Final Points**		**Final Points**
[redacted]							
Telligen	334,050	1	300				
KePro	504,945	0.66	198				

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Keystone Peer Review Organization, Inc.

This 1st Amendment to the Keystone Peer Review Organization, Inc., contract (hereinafter referred to as "Amendment One") dated this 15th day of May, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Keystone Peer Review Organization, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 777 East Park Drive, Harrisburg, PA 17111.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 5, 2013, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

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

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to fund continued medical reviews for prior authorization and service limit overrides:

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

Scope of Amendment

- Except as specifically amended and modified by the terms and conditions in this Amendment, the obligations of the parties shall remain in full force and effect in accordance with the terms and conditions set forth in the contract referenced above

- Form P-37, to change:
  Block 1.8 to read: $966,827.90

- Exhibit B, Methods and Conditions Precedent to Payment, to add:

  The contract price shall increase by $95,000.00 for SFY 2014, $254,652.84 for SFY 2015, and $6,000 for SFY 2016 for a total increase of $ 355,652.84

  Price Worksheet is replaced with Pricing Worksheet Amendment 1

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

Contractor Initials: _____
Date: 6/2/14

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

State of New Hampshire
Department of Health and Human Services

6/4/14
Date

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

Keystone Peer Review Organization, Inc.

6/2/14
Date

Name: Joseph A. Dougher
Title: President & CEO

Acknowledgement:

State of Pennsylvania, County of Dauphin on 6/2/14, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Stacy J Bolden
Signature of Notary Public or Justice of the Peace

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Stacy J. Bolden, Notary Public
Lower Paxton Twp., Dauphin County
My Commission Expires June 29, 2017
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

Notary
Name and Title of Notary or Justice of the Peace

My Commission Expires: June 29 2017

Contractor Initials:
Date: 6/2/14

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

OFFICE OF THE ATTORNEY GENERAL

6/4/14
Date

Michael K. Brown
Name: Michael K. Brown
Title: Sr. Assist. Att'y General

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

OFFICE OF THE SECRETARY OF STATE

_____
Date

_____
Name:
Title:

Contractor Initials: _____
Date: 6/2/14

Pricing Worksheet for Amendment 1

Agreement pricing is based on the volume of medical reviews anticipated in accordance with Department estimates as set forth below:

Medical Reviews	Estimated Lives	Benefit Decisions per month	Estimated benefit decisions over 250 per month	Fair Hearings
Management of FSS beneficiaries not enrolled in Medicaid Care Management STEP 1	18,000 beneficiaries per year	250/ month at $16,685.94 per month	200 per month at $50.00 per review	15/year
Management of FSS beneficiaries not enrolled in Medicaid Care Management STEP 2	5000 beneficiaries per year	16/ month at $5464.87 per month	10 per month at $50 per review	5/year
Management of FSS beneficiaries not enrolled in Medicaid Care Management STEP 3	5000 beneficiaries per year	16/ month at $5464.87 per month	10 per month at $50 per review	5/year

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Keystone Peer Review Organization, Inc. a(n) Pennsylvania corporation, is authorized to transact business in New Hampshire and qualified on April 4, 2006. I further certify that all fees and annual reports required by the Secretary of State's office have been received.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 30th day of May, A.D. 2014

William M. Gardner
Secretary of State

KEPRO
INTELLIGENT VALUE

MEETING OF THE BOARD OF DIRECTORS

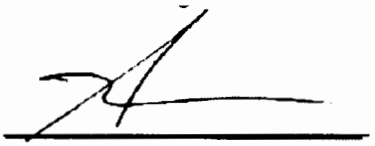
OF

Keystone Peer Review Organization, Inc. (KEPRO)

A meeting of the Board of Directors of KEPRO

was held whereby a resolution was passed authorizing the President/Chief Executive Officer as THE INDIVIDUAL AUTHORIZED TO SIGN ON BEHALF OF KEPRO, Inc.

By this signature, the undersigned may enter into any and all contractual obligations on behalf of this corporation.



Stephen McKenna, Managing Partner

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/2/2014

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

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

PRODUCER	CONTACT NAME: Joel Ellis
PSA Insurance & Financial Services 11311 McCormick Road, Ste 500 Hunt Valley MD 21031-8622	PHONE (A/C, No, Ext): (443) 798-7384 FAX (A/C, No): (443) 798-7300 E-MAIL ADDRESS: jellis@psafinancial.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hartford Fire Insurance Co	19682
INSURER B : Hartford Casualty Insurance Co	29424
INSURER C : Hartford Insurance Co Midwest	37478
INSURER D : Atlantic Specialty	
INSURER E :	
INSURER F :	

INSURED
Keystone Peer Review Organization, Inc.
777 East Park Drive
Harrisburg PA 17111

COVERAGES **CERTIFICATE NUMBER:** 2014-15 Renewal Master **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC			30UUNAT1219	5/29/2014	1/1/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ $	1,000,000 300,000 10,000 1,000,000 2,000,000 2,000,000
A	AUTOMOBILE LIABILITY [X] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [ ] HIRED AUTOS [ ] NON-OWNED AUTOS			30UUNAT1219	5/29/2014	1/1/2015	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Underinsured motorist	$ $ $ $ $	1,000,000 1,000,000
B	[X] UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [X] RETENTION $ 10,000			30RHUAT1302	5/29/2014	1/1/2015	EACH OCCURRENCE AGGREGATE	$ $	10,000,000 10,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		30WECM3723	5/29/2014	1/1/2015	WC STATU-TORY LIMITS [X] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $	 1,000,000 1,000,000 1,000,000
D	Professional Liability			MCR-6939-14	1/1/2014	1/1/2015	Limit of Liabiltiy		$5,000,000

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

CERTIFICATE HOLDER

Department of Health and Human Services
Office of Medicaid Business and Policy
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Joel Ellis/LLM Joel Ellis

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
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May 15, 2013

Approved by G+C
Date 06/05/13
Page
Item # 88
Contract #

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

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy to enter into an agreement, not to exceed $611,175.06, with Keystone Peer Review Organization, Inc. (KePRO), Vendor #166973, Harrisburg, Pennsylvania, to provide prior authorization, service limit override, and other Medicaid benefit determination services for New Hampshire's Medicaid Fee for Service (FFS) Program beneficiaries. The agreement would be effective July 1, 2013, or the date of Governor and Council approval, whichever date is later, through June 30, 2016, with an option for two, two-year extensions of the contract.

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

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

State Fiscal Year	Class Account	Class Title	Budget Amount
2014	102/500/731	Contracts for Program Services	$480,018.18
2015	102/500/731	Contracts for Program Services	$ 65,578.44
2016	102/500/731	Contracts for Program Services	$ 65,578.44
		Total	$611,175.06

EXPLANATION

The purpose of this agreement is to provide for high quality and cost efficient prior authorization, service limit override, and other benefit determination services for New Hampshire Medicaid Fee for Service Program beneficiaries. KePRO will provide benefit determination services consistent with evidence-based clinical assessment and current federal and state regulations governing the Medicaid Program. This agreement will ensure that the Department meets its responsibility for managing healthcare-related programs, maintaining beneficiary access to healthcare, containing healthcare costs, and ensuring the appropriateness and quality of care provided to New Hampshire Medicaid beneficiaries.

The Department's Medicaid Program provided healthcare services coverage for more than 130,000 beneficiaries during State Fiscal Year (SFY) 2012. New Hampshire Medicaid currently provides healthcare coverage using a Fee for Service delivery model. With the advent of its Medicaid Care Management program, the Department's need for benefits management, although changed, will continue. The Department has anticipated and addressed those changes in this contract.

The volume of work required of the Medicaid benefits contractor will decrease with each step of the implementation of New Hampshire Medicaid Care Management. Upon approval of this agreement, KePRO will provide Medicaid benefits management services for approximately 130,000 beneficiaries receiving healthcare coverage on a Fee for Service basis (estimated covered lives), which will result in an estimated 19,000 benefit decisions (prior authorizations, service limit overrides, special requests) per year. Upon implementation of Step One of Medicaid Care Management, KePRO will be required to provide benefit management services for an estimated 16,000 beneficiaries, which is expected to result in approximately 3,000 benefit decisions per year. Implementation of Step Two and Step Three will require KePRO to provide services for an estimated 5,000 beneficiaries per year, resulting in an estimated 200 benefit decisions. This agreement is based on an estimated number of covered lives, benefit decisions, and fair hearings addressing appeals of KePRO decisions. The costs associated with this agreement will be in accordance with the schedule set forth below:

Benefit Management for Fee For Service Medicaid Beneficiaries:
Price Limit per Month: $63,317.09

Management of Remaining FFS Beneficiaries during Step 1 of the Medicaid Care Management Program:
Price Limit per Month: $16,685.94

Management of Remaining FF Beneficiaries during Step 2 and Step 3 of the Medicaid Care Management Program:
Price Limit per Month: $5,464.87

These estimates result in a pricing limitation of $611,175.06. The Department contractually reserved the right to unilaterally change the timing and pricing estimates at any time. Actual costs will not exceed the pricing limits provided above absent an amendment to this agreement.

Should the Governor and Executive Council withhold its approval of this request, the Department would be responsible for conducting prior authorization activities for services reimbursed on a fee for service basis utilizing existing Department staff. Existing Department staffing constraints make it highly unlikely that staff would be able to meet performance standards, contractually required of KePRO, involving the timeliness of Medicaid benefit and authorization decisions. Untimely decisions on both routine and urgent medical service requests for authorization would subject Medicaid beneficiaries to considerable delay in accessing healthcare services, and considerable risk resulting from untimely medical service delivery. Delayed decision-making would also subject healthcare providers to additional administrative burden and increase the Department's exposure to the risk of litigation.

This contract with KePRO will allow the Department to continue to successfully manage the provision of healthcare services to Medicaid beneficiaries remaining in its Fee for Service Program. The Department has determined that quality of care and cost avoidance is realized as a result of Medicaid benefit administrative activities. These Medicaid benefit administrative activities will be continued with KePRO. The Department will actively monitor the KePRO contract through ongoing performance measurement.

Competitive Bidding

The KePRO contract was the result of a competitive bidding process. The Department released a Request for Proposals for Medicaid Benefits Management for New Hampshire Medicaid Beneficiaries under Fee for Service Payment Arrangements on February 8, 2013. Two potential bidders sent Letters of Intent in response to the Request for Proposals to the Department, and then submitted their proposals on March 14, 2013. The Department appointed an evaluation team from Finance, Policy, and Clinical Administration to review, and score the two proposals submitted. Using a weighted evaluation tool, the team evaluated the proposals based on three broad criteria, Vendor Qualifications and Experience, Technical Approach, and Cost. The Technical Approach assessment included evaluation of the Bidders' proposals regarding thirteen programmatic criteria. KePRO achieved the highest score with a total score of 838 out of a possible 1025 total points. The proposal scoring sheet is attached hereto. Based upon the evaluation team's findings, the Commissioner determined that KePRO is the best-qualified contractor to provide Medicaid benefit management services for the Department's Medicaid beneficiaries.

The evaluation team's final assessment reflected that, in particular, KePRO received the overall higher ranking on the service and programmatic attributes and proposed a reasonable financial structure for the Department as it transitions its Medicaid Fee for Service Program to a Medicaid Care Management Program. The evaluation team concluded that KePRO was more likely than the other bidder to be successful in implementing and managing cost-effective enhanced care coordination and utilization management programs to improve the health status of the target population and was more likely to provide economic benefits to the State.

The contract term may be extended twice for two-year extensions, at the option of the Department, subject to the parties' prior written agreement on applicable fees for each extended term, up to June 30, 2020, and upon satisfactory performance of the contractor and approval by the Governor and Executive Council.

Geographic Area Served

The geographic area to be served is statewide.

Source of Funds

The source of funds for SFY 2014 is an enhanced federal match of 75 % Federal Funds and 25 % General Funds for prior authorization and concurrent review activities that are considered Quality Improvement Organization functions, and for any remaining activities is 50% Federal Funds and 50% General Funds.

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

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

Form Number P-37 (version 1/09)

Subject: KePRO, Inc.

AGREEMENT

GENERAL PROVISIONS

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

1. IDENTIFICATION:

1.1 State Agency Name New Hampshire Department of Health and Human Services	1.2 State Agency Address NHDHHS Brown Building, 129 Pleasant Street Concord, NH 03301
1.3 Contractor Name Keystone Peer Review Organization, Inc. (KePRO)	1.4 Contractor Address 777 East Park Drive, Harrisburg, PA 17111-2754

1.5 Contractor Phone Number	1.6 Account Number	1.7 Completion Date	1.8 Price Limitation
(717) 303-6177		06/30/2016	$611,175.06

1.9 Contracting Officer for State Agency Kathleen Dunn, Associate Commissioner	1.10 State Agency Telephone Number (603) 271-9421
1.11 Contractor Signature [signature]	1.12 Name and Title of Contractor Signatory Joseph A. Dougher President and CEO

1.13 Acknowledgement: State of PA, County of Dauphin

On 5-14-13 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12. COMMONWEALTH OF PENNSYLVANIA

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal]

Stacy J. Bolden, Notary Public
Lower Paxton Twp., Dauphin County
My Commission Expires June 29, 2013
Member, Pennsylvania Association of Notaries

[signature] Stacy J. Bolden

1.13.2 Name and Title of Notary or Justice of the Peace

1.14 State Agency Signature [signature]	1.15 Name and Title of State Agency Signatory Kathleen Dunn, Associate Commissioner

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

By: Director, On:

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

By: [signature] Jeanne P. Herrick, Attorney On: 17 May 2013

1.18 Approval by the Governor and Executive Council

By: On:

EXHIBIT A

SCOPE OF SERVICES

TABLE OF CONTENTS

Initial

Initial

1. Introduction.

1.1. Purpose.

The purpose of this Agreement is to set forth the terms by which the Keystone Peer Review Organization, Inc. (KePRO) agrees with the New Hampshire Department of Health and Human Services (DHHS) to provide prior authorization, service limit override, and other benefits management services for New Hampshire Medicaid's Fee for Service (FFS) Program.

1.2. Agreement Period.

The initial term of this Agreement shall be from July 1, 2013, or approval by the New Hampshire Governor and Executive Council, whichever occurs last, through June 30, 2016. DHHS, in its sole discretion, may offer two (2) additional periods of two (2) years each for a total potential Agreement term of seven (7) years. The option may be exercised by mutual agreement between KePRO and DHHS upon acceptable performance of the tasks outlined in the Statement of Work and would be subject to the availability of funding and approval by New Hampshire's Governor and Executive Council.

2. Acronyms.

2.1. Acronyms.

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

ACA	Patient Protection and Affordable Care Act
BBA	Balanced Budget Act of 1997
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CHIP	Children's Health Insurance Program
CSHCN	Children with Special Health Care Needs
DHHS	New Hampshire Department of Health and Human Services
FFP	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
FTE	Full-Time-Equivalent
G&C	Governor and Executive Council
HIPAA	Health Insurance Portability and Accountability Act
KePRO	Keystone Peer Review Organization, Inc.
LTC	Long Term Care
MCO	Managed Care Organization
MCIS	Managed Care Information System
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assessment

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NH	New Hampshire
NHDHHS	New Hampshire Department of Health and Human Services
OMBP	Office of Medicaid Business and Policy
PCP	Primary Care Physician
RFP	Request for Proposal
SFY	State Fiscal Year
SPA	State Plan Amendment
SURS	Surveillance and Utilization Review Unit (within the Office of Improvement and Integrity)
URAC	Utilization Review Accreditation Commission

3. General Terms and Conditions.

3.1. Agreement elements:

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

3.1.1. **Form P 37**, Agreement, General Provisions;

3.1.2. **Exhibit A**, Statement of Work for all services provided as agreed between DHHS and KePRO;

3.1.3. **Exhibit B**, Methods and Conditions Precedent to Payment

3.1.3. **Exhibit C**, Special Provisions, Provisions and requirements in addition to those outlined in Form P-37;

3.1.4. **Exhibit D**, Certification Regarding Drug-Free Workplace Requirements as required by the federal Drug-Free Workplace Act of 1988, 41 U.S.C. 701;

3.1.5. **Exhibit E**, Certification Regarding Lobbying, KePRO's Agreement to comply with specified lobbying restrictions;

3.1.6. **Exhibit F**, Certification Regarding Debarment, Suspension, and Other Contractor Responsibility Matters – restrictions and rights of parties who have been disbarred, suspended, or become ineligible from participating in this Agreement;

3.1.7. **Exhibit G**, Certification Regarding the federal Americans with Disabilities Act Compliance; KePRO's agreement to make reasonable efforts to comply with the American with Disabilities Act (ADA); 42 U.S.C. 12101 et seq.

3.1.8. **Exhibit H**, Certification Regarding Environmental Tobacco Smoke; KePRO's agreement to make reasonable efforts to comply with the Pro-Children Act of 1994 as it pertains to environmental tobacco smoke in certain facilities;

3.1.9. **Exhibit I**, Health Insurance Portability and Accountability Act of 1996 (HIPAA) Business Associate Agreement; rights and responsibilities of KePRO in reference to this federal Act;

3.1.10. **Exhibit J**, Certification regarding Federal Funding Accountability and Transparency Act (FFATA) compliance;

3.1.11. DHHS' RFP for Medicaid Benefits Management (#13-OMBP-PA-02); and

3.1.12. KePRO's March 14, 2013 Medicaid Benefits Management Technical Proposal.

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3.2. **Order and Interpretation of Documents.**

In the event of any conflict or contradiction between the Agreement documents, the documents shall control in the above order of precedence. In the event of a dispute regarding the interpretation of Agreement terms, analysis of the these terms shall be informed by reference to DHHS' RFP for Medicaid Benefits Management Services (#13-OMBP-PA-02) and KePRO's March 14, 2013 Medicaid Benefits Management Technical Proposal, which shall both be incorporated within this Agreement, for any purpose, by reference hereto.

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

3.2.2. Errors & Omissions. Neither KePRO nor DHHS shall take advantage of any errors or omissions in the RFP or the resulting Agreement. KePRO shall promptly notify DHHS of any such errors and/or omissions as they are discovered.

3.3. **CMS Approval of Agreement & Any Amendments.**

Prior approval of this Agreement by the Centers for Medicare and Medicaid Services (CMS) is not required by federal or state law. CMS may perform a retrospective review of the Agreement for financial auditing purposes.

3.4. **Cooperation With Other Vendors And Prospective Vendors.**

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

3.5. **Renegotiation and Reprocurement Rights.**

3.5.1. Renegotiation of Agreement terms.

Notwithstanding anything in this Agreement to the contrary, DHHS shall be permitted, at any time during the term of the Agreement, to notify KePRO that DHHS has elected to renegotiate certain terms of this Agreement. Upon KePRO's receipt of DHHS' notice pursuant to this Section, KePRO and DHHS shall commence good faith negotiations of the identified Agreement terms, and may execute an amendment to this Agreement.

3.5.2. Reprocurement of services or procurement of additional services by DHHS.

Notwithstanding anything in this Agreement to the contrary, and whether or not DHHS accepted or rejected KePRO's services and/or deliverables provided during this Agreement, DHHS shall at any time be permitted to issue requests for proposals or contract offers to other potential contractors for the performance of work covered by this Agreement or for performance of work comparable to the work performed by KePRO under the terms of this Agreement. DHHS shall give KePRO ninety (90) calendar days advance notice of its intent to replace KePRO

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with another benefits management contractor or of its intent to contract with an additional benefits management contractor.

3.5.3. Termination Rights upon Re-procurement.

If upon procuring services or deliverables, or any portion of the services or deliverables from another vendor in accordance with this Section, DHHS elects to terminate this Agreement, KePRO shall have the rights and responsibilities set forth in Section 13 ("Termination"), Section 14 ("Agreement Closeout"), and Section 16 ("Dispute Resolution Process").

3.6. **Implementation of Medicaid Care Management Program.**

The parties agree that at such time when the New Hampshire Medicaid Care Management Program begins, KePRO shall continue to provide prior authorization, service limit override, and other benefits management services for the beneficiaries remaining in the FFS Program after each implementation phase of the MCM Program. DHHS shall provide Sixty (60) days advance written notice in advance of each implementation phase and the concomitant reduction in covered lives and fees.

4. Organization.

4.1. **Organization Requirements.**

Registrations, Licenses, and Certifications.

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

4.2. **Articles & Bylaws.**

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

4.3. **Relationships.**

4.3.1. Ownership and Control

4.3.1.1. KePRO is wholly owned by the Pennsylvania Medical Society (PennMed). KePRO shall notify DHHS of any person or corporation that has, or obtains over the course of this agreement, a five percent (5%) or more ownership or controlling interest in KePRO, a parent organization, subsidiaries, and/or any affiliates, and shall provide financial statements for all owners meeting this criterion.

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

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4.3.1.3. KePRO shall notify its primary contact within DHHS, by phone and by email, within twenty-four hours of key staff learning of any actual or threatened litigation, complaint, claim, investigation, transaction or any event that has the potential to have a material financial or other impact on, or otherwise impair the ability of KePRO, or any of its subcontractors, to perform its obligations under the terms of this Agreement with DHHS.

4.3.2. Prohibited Business Relationships.

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

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

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

4.3.2.2.1. A director, officer, or partner of KePRO;

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

4.3.2.2.3. A person with an employment, consulting, or other arrangement with KePRO's obligations under its Agreement with DHHS.

4.3.3. KePRO shall conduct background checks on all employees actively engaged at KePRO. In particular, those background checks shall screen for exclusions from any federal programs and sanctions from licensing oversight boards, both in-state and out-of-state.

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

4.3.4.1. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 or 1128A of the Social Security Act (42 USC 1320a-7) for the provision of health care, utilization review, medical social work, or administrative services or who excluded under Section 1128(b)(8) of the Social Security Act (42 USC 1320a-7(b)) as being controlled by a sanctioned individual;

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

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

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

4.3.4.5. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act. See 42 U.S.C. 1320a-7 (b)(8).

5. Sub-Contractors.

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5.1. Contractor's Obligations Regarding Subcontractors.

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

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

5.2. Notice and Approval.

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

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

5.2.3. DHHS approval of a subcontractor agreement does not relieve KePRO from any obligation or responsibility regarding the subcontractor and does not imply that DHHS has any obligation or responsibility regarding the subcontractor or subcontractor agreement.

5.2.4. DHHS may grant a written exception to KePRO for the notice requirements of 5.2.1 and 5.2.2 if, in DHHS's determination, KePRO has shown good cause for a shorter notice period.

5.2.5. KePRO shall notify DHHS within one (1) calendar day after receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

5.2.6. KePRO shall notify DHHS of any material breach of an agreement between KePRO and its subcontractor within one (1) calendar day of confirmation that such breach has occurred.

5.3. Contractor's Oversight.

5.3.1. KePRO shall oversee and be held accountable for any functions and responsibilities that it delegates to any subcontractor, including:

5.3.1.1. KePRO shall have a written agreement between the KePRO and the subcontractor that specifies the activities and responsibilities delegated to the subcontractor; its termination transition plan, and provisions for revoking

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delegation, or imposing other sanctions if the subcontractor's performance is inadequate.

5.3.1.2. KePRO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

5.3.1.3. KePRO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by DHHS, consistent with industry standards, State Contractor laws and regulations, and this Agreement between KePRO and DHHS.

5.3.1.4. KePRO shall identify deficiencies or areas for improvement, if any, and KePRO and the subcontractor shall take corrective action within seven (7) calendar days of identification of each deficiency. KEPRO shall provide DHHS with a copy of the Corrective Action Plan for DHHS' review and approval.

5.4. Transition Plan.

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

6. Staffing.

6.1. **KePRO Key Staff Positions**

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

6.1.1. Chief Operations Officer to provide leadership and oversee all of the activities required under this agreement, including the activities of the Implementation Manager and Project Manager;

6.1.2. Project Manager to oversee all of the activities of the Medicaid Benefits Management contract with DHHS, to work with the Implementation Manager to oversee implementation of the project activities and technology requirements, and to be the primary point of contact within KePRO for all DHHS inquiries and requests for responsive action;

6.1.3. Medical Director as needed for medical expertise, to oversee physician peer reviewers and consultants, and to provide hearing testimony and support for KePRO benefit decisions on appeal;

6.1.4. Nurse reviewers or other licensed health care professionals as deemed appropriate to interpret and apply clinical review criteria to benefits determinations and prior authorization requests;

6.1.5. Call Center Manager to provide oversight of call center operations;

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

6.1.7. KePRO shall be permitted to revise the above-outlined staffing requirements, and shall propose for DHHS' review and approval, a revised staffing plan no later than thirty (30) days before both the implementation of Step 2, and the implementation of Step 3 of New Hampshire Medicaid's Care Management Program.

6.2. DHHS Review of KePRO and Subcontractor Staff

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

6.3. **KePRO and Subcontractor Qualifications**

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

6.4. **RFP Staffing**

KePRO shall staff the Medicaid Benefits Management program, at a minimum, with all proposed staff indicated in its Proposed Organizational Chart on page 106 of its March 14, 2013 Medicaid Benefits Management Technical Proposal Response to DHHS' RFP for Medicaid Benefit Services, and with any additional personnel who are or become necessary to conduct all tasks outlined in section eight of this Agreement on a timely basis. Or, KePRO will supply staff of equal or greater qualifications than those proposed with DHHS approval.

6.5. **Provision of Staffing List**

KePRO shall provide to DHHS, for its review and approval, a complete listing of key personnel and their qualifications no later than fifteen (15) calendar days prior to the start of the New Hampshire Medicaid benefits management program.

6.6. **Maintenance of Staffing**

KePRO shall provide and maintain sufficient staff to perform all review activities and tasks specified in this agreement. In the event that KEPRO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS shall be permitted to impose liquidated damages, in accordance with section 15.2.

6.7. **Availability of Staff**

KePRO's Project and Implementation Managers shall be available to DHHS during DHHS' hours of operation and available for in-person or video-conference meetings as requested by DHHS. Key personnel, and others as required by DHHS, shall be available for monthly, in-person, or video-conference meetings with DHHS.

6.8. **Notification of Staff Changes**

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

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6.9. Staffing Contingency Plan

KePRO shall, within sixty (60) calendar days of signing this agreement, deliver to DHHS a staffing contingency plan that includes:

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

6.9.2. Provision of additional staffing resources to this agreement if KePRO is unable to meet any performance standard on a timely basis;

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

6.9.4. KePRO's ability to provide similarly qualified replacement personnel and timeframes for securing replacement personnel; and

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

7. Implementation.

7.1. Program Implementation.

KePRO shall provide clinical support for benefit review and Medicaid coverage determinations on July 1, 2013. KePRO shall achieve full operational readiness and implement all the activities covered by this agreement on or before July 15, 2013 or the date that this agreement is approved by the New Hampshire Governor and Council, whichever is later. KePRO shall use a software-based Project Management Plan, such as Microsoft Project, to ensure the efficient and effective implementation of management, monitoring, communication, and other administrative processes necessary for benefits management. The detailed schedule of activities and functional requirements needed to accomplish all of the tasks outlined in the Statement of Work shall include the following:

7.1.1. Any assumptions or constraints identified by KePRO both in developing and in completing the project work plan in order for it to be fully operational to perform Medicaid Benefit Management activities;

7.1.2. Major milestones, as planned by KePRO, including staff hiring, and time-estimating procedures;

7.1.3. A network diagram showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks and identifying the critical path;

7.1.4. A Gant chart showing the planned start and end dates of all tasks and subtasks;

7.1.5. A discussion of how the work plan provides for methods for project status reporting; an approach to internal project management structure by project phase; internal quality control monitoring of project deliverables, sign-off procedures for completion of deliverables and major activities; and an approach to problem identification and resolution; and

7.1.6. A schedule of all deliverables, which provides DHHS with a minimum of seven (7) calendar days for review.

8. Representation and Warranties.

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8.1. Warranty of Agreement

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

8.2. RFP Acknowledgment

KePRO acknowledges that by entering this Agreement, DHHS has relied upon all representations made by KePRO in its March 14, 2013 Medicaid Benefits Management Proposal, which KePRO made in response to DHHS' RFP #13-OMBP-PA-02, including all representations contained in its Technical Proposal, Addenda, and Cost Proposal. KePRO's March 14, 2013 proposal is incorporated within this agreement by reference hereto.

9. Statement of the Work.

9.1. Call Center Operation and Benefits Management.

KePRO shall perform the following activities related to New Hampshire Medicaid Benefits Management:

9.1.1. The Call Center.

KePRO shall design, implement and operate a Call Center for the New Hampshire Medicaid Program.

9.1.1.1. KePRO's Call Center will serve as a single point of contact for the providers and beneficiaries to obtain information, authorization for Medicaid benefits and other medical services and procedures. It will also serve as the single point of contact for providers seeking information, access to web portal technology, procedures for requesting authorization and processing requirements, and other pertinent program assistance from KePRO's Help Desk technician.

9.1.1.2. KePRO's call processing center will be available to respond to inquiries and requests between Monday through Friday, two days per week (8:00am and 5:00 p.m. EST) and three days per week (8:00 a.m. - 8:00 p.m. EST). KePRO's messaging systems, which support data information from phone, fax, and email, will be in place after hours and on recognized holidays to enable providers to have full access to KePRO services 24 hours a day, seven days a week. KePRO will work with DHHS during the implementation phase of this Agreement to provide for an online electronic authorization submission system that will integrate with DHHS' MMIS and will be available to providers 24 hours a day, seven days a week for the duration of this Agreement.

9.1.1.3. KePRO shall maintain full access to a language translation line in order to offer language assistance to any caller who is not fluent or has difficulty communicating in English.

9.1.1.4. KePRO shall analyze staffing demands to ensure sufficient staffing to meet URAC call center timeliness standards, and to ensure that an ample number of staff is available to assist during peak volumes or to meet any increased usage.

9.1.1.5. KePRO shall develop and maintain an operator ("0") prompt to permit providers to speak immediately with the Help Desk Technician.

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9.1.1.6. KePRO shall comply with all call center standards set forth in the table below in the operation of its Call Center:

Table 1. Call Center Timeliness Standards.

[illegible]	KePRO Proposed Standard
Monthly average hold time	60 sec
Monthly average speed to answer	< 15 seconds for 100% of calls
Monthly average queue time	60 sec
Abandonment rate	3% or less
Voice Messages Returned	50% returned same day, 100% returned next business day
Call Duration Limits	None shall be in place
Option to Speak with a "live" person	Offered 100% of the time

9.1.2. Prior Authorization: Development of New Clinical Review Criteria.

KePRO shall identify new services requiring prior authorization and other benefit management strategies and establish policies and procedures for requesting, reviewing, and approving or denying medical service requests. Guidelines used and developed must be based first on evidence-based information and may also be consider, to the extent that they are based on evidence, nationally-accepted guidelines.

9.1.2.1. KePRO and DHHS agree that medical evidence is the foundation for good medical care and ensuring that medical criteria applied to program operations is based on solid, defendable research, will not only eliminate unnecessary utilization and improve beneficiary health outcomes but will also reduce appeals and grievances.

9.1.2.2. KePRO's criteria development shall include the following stages:

9.1.2.2.1. KePRO's clinical team will perform a comprehensive review of evidence-based and general medical and behavioral health literature;

9.1.2.2.2. Clinical consultants will review the content and suggest revisions to KePRO's clinical team, which synthesizes them and then sends the content back to the consultants for further reviews;

9.1.2.2.3. Clinical consultants who have not been part of the process up to this point assess and validate the content for clinical accuracy. KePRO shall maintain its network of over 2500 specialty and subspecialty physicians available for consultation and review of criteria;

9.1.2.2.4. Content will be reviewed for clinical consistency and completeness by KePRO's clinical operational staff, and once that review is complete, it will be provided to DHHS for its review and approval;

9.1.2.2.5. KePRO will prepare a draft in a format approved by DHHS and present to DHHS for approval KePRO's recommended coverage criteria based on a schedule agreed upon by KePRO and DHHS during project implementation meetings. Information contained in KEPRO's approval for coverage criteria request form for DHHS shall include:

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a. Service, Supply, Equipment and CPT/HCPCS applicable code;
b. Reason for revision;
c. Date of revision;
d. Approved by;
e. Implementation date;
f. Changes from prior criteria;
g. Old Criteria;
h. Proposed New Criteria;
i. Anticipated Medicaid program impact, both clinical impact and financial impact, and References used to develop criteria.

9.1.2.2.6. Content will be prepared for KePRO software and operations following review and approval by DHHS.

9.1.2.3. KePRO will continue to make recommendations for criteria development and revision throughout the life of the contract. Priorities shall be determined by DHHS during monthly status meetings. In addition, KePRO will provide DHHS with suggestions for areas requiring modifications.

9.1.2.4. KePRO will conduct research as necessary but no less than annually regarding the current body of medical evidence for a particular medical item or service to ensure that criteria and/or guidelines are evidenced-based.

9.1.3. Prior Authorization: Review of Current New Hampshire Medicaid Criteria.

9.1.3.1. KePRO shall undertake a review on no less than an annual basis, and as deemed necessary by either DHHS or KePRO, of existing DHHS prior authorization and benefit management policies, and shall:

9.1.3.1.1. Review historical prior authorization data for New Hampshire Medicaid, review medical evidence and other national standards for comparison to New Hampshire Medicaid's prior authorization criteria, and work with DHHS to develop an expedited review process for specific requests with a high rate (>98%) of approval ;

9.1.3.1.2. Recommend modifications to existing policies and procedures;

9.1.3.1.3. Determine which services should and which services should not continue to be subject to prior authorization;

9.1.3.1.4. Determine whether and what additional service limitations should be considered; and

9.1.3.1.5. Explain its reasoning for continuing or changing prior authorization requirements with their recommendations to DHHS for changes to the current menu of services requiring prior authorization.

9.1.3.2. KePRO shall assist DHHS in the development of documentation required for procedure code, and administrative rule and/or state plan amendment (SPA) changes.

9.1.3.3. KePRO shall, on an ongoing and timely basis and throughout the duration of this Agreement, identify new procedure codes requiring modification and notify DHHS and MMIS administrators of the need for code changes so that the claims system can be updated as required.

9.1.4. Coverage Determination Process.

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9.1.4.1. KePRO shall review all requests for authorization of services, and shall make benefit determinations and prior authorization decisions for these services for Medicaid beneficiaries in accordance with established policies and procedures. KePRO shall consistently apply appropriate clinical criteria to determine medical necessity, taking into consideration each Medicaid beneficiary's individual health care needs, and provide for the administration and management of health care benefits and services.

9.1.4.2. KePRO shall assign staff to this project with appropriate clinical licensure, certification, expertise, and training to be able to accurately interpret and apply clinical review criteria. KePRO assures that all Clinical Review staff remains compliant with current regulations and in compliance with State and Federal law, regulations, policy, and administrative rules thorough education, training, quality assurance and frequent and thorough communications.

9.1.4.3. KePRO shall verify that each beneficiary's eligibility for benefits during the date span for the services requested and that the requested health care services meet all applicable provisions of the New Hampshire Code of Administrative Rules.

9.1.4.4. In instances where the provided information associated with a request for prior authorization or benefit determination is insufficient to meet criteria, KePRO will place the case in a pending status in the MMIS system, fax notification to the provider, post its decision to MMIS, and display it electronically on KePRO's provider web portal. KePRO shall permit providers to submit additional information through the Web portal, by phone, by mail or by Fax. Once the registered nurse or physician is able to validate that criteria are met, the case will be routed in a complete status (The case will be designated as complete). KePRO shall post the status of its determination in MMIS within 24 hours of validation that criteria are met, and will post the determination to the provider web portal, fax providers, and mail approval notices to beneficiaries.

9.1.4.5. KePRO shall have sufficient intake staff to screen requests for completeness and request non-clinical information as appropriate for requested services within one business day of KePRO's receipt of the information.

9.1.4.6. KePRO shall provide that its nurse reviewer forward any authorization request where it is determined that criteria are not met to a board-certified, licensed (in the state where the physician practices) physician in good standing. The physician evaluator shall:

9.1.4.6.1. Review the medical record and all supporting documentation pertaining to an admission before rendering a decision.

9.1.4.6.2. Attempt to contact the ordering physician or hospital for further documentation if the evaluating physician requires more information or clarification to make a determination before making a decision or suspending the case.

9.1.4.6.3. Inform the attending physician's staff of the purpose of the call if the attending physician is unavailable and provide verbal instructions on how to arrange for a peer-to-peer discussion; and

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9.1.4.6.4. Issue a written determination based on the information available to the evaluating physician in the event that the attending physician does not call back for a peer-to-peer discussion.

9.1.4.7. When requests do not meet clinical review criteria, KePRO shall fax a written denial notice to the provider, post the notice on its secure provider web page, and mail the denial notice to the beneficiary. The notice shall contain the following information:

- Date of notice;
- Brief statement of KePRO's authority and responsibility for review;
- Provider name;
- From and through requested date(s) of service;
- Date(s) of service and procedure(s) approved, denied, or modified; approvals also include number of units/days of service;
- Prior authorization number, for partial approvals;
- Clear specific reason for approval or denial, including a reference to the appropriate criteria utilized and administrative rule; and
- Detailed information regarding DHHS' appeals and fair hearing process.

9.1.4.8. KePRO shall perform all reviews within DHHS required timeframes, unless otherwise agreed in writing. Urgent requests requiring immediate attention and emergent requests receive first priority in the work queue and are processed within one (1) business day of request. KePRO will perform routine high tech diagnostic radiology requests within two business days, and routine requests for all other services within ten calendar days.

9.1.4.9. KePRO shall enter its benefit determinations, and prior authorization of service decisions, i.e., service request approvals, denials, or pending dispositions, into New Hampshire Medicaid's MMIS. KePRO shall collaborate with DHHS to design and implement an effective interface with New Hampshire Medicaid's MMIS during the implementation phase and, as necessary, during the pendency of this Agreement.

9.1.5. Communications and Notice of Coverage Determinations.

9.1.5.1. KePRO shall establish and maintain a telephone-based (telephone and fax) service for Medicaid beneficiaries and providers requesting prior authorization and benefit determinations.

9.1.5.2. KePRO shall have the capability to accept and respond to e-mail correspondence from providers.

9.1.5.3. KePRO shall document and maintain written documentation of all of its efforts to obtain pertinent clinical and other information necessary for a benefit determination before it issues any denial based upon insufficient clinical information.

9.1.5.4. KePRO shall have the capability to provide timely notice of benefits determination decisions to providers via fax, and beneficiaries via first class, postage prepaid, U.S.P.S. mail. Although KePRO will be permitted to communicate with providers regarding its benefit determinations by telephone or

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email, KePRO shall provide written notice of its prior authorization and benefit determination denials to providers and beneficiaries.

9.1.5.5. KePRO will work with DHHS to design and implement a secure, web-based Medicaid management platform for entering and processing provider coverage determination requests.

9.1.5.6. KePRO will develop and maintain a comprehensive DHHS-specific website, with links to general program information, including service-specific programs, clinical criteria used to make coverage determinations, benefit limitations, forms needed to request service authorizations, program manuals, direct access to KePRO's web-based system for secure online service requests and checking review status, fax notification letters, and links to DHHS' website.

9.1.6. Appeals and Grievances.

KePRO shall address all beneficiary appeals, and provider and beneficiary complaints and grievances, including expedited appeal requests from its authorization and benefit determinations. KePRO, at a minimum, shall:

9.1.6.1. Provide notice to all providers and beneficiaries whose requests for authorization of services is denied or reduced, that they may submit a request for appeal or expedited appeal to KePRO within ten(10) calendar days of the date of KePRO's denial notification. If KePRO upholds its original adverse decision, or if there is no request for appeal submitted to KePRO within ten calendar days of the adverse decision, KePRO shall provide written notice to the provider and beneficiary that they may appeal KePRO's decision to DHHS within thirty (30) calendar days of the date of its decision or notice. KePRO's written notice shall be sent out within three (3) calendar days of the date of its decision or the date of expiration of the ten-day notice period in the event that it receives no appeal of its original decision. If the last day of the notice or appeal period falls on a weekend or holiday, the deadline shall be extended to the next business day.

9.1.6.1. Establish and comply with DHHS-approved notice standards for issuing its decisions in prior authorization and benefit determinations appeals;

9.1.6.2. Represent that its benefit determination decisions are the decisions of DHHS;

9.1.6.3. Provide a detailed notice, as approved by DHHS, with its adverse determinations regarding DHHS' administrative appeals and fair hearing process

9.1.6.4. Ensure that KePRO's Medical Director and any other staff member involved in benefit decisions are available to appear by telephone or other electronic medium, and shall testify in support of its benefit decisions on appeal at fair hearing;

9.1.6.5. Collaborate with DHHS to prepare for and handle beneficiary fair hearing cases involving appeals of KePRO staff decisions; and

9.1.6.6. Establish and maintain a comprehensive grievance response system for handling provider and Medicaid beneficiary grievances about KePRO's Call Center activities in accordance with the following:

9.1.6.6.1. Voicemail and emailed grievances and complaints shall receive a response from KePRO acknowledging receipt of the grievance or complaint within one (1) business day of KePRO's receipt of the grievance or complaint. All telephonic, electronic, faxed, or mailed

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complaints/grievances must be logged, tracked and resolved by the individual receiving it. Resolution of the case must not extend beyond seven (7) calendar days. If resolution cannot be achieved within that timeframe, KePRO shall notify DHHS and provide documentation associated with the grievance or complaint. All providers will be notified of actions taken for resolution; and

9.1.6.6.2. KePRO shall provide a Complaint and Grievance Summary Report to DHHS on a monthly basis.

9.1.7. Redirection for Sites of Service

9.1.7.1. KePRO shall, as part of its prior authorization and benefit determination responsibilities, encourage the utilization of primary care providers (PCPs) and other appropriate care settings by Medicaid beneficiaries and discourage inappropriate use of Hospital Emergency Departments or other specialized settings.

9.1.7.2. KePRO's approach must reflect an understanding of appropriate care for the medical circumstances and shall be consistent with an efficient utilization of resources available to beneficiaries within the New Hampshire Medicaid program.

9.1.7.3. KePRO shall comply with 42 CFR 476 when conducting reviews. In addition to reviewing service requests for reasonableness and medical necessity of the services, KePRO shall also evaluate where the services are to be performed. KePRO's reviews shall ensure that beneficiaries receive appropriate services in a timely and cost effective manner and ensure the setting of care is appropriate for the procedure or service, taking into consideration the unique needs and health status of each Medicaid beneficiary.

9.1.8. Quality Assurance and Inter-Rater Reliability.

9.1.8.1. KePRO shall conduct quality assurance audits to ensure the appropriateness and accuracy of its staff's review decisions.

9.1.8.2. KePRO shall report the outcome of staff audits to DHHS on a bi-annual basis. KePRO reports shall include its determination of its staff's inter-rater reliability, as well as the basis for its reliability determination.

9.1.8.3. KePRO shall identify for DHHS corrective actions it has implemented to improve staff consistency and compliance with prior authorization and utilization management policies and procedures.

9.1.8.4. DHHS shall be permitted, at any time during the pendency of the contract, to conduct additional compliance reviews as, in its sole discretion, it determines to be warranted.

9.1.9. Physician Staffing.

9.1.9.1. KePRO shall consult with a licensed physician in good standing, with a thorough clinical understanding of medical service needs, Medicaid benefits, and service limitations.

9.1.9.2. KePRO shall ensure that a licensed physician in good standing and with a thorough clinical understanding of medical service needs, Medicaid benefits and service limitations, makes the medical determination on any appeal of service limitations.

9.1.9.3. KePRO's medical director shall conduct internal quality performance monitoring on a random set of reviewed claims to assess the quality and accuracy

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of each physician reviewer to ensure all reviewers are making accurate and appropriate medical necessity determinations for the contact in which they perform review. Information from the monitoring process shall be provided to DHHS no less than annually.

9.1.10. Accreditation.

KePRO shall be accredited by and remain in compliance with the standards of the NCQA (National Commission on Quality Assurance) or URAC (Utilization Review Accreditation Commission). Copies of KePRO's current accreditations and certifications shall be provided to DHHS at the time of execution of this Agreement.

9.1.11. Network Provider Education and Support.

KePRO shall, with DHHS' review and approval, train providers regarding KePRO's Call Center review procedures, their decision-making framework, and reconsideration and appeal procedures.

9.1.11.1. For the remainder of calendar year 2013, KePRO shall engage providers in the training they need for successful participation in their Medicaid Benefits Management program in accordance with the table set forth below:

Table 2. Proposed Provider Training Schedule for 2013.

Acute Service Authorizations: • Inpatient (Medical, Psych) • Transplant, Rehab, ER, out of state admission	X	X	X			
Outpatient Service Authorizations • DME, X-Ray, Med Tech W/C/Incontinence • Hearing, Vision, Podiatry, and Psychology • OT, SP, and PT	X	X		X		
Home Care and PDN Service Authorizations	X	X			X	
Personal Care and EPSTD Service Authorizations	X	X			X	
Denials, Appeals, and Hearing Support	X	X	X			
Criteria Changes	X	X				

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Policy, Service, and Process Changes	X	X				X
Web-based Systems • *Rules-Driven Auto Approval (RDAA)* • Electronic Submission Process • Provider Portal	X		X		X	

9.1.11.2. Once KePRO's benefit management program is implemented and providers have been trained in its procedures, KePRO shall provide DHHS and providers with, at a minimum, one annual in-person training and three training webinars on topics KePRO recommends to and are approved by DHHS.

9.1.12. Regulatory Development and Compliance.

KePRO shall remain current and in compliance with state and federal law, regulations, and policies, including 42 CFR 476, and integrate their work with New Hampshire Medicaid in order to ensure legal compliance and assist DHHS in work related drafting and updating administrative rules, the New Hampshire State Plan Amendment (SPA), and procedure code and operational changes. To ensure compliance with state and federal law, KePRO shall:

9.1.12.1. Have a compliance officer who is responsible for developing, operating, and monitoring the compliance program. The compliance officer will oversee the program, including making revisions as needs change, coordinating and participating in training and education for employees, independently investigating compliance matters, and ensuring that any necessary corrective action is taken;

9.1.12.2. Ensure that its compliance officer creates and maintains effective lines of communication with all employees. This should include a process, such as a hotline or other reporting system, to encourage questions and complaints and procedures to protect the confidentiality of reports and anonymity of the complainants and to protect employees against retaliation;

9.1.12.3. Implement and maintain a record retention system that ensures complete and accurate medical record documentation, including policies and procedures addressing documentation of services records, retention and destruction of records and privacy concerns. KePRO's managers shall be able at all times to demonstrate the integrity of the company's compliance process, its effectiveness, and the company's efforts to comply with all applicable statutes and regulations;

9.1.12.4. Provide periodic education and training of all managers, physicians and company personnel at all levels. The content may vary according to the specific group being trained, but all must, at a minimum, understand the company's standards of conduct, Federal, State, and Agency level requirements and the necessity of compliance with those requirements, proper documentation in clinical and financial records, the prohibition on payment for referrals, residents' rights, and the duty to report misconduct;

9.1.12.5. Require its managers to discuss with all supervised employees and contractors, the compliance policies and legal requirements related to their

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respective functions, inform personnel that strict compliance with those policies and requirements are conditions of their employment, and warn them that KePRO is required to take disciplinary action in the event of any violations;

9.1.12.6. Maintain and enforce standards through well-publicized disciplinary guidelines that require compliance and provide for consequences for any breach of policy;

9.1.12.7. Monitor its implementation of the compliance program through a process of ongoing evaluation, including regular, periodic compliance audits by internal or external evaluators with the expertise in Federal and State requirements;

9.1.12.8. Launch an immediate investigation if the compliance officer receives reports or reasonable indications of suspected noncompliance to determine if there has been a violation of law or other requirements and, if so, take appropriate steps to correct the problem. Corrective action may, among other things, include developing a plan of action, returning overpayments, or making a referral to criminal or civil law authorities;

9.1.12.9. Evaluate the compliance program on a biannual basis to assess its effectiveness as a whole, including how the compliance policies perform in practice to monitor the company's operations on a day-to-day basis; and

9.1.12.10. Develop, post, and distribute to KePRO personnel written compliance standards, procedures, and practices, which shall include a code of conduct detailing the fundamental principles, values and framework for action within the organization; general corporate policies and procedures; a synthesis of key Federal and State laws, and specific provisions for various internal clinical, financial, and administrative functions. The written standards, procedures, and practices should be readily understood by all employees, as well as physicians, suppliers, agents, and contractors.

9.2. Reporting Requirements.

KePRO shall produce reports in accordance with the requirements set forth in Table 1 below:

Table 3. Reporting Requirements.

Report Name	Frequency	Format
Operational statistics report including Call center operations oversight, benefit management activities, grievances, appeals, fair hearings	Monthly for the first 6 months of Year One, then quarterly thereafter, with 12 month trends	Format to be determined as part of readiness review Enumeration of Benefits Management activities, with narrative addressing resolution or action steps for grievances, appeals and fair hearing
Diagnostic Radiology reports	Monthly for the first 6 months of Year One, then Quarterly thereafter, with 12 month trends	Format to be determined as part of readiness review

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Out of State Hospital admissions report	Quarterly with 12 month trends	Format to be determined as part of readiness review
Quality assurance audits and inter-rater reliability report (IRR)	Quarterly with 12 month trends	Report of findings including narrative as to corrective action plan
Staffing report including verification of licensure and /or certification; Key Staff contact list including corporate contacts	Annually, leadership updates should be communicated to DHHS within 3 business days	Format to be determined as part of readiness review and to be included as part of operational report A list of names, title, physical location, email address, phone number, cell phone number, and fax number
Annual Report for Benefits Management program activities	Annual report for 2014, 2015 and 2016 shall be received by the State no later than forty- five (45) calendar days after the close of the State fiscal year i.e. by August 15, 2014 for SFY2014 and so on	Annual report for Benefits Management program activities which shall include: 1) Executive summary of Benefits Management program activities, and opportunities for improvement; 2) Impact of Benefits Management program on medical services utilization and identification of any unintended consequences; 3) Summary of operational performance measures and trends;

10. Cultural Considerations.

KePRO shall have a comprehensive, written Cultural Competency Plan describing how KePRO ensures that its services are provided and its interactions with Medicaid beneficiaries and MCO members, including those with limited English proficiency, occur in a culturally competent manner. The Cultural Competency Plan shall describe how KePRO and all of its subcontractors interact with people of all cultures, races, religions, ethnic and economic backgrounds in a manner that recognizes values, and respects the worth and dignity of individual Medicaid beneficiaries. The plan shall be provided to DHHS 10 calendar days prior to implementation. KePRO shall work with DHHS, and the U.S. Department of Health and Human Services Office of Minority Health and Refugee Affairs to address any issues of cultural competence that arise.

11. Survival.

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The following provisions survive expiration, cancellation, or termination of this agreement: section 12, Compliance with State and Federal Laws; section 13, Termination; section 14, Agreement Closeout; section 15, Remedies; section 16, Dispute Resolution Process; section 17, Confidentiality; and section 18, Publicity.

12. Compliance with State and Federal Laws.

12.1. General.

12.1.1. KePRO, its subcontractors, and the providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

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

12.1.3. KePRO shall comply with the following Federal and State Medicaid statutes, regulations, and policies:

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

12.1.3.2. Related rules: Title 42 Chapter IV;

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

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

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

12.1.3.6. Regulations promulgated there under: 42 CFR 457;

12.1.3.7. Patient Protection and Affordable Care Act of 2010;

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

12.1.3.9. American Recovery and Reinvestment Act.

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

12.2. Non-Discrimination.

KePRO shall require its providers and subcontractors to comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or

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physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

12.3. ADA Compliance.

12.3.1. KePRO shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, KePRO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

12.3.2. KePRO shall submit to DHHS, ten days prior to implementation, a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of KePRO's knowledge. KePRO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by KePRO and shall be available for inspection by the DHHS. KePRO 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 KePRO to be in compliance with the ADA. Where applicable, KEPRO shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

12.3.3. KePRO shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all members who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

12.3.4. KePRO shall forward to DHHS copies of all grievances alleging discrimination against members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability for review and appropriate action within five (5) calendar days of receipt by KePRO.

12.4. Non-Discrimination in Employment.

12.4.1. KePRO will not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. KePRO 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 race, color, religion, sex or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. KePRO 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.

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

12.4.3. KePRO will send to each labor union or representative of workers with which he has a collective bargaining Agreement or other Agreement or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of KePRO's commitments under Section 202 of President Johnson's Executive Order No. 11246 of September 24, 1965, which established requirements for non-discriminatory practice in hiring and employment on the part of federal contractors, and shall post copies of the notice in conspicuous places available to employees and applicants for employment. See Exec. Order No. 11,246, 3C.F.R. 339 [1964–1965]. See also 42 U.S.C. 2000e.

12.4.4. KePRO will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the United States Secretary of Labor.

12.4.5. KePRO 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.

12.4.6. In the event of KePRO's noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and KEPRO 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.

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

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threatened with, litigation with a subcontractor or vendor as a result of such direction, KEPRO may request the United States to enter into such litigation to protect the interests of the United States.

12.5. Changes in Law.

KePRO shall remain current and comply with all relevant and applicable changes in federal and state law. KePRO shall implement appropriate system changes, as required by changes to federal and state laws, regulations, or policy.

13. Termination.

13.1. Transition Assistance.

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

13.1.1. Transition Plan

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

13.1.2. Data

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

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

13.2. Termination for Cause.

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

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

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

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

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13.2.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within thirty (30) calendar days of DHHS' notice of breach and written request for compliance. DHHS' notice shall be effective the date it is sent to KePRO;

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

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

13.2.1.7. Becomes insolvent;

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

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

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

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

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

13.3. Termination for Other Reasons.

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

13.4. Survival of terms.

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

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

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

14. Agreement Closeout.

14.1. Closeout Period.

A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day of KePRO's contract with DHHS. During the closeout period, KePRO shall work cooperatively with, and supply program information to, any subsequent contractor and

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DHHS. DHHS shall define the program information, and the working relationship between KePRO and the subsequent contractor.

14.2. Data.

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

14.2.2. All data and information provided by KePRO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. KePRO 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.

15. Remedies.

15.1. Reservation of Rights and Remedies.

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

15.2. Liquidated Damages.

15.2.1. DHHS and KePRO agree that it will be extremely impracticable and difficult to determine the actual damages that DHHS will sustain if KePRO fails to maintain the required performance standards throughout the life of this Agreement. Any breach by KePRO would delay and disrupt DHHS's operations and obligations, and would lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the table below are reasonable.

15.2.2. Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies as may be available to DHHS. Except and to the extent expressly

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provided herein, DHHS shall be entitled to recover liquidated damages cumulatively under each section applicable to any given incident.

15.2.3. DHHS shall make all assessments of liquidated damages. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify KePRO as specified in Section 15.5. of this Agreement.

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

15.2.5. KePRO agrees that as determined by DHHS, failure to provide services meeting the performance standards would result in liquidated damages as specified. KePRO agrees to abide by the Performance Standards and Liquidated Damages as specified. DHHS' decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

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

15.2.7. Liquidated damages will be assessed for each day, incidence or occurrence, as applicable, of a violation or failure.

15.2.8. KePRO agrees that failure to provide services meeting the performance standards set forth in the table below, as determined by DHHS, will result in the imposition of liquidated damages as indicated:

Table 4. Liquidated Damages.

1.) Operational Readiness	Must be achieved by August 1, 2013.	DHHS may access liquidated damages in the amount of $2000 per business day for failure to implement the UM program on time. KePRO shall not be held liable for delays in implementation imposed by the State.
2) Key personnel	Key personnel vacancies must be filled within 60 calendar days of a vacancy	DHHS may access liquidated damages in the amount of $100 per business day for failure to fill key personnel vacancies within 60 calendar days of a vacancy
3) Notification of staffing changes	DHHS must be notified in writing within three (3) business days of any temporary or permanent changes to the personnel commitments made in the Contractor's proposal or DHHS approved staffing plan	DHHS may access liquidated damages in the amount of $50 per day for failure to notify DHHS of personnel changes in writing within three (3) business days
4) Reporting Requirements	The Contractor shall provide all reports specified in an acceptable format to DHHS	DHHS may access liquidated damages in the amount of $500 per report per business day for failure to provide any

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Service Performance	Standard	Potential Liquidated Damages
	within the stated time period	of the required reports in an acceptable format and/or on time. Damages shall accumulate daily on an ongoing basis until the report(s) is provided and is in an acceptable format to DHHS
5) Project Plan Noncompliance	The Project Plan submitted by the Contractor reflects policies, procedures and processes used in the execution of the Contract. Any deviation will require the prior written approval of DHHS and amendment of the Project Plan.	DHHS may access liquidated damages in the amount of $1000 per business day for each day in which the Contractor fails to maintain the project Plan, to follow its provisions, or initiates any actions not covered and /or not approved by DHHS. Damages shall accumulate daily on an ongoing basis until the Contractor's performance is in compliance with a DHHS approved Project Plan.
6) Performance Standards	Performance standards used in the execution of the Contract are to be adhered to throughout the Contract period. Any deviation from the aged upon performance standards will require the prior written approval of DHHS	DHHS may access liquidated damages in the amount of $1000 per business day for failure to adhere to any of the established performance standards.

15.3. Suspension of Payment.

15.3.1. Payments to KePRO shall be suspended when:

15.3.1.1. KEPRO fails to cure a default under this Agreement within thirty (30) calendar days of written notification; or

15.3.1.2. KEPRO fails to act on identified Corrective Action Plan.

15.3.2. Upon correction of the deficiency or omission, payments shall be reinstated.

15.4. Administrative and Other Remedies.

In addition to liquidated damages, DHHS may impose the following other remedies:

15.4.1. Termination of the Agreement if KePRO fails to carry out the substantive terms of the Agreement.

15.5. Notice of Remedies.

Prior to the imposition of either liquidated damages or any other remedies under this Agreement, including termination for breach, with the exception of requirements related to the Implementation Plan, DHHS will issue a written notice of remedies to KePRO that will include, as applicable, the following:

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

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

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15.5.3. The basis for DHHS's determination that the remedies shall be imposed;
15.5.4. A request for a Corrective Action Plan;
15.5.5. The timeframe and procedure for KePRO to dispute DHHS's determination, with the provision that KePRO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and
15.5.6. A statement that if the failure is not resolved within the cure period, DHHS shall be permitted to impose liquidated damages retroactively to the date of the Contractor's failure to perform, and shall continue to accrue until the failure is cured, or any resulting dispute is resolved in the Contractor's favor.

16. Dispute Resolution Process.

16.1. Informal Dispute Process.

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

16.2. No Waiver.

KePRO's exercise of its rights under Section 16.1 shall not limit, be deemed a waiver of, or otherwise affect the parties' rights or remedies otherwise available under law or this Agreement, including KePRO's right to appeal a DHHS decision under RSA chapter 541-A, or any applicable provisions of the New Hampshire Code of Administrative Rules, including Chapter He-C 200 Rules of Practice and Procedure.

16. Confidentiality.

16.1. Disclosure of Confidential Records.

All information, reports, data, and records maintained hereunder or collected in connection with the performance of the services performed under this Agreement are confidential. KePRO shall not disclose any confidential information except to public officials requiring such information in connection with their official duties and with the administration of the contracted services and the Agreement pursuant to State law and DHHS regulations regarding the permissible use and disclosure of such information. The use or disclosure of any information by any party about a Medicaid beneficiary for any

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purpose not directly related to DHHS' or KePRO's responsibilities hereunder is prohibited unless disclosure is specifically permitted by written consent of the beneficiary, the beneficiary's Attorney, or the beneficiary's guardian.

16.2. **Confidentiality of Records.**

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

17. Publicity.

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

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EXHIBIT B

METHODS AND CONDITIONS PRECEDENT TO PAYMENT
MEDICAID BENEFITS MANAGEMENT FOR NEW HAMPSHIRE
MEDICAID BENEFICIARIES UNDER FEE FOR SERVICE PAYMENT ARRANGEMENTS

This agreement is reimbursed on a monthly basis for a three-year Agreement term, subject to all conditions contained within Exhibit A. Reimbursement for the first year of the Agreement shall commence on July 1, 2013, or the date of approval of the contract by the New Hampshire Governor and Executive Council, whichever is later.

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

Jane M. Hybsch, RN BSN MHA
Administrator, Medicaid Care Management Programs
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Brown Building
Concord, NH 03301-3857

The monthly invoice shall identify charges for deliverables and support aggregated to a total amount for the month based on the current implementation stage of the New Hampshire Medicaid Care Management Program.

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

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

The Contractor agrees to use and apply all payments made by the State for direct and indirect costs and expenses associated with the execution of this Agreement. The Contractor's expenses for administration of any subcontractors shall not exceed the amounts identified in the project budget. Allowable costs and expenses shall be determined by the State in accordance with the project budget and applicable state and federal laws and regulations.

The Contractor agrees not to use or apply such payments for capital additions or improvements, dues to societies and organizations, entertainment costs, or any other costs not approved in advance and in writing by DHHS.

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

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Price Limitation. This Agreement is based on an estimated number of covered lives, benefit decisions, and fair hearings. These estimates will be impacted and reduced as New Hampshire Medicaid's Care Management Program is implemented. The exact timing of each step of this implementation is not currently known. Pricing will depend on which step of implementation the Medicaid Care Management Program is in.

The initial number of estimated benefit determinations is based on the current number of Fee For Service Medicaid beneficiaries and benefit determinations. The prospective estimated number of benefit determinations, prior to implementation of Medicaid Care Management, is 19,000 per year. The parties agree that benefit determinations and pricing are estimated to decrease during each phase of implementation as set forth above. The costs will decrease with each step of implementation of Medicaid Care Management. The parties agree that DHHS will provide sixty (60) days advance written notice to KePRO of the commencement of each step of Care Management implementation and the concomitant reduction in covered lives and fees.

DHHS estimates for the purposes of this agreement, and subject to amendment as needed, that KePRO will be required to provide benefit management services:

- for the current level of FFS Medicaid beneficiaries from July 1, 2013, through December 31, 2013,
- for FFS Medicaid beneficiaries in Step One of Medicaid Care Management implementation from January 1, 2014 through June 30, 2014, and
- for FFS Medicaid beneficiaries in Step Two and Step Three of Medicaid Care Management from July 1, 2014 through the remainder of the contract period.

Thess estimations result in a pricing limitation of $611,175.06. Nothing in this Exhibit shall obligate DHHS to pay amounts greater than those monthly amounts set forth above to correlate with the various phases of Medicaid Care Management for services provided during the respective phases of Medicaid Care Management. This estimation is an estimation of facts and circumstances that are not currently known, and is therefore subject to change as circumstances change. DHHS reserves the right at any time to change both its timing and its pricing estimates. Actual costs shall not exceed the pricing limits provided above absent an amendment to this agreement.

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

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Pricing Worksheet

Agreement Pricing is based on the volume of work anticipated in accordance with DHHS estimates as set forth below:

	Estimated Covered Lives	Benefit Decisions, i.e. PA, SLOC and special needs SSO	Fair Hearings
Current Medicaid Beneficiaries - Prior to Medicaid Care Management Enrollment	130,000 beneficiaries per year	19,000/ year	25 / year
Management of Remaining FFS Beneficiaries not enrolled in Medicaid Care Management STEP 1	16,000 beneficiaries per year	3,000/year	15 / year
Management of Remaining FFS Beneficiaries not enrolled in Medicaid Care Management STEP 2	5,000 beneficiaries per year	200/year	5 / year
Management of Remaining FFS Beneficiaries not enrolled in Medicaid Care Management STEP 3 - Medicaid Expansion and dual eligibles	5,000 beneficiaries per year	200/year	5/ year

Management of Current Level of Medicaid Beneficiaries (Pre-Implementation of the Medicaid Care Management Program).
Price Limit per Month: $63,317.09

Management of Remaining FFS Beneficiaries not enrolled in Medicaid Care Management during Step 1 of the implementation of the Medicaid Care Management Program.
Price Limit per Month: $16,685.94

Management of Remaining FF Beneficiaries not enrolled in Medicaid Care Management during Step 2 of the implementation of the Medicaid Care Management Program.
Price Limit per Month: $5,464.87

Management of Remaining FF Beneficiaries not enrolled in Medicaid Care Management during Step 3 of the implementation of the Medicaid Care Management Program.
Price Limit per Month: $5,464.87

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