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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-5934 1-800-852-3345 Ext. 5934
Fax: 603-271-4506 TDD Access: 1-800-735-2964

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Nicholas A. Toumpas
Commissioner

Marcella J. Bobinsky
Acting Director

July 2, 2015

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to exercise a renewal option and amend a contract with the Foundation for Healthy Communities, Purchase Order #1040653, Vendor #154533-B001, 125 Airport Road, Concord, NH 03301,to continue assisting Critical Access Hospitals to improve quality of care for Medicare beneficiaries, by increasing the Price Limitation by $260,476 from $279,000 to an amount not to exceed $539,476, and by extending the Completion Date from August 31, 2015 to August 31, 2017, effective September 1, 2015 or the date of Governor and Council approval, whichever is later. This agreement was originally approved by Governor and Council on September 3, 2014, Item #20. 100% Federal Funds.

Funding is available in the accounts listed below; pending legislative approval of the next biennial budget, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval from Governor and Executive Council.

05-95-90-901010-2218 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY, & PERFORMANCE, HOSPITAL FLEX PROGRAM

State Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Total Amount
2015	102-500731	Contracts for Prog Svc	90076000	215,000	0.00	215,000
2016	102-500731	Contracts for Prog Svc	90076000	64,000	108,532	172,532
2017	102-500731	Contracts for Prog Svc	90076000	0.00	130,238	130,238
2018	102-500731	Contracts for Prog Svc	90076000	0.00	21,706	21,706
			Total	$279,000	$260,476	$539,476

EXPLANATION

Funds in this agreement will be used to continue to provide evidence-based practices to assist the Critical Access Hospitals to improve quality and performance across the range of activities to ensure quality of care for Medicare beneficiaries in Critical Access Hospitals, ensure the financial viability of Critical Access Hospitals in order to support local access to care for Medicare beneficiaries,

and develop and sustain systems of care between Critical Access Hospitals and other community health services in order to provide comprehensive care for Medicare beneficiaries.

The contractor will 1) work with Critical Access Hospitals on quality improvement projects; 2) work with Critical Access Hospitals on financial and operational improvement projects; 3) assist with the development of statewide systems of care focused on improving trauma, heart attack and stroke patient outcomes, and assist Critical Access Hospitals and their Public Health Networks with their community needs assessments.

According to the New Hampshire definition of rural, approximately 37% of the population and 84% of the landmass in New Hampshire is considered rural. As with most rural populations, those within New Hampshire tend to be proportionately older, are more likely to be dependent upon Medicaid or Medicare, or are uninsured, and reside in areas designated as Health Professional Shortage Areas or Medically Underserved Areas. New Hampshire residents in rural communities face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals. Access to oral, mental, primary, specialty and/or reproductive health care can be a significant challenge, whether it's a few blocks or several hours away.

Although New Hampshire's population is slowly growing, it is also aging. 35.6% of the population is over age 50; about 20% are over 60; and over 9% are over 70. The Carsey Institute estimates that the population of those 65 and over will double in the next 20 years. New Hampshire will move from ranking 37 to 17 in terms of elderly population by 2030. These age structure shifts are not occurring evenly. Northern and central New Hampshire already contains a substantially larger proportion of residents age 65 and over than do other parts of the state. Much of this is a function of aging in place among current residents of these regions, coupled with a continuing loss of young adults. The senior population is much more likely to live in poverty and have significant medical and social services needs than those under 55. What's more, the majority of NH seniors live in the northern, rural areas of the State where there are significant access barriers to health care.

Should Governor and Executive Council not authorize this Request, this will result in the discontinuation of program initiatives in developing and sustaining creative, effective access to quality health care services in rural NH communities.

The Foundation for Healthy Communities was selected for this project through a competitive bid process. The Bid Summary is attached.

As referenced in the Exhibit C-1 of the contract, the Department of Health and Human Services in its sole discretion may decide to offer a two (2) year extension of this competitively procured agreement, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. The Department is exercising this option.

The Foundation for Healthy Communities has achieved the major deliverables expected and continues to enhance the state's critical access hospitals quality performance through the use of these funds. With the help of this funding, New Hampshire hospitals continue to out-perform most states in reporting quality measures, have made important advances in their Financial Improvement Network regarding the rollout of the state's Medicaid Managed Care program, and have helped the hospitals avoid penalties from Center for Medicaid and Medicare Services with regard to quality measures.

Funds have also been used to develop a Physician Peer Review network that will further enhance quality measures by using existing physician resources in the hospital and strengthening ties between these hospitals. Continuing the contract with the Foundation will provide an opportunity to build on successes and transition seamlessly to new measures and quality initiatives being mandated by the federal funder.

The Contractor shall ensure that following performance measures are annually achieved and monitored monthly to measure the effectiveness of the agreement:

- Number and percent of change in state reporting by Critical Access Hospitals on at least one Medicare Beneficiary Quality Improvement Project outpatient measure.
- Number of Critical Access Hospitals in state reporting Hospital Consumer Assessment of Healthcare Providers and Systems data.
- Number of hospitals that define their influenza vaccine targets based on the baseline from their reporting in previous years, and the change in performance at end of flu season.
- Number of participating hospitals reporting emergency department transfer communication measures.
- Number of participating hospitals that have evaluated their outpatient quality improvement measures and the improvements made in reporting and in quality improvement metrics.
- Number of hospitals doing needs assessment reporting on yearly basis and report the activities initiated for ongoing improvement in finance, operations, and quality improvement.
- Number of hospitals where revenue cycles are enhanced and penalties for non-compliance are avoided based on technical assistance or training provided.

Area served: Statewide.

Source of Funds: 100% Federal Funds from the US Department of Health and Human Services, Health Resources and Services Administration.

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

Respectfully submitted,

Marcella J. Bobinsky, MPH
Acting Director

Approved by:
Nicholas A. Toumpas
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
NH Medicare Rural Hospital Flexibility Program

This 1st Amendment to the NH Medicare Rural Hospital Flexibility Program contract (hereinafter referred to as "Amendment One") dated this 30th day of June, 2015, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Foundation for Healthy Communities, (hereinafter referred to as "the Contractor"), a corporation with a place of business at 125 Airport Road, Concord, NH 03301.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on September 3, 2014, Item #20, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

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

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

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, and modify the scope of services to support continued delivery of these services, and

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

1. Amend Form P-37, Block 1.7, to read August 31, 2017.
2. Amend Form P-37, Block 1.8, to read $539,476.
3. Amend Form P-37, Block 1.9, to read Eric Borrin, Director of Contracts and Procurement.
4. Amend Form P-37, Block 1.10 to read 603-271-9558.
5. Delete Exhibit A in its entirety and replace with Exhibit A Amendment #1
6. Amend Exhibit B to:

   - Add to paragraph 1 Funding Sources:
     c) $260,476 - 100% federal funds from the US Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.241, Federal Award Identification Number (FAIN) H54RH00022.

   - Delete paragraph 8 and replace with:
     8) Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers and Exhibit B-1 Budgets, within the price limitation, and to adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Contractor Initials: SM
Date: 6/30/15

7. Amend Budget to add:
   - Exhibit B-1 Amendment #1 Budget SFY 2016
   - Exhibit B-1 Amendment #1 Budget SFY 2017
   - Exhibit B-1 Amendment #1 Budget SFY 2018

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

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

State of New Hampshire
Department of Health and Human Services

7/10/15
Date

Brook Dupee
Bureau Chief

Foundation for Healthy Communities

6/30/2015
Date

Name: Shawn LaFrance
Title: Executive Director

Acknowledgement:

State of NH, County of Merrimack on June 30, 2015, 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.

Noreen M. Cronin
Signature of Notary Public or Justice of the Peace

Noreen M. Cronin Program & Grants Manager
Name and Title of Notary or Justice of the Peace

My Commission Expires: June 5, 2018

Contractor Initials: SL
Date: 6/30/15

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

OFFICE OF THE ATTORNEY GENERAL

7/21/15
Date

Name: Meagan A. Tipp
Title: Attorney

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

OFFICE OF THE SECRETARY OF STATE

_____
Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

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

2. Scope of Services

The Contractor shall:

2.1. Use evidence based practices to assist the Critical Access Hospitals (CAHS) to improve quality and performance across the range of activities described below, especially as these activities pertain to Medicare beneficiaries.

2.2. Ensure Critical Access Hospitals (CAHs) to publicly report data to Hospital Compare federal quality reporting system: http://www.medicare.gov/hospitalcompare/search.html, on relevant process of care quality measures for inpatient and outpatient care, and *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) patient experience of care survey results:

2.2.1. Provide technical assistance to foster robust participation in the Medicare Beneficiary Quality Improvement Project (MBQIP) Phases II and III, and use the identified measures to target specific interventions within New Hampshire Critical Access Hospital (CAHs).

2.2.2. Provide technical assistance to the 13 Critical Access Hospitals to ensure continued reporting of data to Hospital Compare.

2.2.3. Provide technical assistance to the 13 Critical Access Hospitals to expand the number of measures reported under Phase II and III of Medicare Beneficiary Quality Improvement Project (MBQIP).

2.2.4. Provide technical assistance to support hospitals not in compliance with HCAHPS programs, and support activities to make improvements in patient experiences of care.

2.2.5. Evaluate the technical and personnel needs for improvement activities in inpatient and outpatient measures, and implement solutions.

2.3. Improve the transitions of care from the CAH to other healthcare settings in order to improve patient outcomes:

2.3.1. Provide intensive technical assistance with the Rural Health Coalition (the CAHs) as a cohort and with each hospital to address improvement activities regarding ED transition measures. Strategic investments will be made to evaluate the technical and personnel needs for implementing this measure, and solutions implemented in following years

2.4. Ensure every CAH reports their vaccination rates in accordance with state law:

2.4.1. Have each hospital define their targets based on the baseline from their reporting in previous years.

2.4.2. Annually measure success of target at end of flu season in the spring.

2.5. Improve revenue cycle management and implement activities designed to increase profitability within a hospital or group of hospitals:

2.5.1. Provide sessions of technical assistance, educational programs/seminars, user group meetings, and consultation on Revenue Cycle Management, to and through, the Rural Health Coalition and individual hospitals as needed. Example: Defensible Pricing Strategies, strategies to improve the incorporation of Managed Medicaid into operational parameters, improve the ability of each CAH to better manage revenue cycles by complying with the requirements of the Physician Quality Reporting System, and implementation of a Patient Centric Transparency and Quoting Protocol.

2.6. Address areas for improvement (within a hospital or group of hospitals) identified through in-depth operational assessments:

2.6.1. Support CAHs in planning and implementing interventions for improving operational performance. Support may include technical assistance, educational programs/seminars, user group meetings, support for hospital staff to better manage behavioral health issues related to lack of capacity in the state hospital, support for identified needs from hospital community health needs assessments, and consultation provided, facilitated or funded by the State Flex Program.

3. Delegation and Subcontractors – Fiscal Agent Activities

3.1. New England Rural Health Roundtable (NERHRT)

3.1.1. Execute a subcontract annually in the amount of $25,000 with the New England Rural Health Round Table (NERHRT) to coordinate participation of New Hampshire small rural hospitals in a multi-state, multi-hospital rural Institute for Healthcare Improvement (IHI) network through the New England Rural Hospital Performance Improvement Initiative (NEPI), and provide an assessment of rural hospitals readiness for the transition from volume to value, by providing:

3.1.1.1. Support ongoing professional education for CAH professionals through the Institute for Healthcare Improvement (IHI). Programs may include but are not

limited to: Open School, Leadership Quality Improvement (LQI) training , Patient Care Processes(various programs available), or Processes to Support Care(various programs available)

3.1.1.2. Provide leadership and funding support for NEPI's regional collaborative infrastructure and projects.

3.1.1.3. Support continued access to useful information and resources through the NEPI web page on NERHRT website.

3.1.1.4. Ensure the NEPI Network (VT, NH, ME and MA Flex Programs) works with the New England Rural Health RoundTable to procure an expert rural healthcare consulting firm to assess the readiness of, and any progress made, with CAHs' transition from a fee-for-service to fee-for-value system of payment and service delivery. Once the assessment is completed the information will be used to develop and implement a regional plan for meaningful improvements and transformation across the "Shaky Bridge" paradigm.

4. Workplan

4.1. The contractor will be required to provide a work plan that demonstrates their plan for the contract required activities. The work plan must be submitted within 30 days of the effective date of the contract. The work plan will be used to assure progress towards meeting the performance measures and the overall program objectives and goals. At intervals specified by the Department of Health and Human Services (DHHS), the contractor will report on their progress towards meeting the performance measures, and overall program goals and objectives to demonstrate they have met the minimum required services for the proposal.

5. Staffing

5.1. The Contractor shall maintain staffing to fulfill the roles and responsibilities to support activities of this project. The Contractor shall address the details to the following requirements to ensure adequate staffing is provided.

5.1.1. Provide sufficient staff to perform all tasks specified in this contract. The Contractor shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion.

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

5.1.3. The Contractor shall develop a Staffing Contingency Plan, after receiving contract award, including but not limited to:

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

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

5.1.3.3. Discussion of time frames necessary for obtaining replacements;

5.1.3.4. Contractor's capabilities to provide, in a timely manner, replacement staff with comparable experience; and

5.1.3.5. The method of bringing replacement staff up-to-date regarding the activities of this project.

5.1.4. Include staffing models that will be used by the subcontractors, if applicable, as defined in Exhibit C, sub section 19. Subcontractors.

6. Reporting

The Contractor shall:

6.1. Attend meetings with representatives from Rural Health and Primary Care and/or other state officials to report on program progress and financial accountability, as requested.

6.2. Provide written semi-annual progress reports, as well as a twenty four month report at the end of the contract. The reports shall outline progress on all deliverables, goals, objectives, and performance measures, and define any problems with attaining desired results.

7. Performance Indicators/Measures

7.1. The Contractor shall ensure that following performance indicators are annually achieved and monitored monthly to measure the effectiveness of the agreement:

7.1.1. Subsection 2.2

7.1.1.1. Total number of Critical Access Hospitals reporting data on at least one Medicare Beneficiary Quality Improvement Project (MBQIP) inpatient measure.

7.1.1.2. Total number of CAHs in state reporting data on at least one MBQIP outpatient measure.

7.1.1.3. Number and percent of change in state reporting by CAHs on at least one MBQIP outpatient measure.

7.1.1.4. Number of CAHs in state reporting *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) data.

7.1.1.5. Number of new CAHs reporting HCAHPS data this budget year.

7.1.1.6. Number of CAHs in state implementing a Quality Improvement (QI) project based on Hospital Compare data.

7.1.2. Subsection 2.3.

7.1.2.1. Number and percent of CAHs participating in a care transitions, and/or readmissions project.

7.1.2.2. Number of CAHs with improvement in one or more measures due to participation in a QI project.

7.1.3. Subsection 2.4.

7.1.3.1. Number of CAHs receiving support and/or Technical Assistance (TA) to support them in reporting vaccination rates.

7.1.3.2. Number of CAHs that have improved vaccination rates.

7.1.4. Subsection 2.5.

7.1.4.1. Number of CAHs receiving Flex-funded financial consultations.

7.1.4.2. Number and percent of CAHs completing analyses.

7.1.4.3. Number of CAHs attending seminars and/or workshops.

7.1.4.4. Improvement in point of service collections as a percent of total revenue.

7.1.4.5. Percent improvement in days in Accounts Receivable (AR), based on gross revenue.

7.1.4.6. Number and type of penalties avoided by CAHs due to technical assistance/education.

7.1.5. Subsection 2.6.

7.1.5.1. Number of CAHs receiving Flex-funded operational consultations.

7.1.5.2. Number of seminars and workshops sponsored.

7.1.5.3. The number of CAHs attending each seminar and/or workshop.

7.1.5.4. The number of total participants in each seminar and/or workshop.

7.1.5.5. Total cost of seminars and workshops.

7.1.5.6. Average cost per seminar.

7.1.5.7. Average cost per workshop.

7.1.6. Subsection 3.1.

7.1.6.1. Report number of seminars and workshops sponsored and percentage of CAHs participating in Institute for Healthcare Improvement (IHI) programming.

7.1.6.2. Provide leadership and funding support for New England Performance Improvement ('s) regional collaborative infrastructure and projects. Report number of NEPI meetings held; number of participants in NEPI project, number of workplan activities addressed; number of projects engage in; number of CAH reached by NEP.

7.1.6.3. Support continued access to useful information and resources through the NEPI web page on New England Rural Health Round Table (NERHRT) website. Report number of resources posted on NEPI web page on NERHRT website; number of new resources identified and posted; number of CAH reached by outreach and marketing effort by NEPI project members; number of page hits; inventory of CAH resources available on website.

7.1.6.4. Provide number of hospitals participating in assessment of readiness for volume to value transition and a report on readiness with proposed improvement activities.

7.2. Annually, the Contractor shall develop and submit to the DHHS, a corrective action plan for any performance measure that was not achieved.

Exhibit B-1 Amendment #1 Budget Form

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Foundation for Healthy Communities

Budget Request for: NH Medicare Rural Hospital Flexibility Program
(Name of RFP)

Budget Period: SFY 2016 (September 1, 2015 - June 30 2016)

1. Total Salary/Wages	$ 22,196.89	$ -	$ 22,196.89
2. Employee Benefits	$ 8,038.18	$ -	$ 8,038.18
3. Consultants	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -
Rental	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -
Educational	$ -	$ -	$ -
Lab	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -
Medical	$ -	$ -	$ -
Office	$ 156.73	$ -	$ 156.73
6. Travel	$ 1,260.00	$ -	$ 1,260.00
7. Occupancy	$ 448.43	$ -	$ 448.43
8. Current Expenses	$ -	$ -	$ -
Telephone	$ 333.20	$ -	$ 333.20
Postage	$ 50.00	$ -	$ 50.00
Subscriptions	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -
Insurance	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -
9. Software	$ 2,844.02	$ -	$ 2,844.02
10. Marketing/Communications	$ -	$ -	$ -
11. Staff Education and Training	$ 750.00	$ -	$ 750.00
12. Subcontracts/Agreements	$ 61,688.00	$ -	$ 61,688.00
13. Other (specific details mandatory):	$ -	$ -	$ -
Meetings	$ 900.00	$ -	$ 900.00
	$ -	$ -	$ -
	$ -	$ -	$ -
Indirect	$ -	$ 9,866.55	$ 9,866.55
	$ -	$ -	$ -
TOTAL	**$ 98,665.45**	**$ 9,866.55**	**$ 108,532.00**

Indirect: 10% corporation standard: support personnel and office support expenses associated with accounting, data analysis, communications, and administrative support.

Indirect As A Percent of Direct 10.0%

Exhibit B-1 Amendment #1 Budget Form

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Foundation for Healthy Communities

Budget Request for: NH Medicare Rural Hospital Flexibility Program
(Name of RFP)

Budget Period: SFY 2017 (July 1, 2016 - June 30 2017)

1. Total Salary/Wages	$ 26,358.64	$ -	$ 26,358.64	
2. Employee Benefits	$ 10,089.09	$ -	$ 10,089.09	
3. Consultants	$ -	$ -	$ -	
4. Equipment:	$ -	$ -	$ -	
Rental	$ -	$ -	$ -	
Repair and Maintenance	$ -	$ -	$ -	
Purchase/Depreciation	$ -	$ -	$ -	
5. Supplies:	$ -	$ -	$ -	
Educational	$ -	$ -	$ -	
Lab	$ -	$ -	$ -	
Pharmacy	$ -	$ -	$ -	
Medical	$ -	$ -	$ -	
Office	$ 188.31	$ -	$ 188.31	
6. Travel	$ 1,680.00	$ -	$ 1,680.00	
7. Occupancy	$ 538.11	$ -	$ 538.11	
8. Current Expenses	$ -	$ -	$ -	
Telephone	$ 399.84	$ -	$ 399.84	
Postage	$ 60.00	$ -	$ 60.00	
Subscriptions	$ -	$ -	$ -	
Audit and Legal	$ -	$ -	$ -	
Insurance	$ -	$ -	$ -	
Board Expenses	$ -	$ -	$ -	
9. Software	$ 3,408.60	$ -	$ 3,408.60	
10. Marketing/Communications	$ -	$ -	$ -	
11. Staff Education and Training	$ 850.00	$ -	$ 850.00	
12. Subcontracts/Agreements	$ 73,828.00	$ -	$ 73,828.00	
13. Other (specific details mandatory):	$ -	$ -	$ -	
Meetings	$ 950.00	$ -	$ 950.00	Indirect: 10% corporation standard: support personnel and office support expenses associated with accounting, data analysis, communications, and administrative support.
	$ -	$ -	$ -	
	$ -	$ -	$ -	
Indirect	$ -	$ 11,887.41	$ 11,887.41	
	$ -	$ -	$ -	
TOTAL	**$ 118,350.59**	**$ 11,887.41**	**$ 130,238.00**	
Indirect As A Percent of Direct		10.0%		

Exhibit B-1 Amendment #1 Budget Form

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Foundation for Healthy Communities

Budget Request for: NH Medicare Rural Hospital Flexibility Program
(Name of RFP)

Budget Period: SFY 2018 (July 1, 2017 - August 31, 2017)

1. Total Salary/Wages	$ 4,629.49	$ -	$ 4,629.49
2. Employee Benefits	$ 1,774.57	$ -	$ 1,774.57
3. Consultants	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -
Rental	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -
Educational	$ -	$ -	$ -
Lab	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -
Medical	$ -	$ -	$ -
Office	$ 32.39	$ -	$ 32.39
6. Travel	$ 50.00	$ -	$ 50.00
7. Occupancy	$ 92.50	$ -	$ 92.50
8. Current Expenses	$ -	$ -	$ -
Telephone	$ 68.68	$ -	$ 68.68
Postage	$ 10.00	$ -	$ 10.00
Subscriptions	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -
Insurance	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -
9. Software	$ 575.10	$ -	$ 575.10
10. Marketing/Communications	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 12,500.00	$ -	$ 12,500.00
13. Other (specific details mandatory):	$ -	$ -	$ -
Meetings	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Indirect	$ -	$ 1,973.27	$ 1,973.27
	$ -	$ -	$ -
TOTAL	**$ 19,732.73**	**$ 1,973.27**	**$ 21,706.00**

Indirect: 10% corporation standard: support personnel and office support expenses associated with accounting, data analysis, communications, and administrative support.

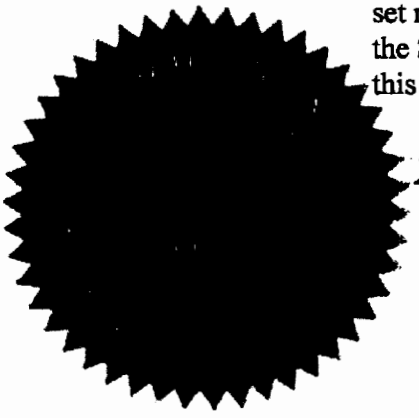
Indirect As A Percent of Direct 10.0%

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 FOUNDATION FOR HEALTHY COMMUNITIES is a New Hampshire nonprofit corporation formed October 28, 1968. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 7th day of May A.D. 2015



William M. Gardner
Secretary of State

CERTIFICATE OF VOTE/AUTHORITY

I, Steve Ahnen, of the Foundation for Healthy Communities, do hereby certify that:

1. I am the duly elected Treasurer of the Foundation for Healthy Communities;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the Foundation Healthy Communities, duly held on October 15, 2009;

   RESOLVED: That this corporation, the Foundation for Healthy Communities, enters into any and all contracts, amendments, renewals, revisions or modifications thereto, with the State of New Hampshire, acting through its Department of Health and Human Services.

   RESOLVED: That the Executive Director for the Foundation for Healthy Communities is hereby authorized on behalf of this corporation to enter into said contracts with the State, and to execute any and all documents, agreements, and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate. Shawn LaFrance is the duly elected Executive Director of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of June 30, 2015.

IN WITNESS WHEREOF, I have hereunto set my hand as the Treasurer of the Foundation for Healthy Communities this 30th day of June, 2015.

Steve Ahnen, Treasurer

STATE OF NH

COUNTY OF MERRIMACK

The foregoing instrument was acknowledged before me this 30th day of June, 2015 by Steve Ahnen.

Notary Public/Justice of the Peace
My Commission Expires: June 5, 2018

Client#: 241406 NHHOSPITAL

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 06/29/2015

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: Melissa Gabis
HUB Healthcare Solutions HUB International New England 299 Ballardvale Street Wilmington, MA 01887	PHONE (A/C, No, Ext): 508-303-9475 FAX (A/C, No): 508-303-9476 E-MAIL ADDRESS: melissa.gabis@hubinternational.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hartford Casualty Ins Co	
INSURER B : Hartford Insurance Co	
INSURER C : Hanover Insurance Co.	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Foundation for Healthy Communities
New Hampshire Hospital Assoc
125 Airport Road
Concord, NH 03301

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

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			08SBAVW2923	06/22/2015	06/22/2016	EACH OCCURRENCE	$1,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$300,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$2,000,000
C	[ ] POLICY [ ] PRO-JECT [ ] LOC			LHNA02932000	06/22/2015	06/22/2016	D&O/EPL	$2,000,000
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS [ ] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	[X] UMBRELLA LIAB [X] OCCUR			08SBAVW2923	06/22/2015	06/22/2016	EACH OCCURRENCE	$2,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$2,000,000
	[ ] DED [X] RETENTION $10000							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			08WECIV5293	06/22/2015	06/22/2016	[ ] WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N]	N/A					E.L. EACH ACCIDENT	$500,000
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$500,000
							E.L. DISEASE - POLICY LIMIT	$500,000
A	Blanket Bldg &BPP			08SBAVW2923	06/22/2015	06/22/2016	$1,939,000	
	Bldg Max Limit						$1,581,300	

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

CERTIFICATE HOLDER

State of NH, DHHS
Contracts & Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

TD002

FOUNDATION FOR
HEALTHY COMMUNITIES

The Foundation's mission is to improve health and health care delivery.

The Foundation's primary objectives are:

1. To collect, analyze, and evaluate data about health and about the delivery, quality, management and organization of health services;
2. To promote, sponsor and conduct applied research and scientific investigation relative to quality, health delivery process improvement and health policy; and
3. To communicate information, sponsor education and training, and facilitate innovation and access for the improvement of health and the creation of healthy communities.

Adopted by Board of Trustees - October 20, 2005

BerryDunn

[redacted]

Foundation *for*
Healthy Communities

FINANCIAL STATEMENTS

December 31, 2014 and 2013

With Independent Auditor's Report

[redacted]

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Foundation for Healthy Communities

We have audited the accompanying financial statements of Foundation for Healthy Communities (the Foundation) which comprise the statements of financial position as of December 31, 2014 and 2013, and the related statements of activities, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Foundation's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Foundation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall financial statement presentation.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Foundation as of December 31, 2014 and 2013, and the changes in its net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
June 5, 2015

FOUNDATION FOR HEALTHY COMMUNITIES

Statements of Financial Position

December 31, 2014 and 2013

ASSETS

	2014	2013
Current assets		
Cash and cash equivalents	$ 816,486	$ 895,998
Accounts receivable	787,115	106,809
Due from affiliate	90,780	61,115
Prepaid expenses	4,256	4,362
Total current assets	1,698,637	1,068,284
Investments	648,056	609,680
Property and equipment		
Leasehold improvements	1,118	1,118
Equipment and furniture	136,010	136,010
	137,128	137,128
Less accumulated depreciation	129,647	124,806
Property and equipment, net	7,481	12,322
Total assets	$2,354,174	$1,690,286

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable	$ 232,775	$ 17,515
Accrued payroll and related amounts	51,573	81,507
Due to affiliate	49,190	38,151
Deferred revenue	205,936	95,985
Total current liabilities and total liabilities	539,474	233,158
Net assets		
Unrestricted	575,041	332,241
Temporarily restricted	1,239,659	1,124,887
Total net assets	1,814,700	1,457,128
Total liabilities and net assets	$2,354,174	$1,690,286

The accompanying notes are an integral part of these financial statements.

FOUNDATION FOR HEALTHY COMMUNITIES

Statements of Activities

Years Ended December 31, 2014 and 2013

	2014	2013
Revenues		
Foundation support	**$ 363,120**	$ 363,120
Program revenue	**1,662,912**	493,099
Seminars, meetings, and workshops	**161,731**	167,215
Interest and dividend income	**15,189**	10,693
Net assets released from restriction used for operations	**1,365,664**	934,331
Total revenues	**3,568,616**	1,968,458
Expenses		
Salaries and related payroll expenses	**1,359,327**	1,051,331
Other operating	**137,232**	130,712
Program expenses	**1,663,366**	627,451
Seminars, meetings, and workshops	**182,418**	142,937
Depreciation	**4,841**	6,615
Total expenses	**3,347,184**	1,959,046
Excess of revenues over expenses	**221,432**	9,412
Net realized and unrealized gain on investments	**21,368**	82,531
Increase in unrestricted net assets	**$ 242,800**	$ 91,943

The accompanying notes are an integral part of these financial statements.

FOUNDATION FOR HEALTHY COMMUNITIES

Statements of Changes in Net Assets

Years Ended December 31, 2014 and 2013

	Unrestricted	Temporarily Restricted	Total
Balance, January 1, 2013	$ 240,298	$ 911,755	$ 1,152,053
Excess of revenues over expenses	9,412	-	9,412
Net realized and unrealized gain on investments	82,531	-	82,531
Grants received	-	1,147,463	1,147,463
Net assets released from restriction used for operations	-	(934,331)	(934,331)
Change in net assets	91,943	213,132	305,075
Balance, December 31, 2013	332,241	1,124,887	1,457,128
Excess of revenues over expenses	**221,432**	**-**	**221,432**
Net realized and unrealized gain on investments	**21,368**	**-**	**21,368**
Grants received	**-**	**1,480,436**	**1,480,436**
Net assets released from restriction used for operations	**-**	**(1,365,664)**	**(1,365,664)**
Change in net assets	**242,800**	**114,772**	**357,572**
Balance, December 31, 2014	**$ 575,041**	**$ 1,239,659**	**$ 1,814,700**

The accompanying notes are an integral part of these financial statements.

FOUNDATION FOR HEALTHY COMMUNITIES

Statements of Cash Flows

Years Ended December 31, 2014 and 2013

	2014	2013
Cash flows from operating activities		
Change in net assets	**$ 357,572**	$ 305,075
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities		
Depreciation	**4,841**	6,615
Net realized and unrealized gain on investments	**(21,368)**	(82,531)
(Increase) decrease in		
Accounts receivable	**(680,306)**	103,519
Prepaid expenses	**106**	208
Increase (decrease) in		
Accounts payable	**215,260**	(6,661)
Accrued payroll and related amounts	**(29,934)**	15,129
Due to/from affiliates	**(18,626)**	(33,917)
Deferred revenue	**109,951**	64,736
Net cash (used) provided by operating activities	**(62,504)**	372,173
Cash flows from investing activities		
Purchases of equipment	**-**	(5,397)
Purchases of investments	**(162,654)**	(410,501)
Proceeds from sale of investments	**145,646**	449,350
Net cash (used) provided by investing activities	**(17,008)**	33,452
Net (decrease) increase in cash and cash equivalents	**(79,512)**	405,625
Cash and cash equivalents, beginning of year	**895,998**	490,373
Cash and cash equivalents, end of year	**$ 816,486**	$ 895,998

The accompanying notes are an integral part of these financial statements.

Organization

Foundation for Healthy Communities (the Foundation) was organized to conduct various activities relating to health care delivery process improvement, health policy, and the creation of healthy communities. The Foundation is controlled by New Hampshire Hospital Association (the Association) whose purpose is to assist its members in improving the health status of the people receiving health care in New Hampshire.

1. Summary of Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

For purposes of reporting in the statements of cash flows, the Foundation considers all bank deposits with an original maturity of three months or less to be cash equivalents.

Accounts Receivable

Accounts receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to earnings and a credit to a valuation allowance based on its assessment of the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to accounts receivable. Management believes all accounts receivable are collectible. Credit is extended without collateral.

Investments

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the statements of financial position. Interest and dividends are included in the excess of expenses over revenues unless they are restricted by donor or law. Realized and unrealized gains and losses on investments are excluded from the excess of revenues over expenses.

Investments, in general, are exposed to various risks such as interest rate, credit, and overall market volatility. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statements of financial position and activities.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of each class of depreciable asset and is computed using the straight-line method.

Employee Fringe Benefits

The Foundation has an "earned time" plan under which each employee earns paid leave for each period worked. These hours of paid leave may be used for vacation or illnesses. Hours earned but not used are vested with the employee and may not exceed 30 days at year end. The Foundation accrues a liability for such paid leave as it is earned.

Revenue Recognition

Grants awarded in advance of expenditures are reported as temporarily restricted support if they are received with stipulations that limit the use of the grant funds. When a grant restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of activities as "net assets released from restriction."

Grant funds conditional upon submission of documentation of qualifying expenditures or matching requirements are deemed to be earned and reported as revenues when the Foundation has met the grant conditions.

The amount of such funds the Foundation will ultimately receive depends on the actual scope of each program, as well as the availability of funds and, accordingly, is not reasonably determinable. The ultimate disposition of grant funds is subject to audit by the awarding agencies.

Resources received from service beneficiaries for specific projects, programs, or activities that have not yet taken place are recognized as deferred revenue to the extent that the earnings process has not been completed.

Contributions of long-lived assets are reported as unrestricted support unless donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long these long-lived assets must be maintained, the Foundation reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service.

Excess of Revenues over Expenses

The statements of activities include excess of revenues over expenses. Changes in unrestricted net assets that are excluded from this measure, consistent with industry practice, include realized and unrealized gains and losses on investments.

Income Taxes

The Foundation is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

Subsequent Events

For purposes of the preparation of these financial statements in conformity with U.S. generally accepted accounting principles, the Foundation has considered transactions or events occurring through June 5, 2015, which was the date that the financial statements were available to be issued.

2. Investments

The composition of investments as of December 31, 2014 and 2013 is set forth in the following table. Investments are stated at fair value.

	2014	2013
Marketable equity securities	$ 268,307	$ 255,481
Mutual funds		
Marketable equity securities	170,067	144,498
Fixed income securities	209,682	209,701
	$ 648,056	$ 609,680

3. Temporarily Restricted Net Assets

Temporarily restricted net assets of $1,239,659 and $1,124,887 consisted of specific grant programs as of December 31, 2014 and 2013, respectively. The grant programs relate to improvements to access and the delivery of health care services to support for the production and distribution of educational materials.

4. Related Party Transactions

The Foundation leases space from the Association. Rental expense under this lease for the years ended December 31, 2014 and 2013 was $46,662 and $46,608, respectively.

The Association provides various accounting, public relation and janitorial services to the Foundation. The amount expensed for these services in 2014 and 2013 was $111,180 and $103,761, respectively. In addition, the Association bills the Foundation for its allocation of shared costs. As of December 31, 2014 and 2013, the Foundation owed the Association $49,190 and $38,151, respectively, for services and products provided by the Association.

The Association owed the Foundation $90,780 and $61,115 as of December 31, 2014 and 2013, respectively, for services provided to the Association.

5. Retirement Plan

The Foundation has a 401(k) profit-sharing plan that covers substantially all employees and allows for employee contributions of up to the maximum allowed under Internal Revenue Service regulations. Employer contributions are discretionary and are determined annually by the Foundation. Retirement plan expense for 2014 and 2013 was $43,351 and $35,958, respectively.

6. Functional Expenses

Expenses related to services provided for the public interest are as follows:

	2014	2013
Program services	$ 3,222,693	$ 1,837,737
General and administrative	124,491	121,309
	$ 3,347,184	$ 1,959,046

7. Concentrations of Credit Risk

The Foundation's total cash deposits from time-to-time exceed the federally insured limit. The Foundation has not incurred any losses and does not expect any in the future.

8. Fair Value Measurements

Financial Accounting Standards Board Accounting Standards Codification (FASB ASC) Title 820, *Fair Value Measurement*, defines fair value, establishes a framework for measuring fair value in accordance with U.S. generally accepted accounting principles, and expands disclosures about fair value measurements.

FASB ASC 820 defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. FASB ASC 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

The Foundation's investments are measured at fair value on a recurring basis and are considered Level 1.

Foundation *for*
Healthy Communities

2015 - BOARD OF TRUSTEES

Scott McKinnon **CHAIR**	President/CEO, The Memorial Hospital, North Conway
Mary DeVeau **VICE CHAIR**	President and CEO, Concord Regional Visiting Nurse Association
Stephen Ahnen **SECRETARY/TREASURER**	President, NHHA
Shawn LaFrance ***ex officio***	Executive Director, FHC
Chris Accashian	CEO, Parkland Medical Center, Derry
George Blike,MD	Chief Quality and Value Officer, Dartmouth-Hitchcock, Lebanon
William Brewster, MD	Medical Director, Harvard Pilgrim Health Care, Manchester
Corin Dechirico, DO	Associate Chief Medical Officer, Southern NH Medical Center, Nashua
Robert Duhaime, RN	VP, Operations, Catholic Medical Center, Manchester
Peter J. Evers	President/CEO, Riverbend Communuity Mental Health Center
Mary Ellen Fleeger, PhD, RN	Professor of Nursing, Keene State College
Paul Gardent	Faculty, Dartmouth Institute & Tuck School of Business, Hanover
Richard Lafleur, MD - **IPC**	Medical Director, Anthem BC/BS of NH, Manchester
Michelle McEwen	President/CEO, Speare Memorial Hospital, Plymouth
Arthur Nichols	President, Cheshire Medical Center, Keene
Arthur O'Leary	Regional VP of Operations, Genesis HealthCare, Concord
Helen C. Pervanas, PharmD	Assistant Professor of Pharmacy Practice, Mass. College of Pharmacy and Health Sciences, Manchester
Rick Phelps, MD	
John F. Robb, MD	Director, Interventional Cardiology at Mary Hitchcock Memorial Hospital, Lebanon
Maria Ryan, PhD, APRN	CEO, Cottage Hospital, Woodsville
Jeanne Ryer	Director, NH Citizens Health Initiative/University of New Hampshire, Concord
Keith Shute, MD	Chief Medical Officer & Senior Vice President, Androscoggin Valley Hospital, Berlin
Helen Taft	Executive Director, Families First, Portsmouth
Trinidad Tellez, MD	Director, Office of Minority Health and Refugee Affairs, NH Department of Health and Human Services
Gregory Walker	President/CEO, Wentworth-Douglas Hospital, Dover

New members in 2015

GREGORY J. VASSE

603-748-9355 | 603-415-4274 | GVasse@healthynh.com
125 Airport Road, Concord, NH 03301

CAREER EXPERIENCE

FOUNDATION FOR HEALTHY COMMUNITIES **(09/19/2011 – present)** **Concord, NH**
Director Rural Quality Improvement Network

AMERICAN NATIONAL RED CROSS BIOMEDICAL SERVICES **(2003-2006)** **Washington, DC**
Senior Vice President **(2004-2006)**

Area Vice President North Central US **(2003-2004)**

SOUTHEASTERN MICHIGAN BLOOD SERVICES REGION / American Red Cross **Detroit, MI**
Chief Executive Officer **(1998-2002)**

HENRY FORD HEALTH SYSTEM **(1986-1998)** **Detroit, MI**
COO Henry Ford Health System / Eastern Region **(1994-1998)**
President & CEO Henry Ford Cottage Hospital **(1988-1998)**

COTTAGE HEALTH SERVICES **(1977-1985)** **Grosse Pointe, MI**
VP Operations / VP Planning & Marketing / Asst Administrator

EDUCATION

CORNELL / JOHNSON SCHOOL - MBA & SLOAN PROGRAM IN HOSPITAL AND HEALTH SERVICES ADMINISTRATION
CORNELL / COLLEGE OF ARTS & SCIENCES - BA BIOLOGICAL SCIENCES (MICROBIOLOGY)
HARVARD / JFK SCHOOL OF GOVERNMENT - PARTNERS IN ORGANIZATIONAL LEADERSHIP

VOLUNTEER POSITIONS

DARTMOUTH HITCHCOCK MEDICAL CENTER **(2011 – 2012)** **Lebanon, NH**
Emergency Department Volunteer

UNITED METHODIST RETIREMENT COMMUNITIES **(2002-2006)** **Chelsea, MI**
Member Board of Directors, Executive Committee and Chairman of the Quality Committee

MILITARY SERVICE

US NAVY HOSPITAL CORPSMAN SECOND CLASS PETTY OFFICER **(1970 – 1974)**

Naval Training Center, Great Lakes Illinois, Hospital Corps School
National Naval Medical Center, Bethesda Maryland, Haematology Oncology Clinic
Naval Training Center, Bainbridge Maryland, Dispensary Clinical Laboratory
Kirk Army Hospital, Aberdeen Proving Ground Maryland, Clinical Microbiology Laboratory

NOREEN M. CREMIN
125 Airport Road
Concord, New Hampshire 03301
ncremin@healthynh.com
(603) 415-4275

EXPERIENCE:

Sept. 2011 – present
Program and Grants Manager – Full Time
Foundation for Healthy Communities, 125 Airport Road, Concord, NH
Assists in the preparation of grant and contract proposals, tracks status of pending and awarded grants, and assists with project reports. Responsible for monitoring active funds for budgetary compliance, preparing financial statements and drafting detailed budgets.

Jan. 2007 – March 2011
Office Manager – Full Time
New Futures, Inc., 10 Ferry Street, Suite 307, Concord, NH
Successfully managed office systems and support staff, vendors, coordinated employee benefits and human resources. Responsible for agency budget development and monthly oversight, fiscal management of accounts, payroll processing, website management, computer and server maintenance, monthly electronic newsletter, and balanced scorecard software updating. Coordinated yearly audits and tax documents. Responsible for grant related reports and financial documentation. Continued with many of the responsibilities listed in previous position.

Aug. 2001 – Dec. 2006
Program Support Associate – Full Time
New Futures, Inc., 10 Ferry Street, Suite 307, Concord, NH
Provided full administrative support for New Futures staff as well as the Community Leadership Initiative Program. Developed and implemented computer protocols, troubleshoot and maintain technology systems for main and satellite office. Provided Human Resource support, tracking benefits and payroll. Established protocol and maintain multiple databases of contacts for mass mailings, formatted PowerPoint presentations and handouts, tracked inventory of resource materials, and planned and organized events and meetings.

Jan. 1995 – June 2001
Administrative Assistant – Full Time
Casey Family Services, New Hampshire Division – Concord, NH
Provided full administrative support for 11 individuals, including word processing, maintaining client records, entering data, scheduling meetings, dictation, research on the Internet, answer multi-line phone, inventory control and office product ordering. Responsible for creating and maintaining master mailing list for mass mailings, annual releases and newsletter mailings in Access. Created a master forms book, filing system, maintain forms, and originated new forms on computer. Presented a workshop on computers and the Internet during agency wide biennial Foster Parent Conference in Boston, Massachusetts.

Jan. 1994 – Jan. 1995
Office Manager – Full Time

Community Chiropractic & Wellness Center, Concord, NH

Provided administrative support, assisted patients with therapy, explained to new patients the philosophy and process of chiropractic care, scheduled appointments, generated correspondence as necessary, processed billing for insurance, and filing of patient records.

May 1990 – Nov. 1993
Program Manager – Full Time

Residential Resources, Inc., Salem, NH

Certification and licensing of home according to state DMH/DS regulations and other related administrative duties. Responsible for the fiscal management of the house budget of $300,000.00. Evaluations, supervision and hiring of staff of 20. Liaison for agency between resident, family and ancillary services. Responsible for quality implementation, review of resident ISPs. Implemented and familiar with behavior modification programs/theory. Interim Manager for a second program for a period of four months, twice, April – July 1992 and June – September 1993. Involved in program downsizing from two staffed apartments to two ISO models. Managed in house Day Program. Available by beeper 24 hours a day providing crisis management/support to staff and program. Also continued with many of the responsibilities held as Residential Educator whenever working relief/direct care (see job description below).

Oct. 1989 – May 1990
Residential Educator – Full Time

Residential Resources, Inc., Salem, NH

Assisted developmentally disabled adults with daily living skills in community based group home. Development and implementation of client ISPs, recording of progress notes, log, data instructional programs and administering of medication. Rotated "on call" crisis scheduling, problem solving/analyzing, providing back up to staff and managing house funds.

EDUCATION:

Bachelor of Science, Accounting
Capella University
Currently enrolled, credits transferred from UNH.
Bachelor of Arts, Psychology
Minor: Education
(Status – Senior level, 4 courses shy of completion)
University of New Hampshire, Durham, NH

SOFTWARE USED:

Microsoft Office Professional, QuickBooks, Visio, Mozilla Firefox and Internet Explorer, Balanced Scorecard Software

QUALIFICATIONS:

Trainings on Microsoft Office –
(Word, Excel, Access, PowerPoint, Publisher)
LEAN training
QuickBooks Training
Nonprofit Management Training Troubleshooting
& Maintaining PCs Supervision/Management
Training in specific areas Notary Public,
Commission expires 6/5/2018

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: FOUNDATION FOR HEALTHY COMMUNITIES

Name of Program: NH Medicare Rural Hospital Flexibility Program

BUDGET PERIOD: (10 Months)

NAME	JOB TITLE	SALARY	% PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Greg Vasse	Director, Rural QIN	$80,976	25.00%	[illegible]
Noreen M. Cremin	Program & Grants Manager	$39,059	5.00%	[illegible]
		$0	0.00%	[illegible]
		$0	0.00%	[illegible]
		$0	0.00%	[illegible]
		$0	0.00%	[illegible]
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				[illegible]

BUDGET PERIOD: (12 Months)

NAME	JOB TITLE	SALARY	% PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Greg Vasse	Director, Rural QIN	$96,158	25.00%	[illegible]
Noreen M. Cremin	Program & Grants Manager	$46,383	5.00%	[illegible]
		$0	0.00%	[illegible]
		$0	0.00%	[illegible]
		$0	0.00%	[illegible]
		$0	0.00%	[illegible]
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				[illegible]

BUDGET PERIOD: (2 Months)

NAME	JOB TITLE	SALARY	% PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Greg Vasse	Director, Rural QIN	$16,889	25.00%	$4,222.17
Noreen M. Cremin	Program & Grants Manager	$8,146	5.00%	$407.32
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				$4,629.49

20 MJT

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-5934 1-800-852-3345 Ext. 5934
Fax: 603-271-4506 TDD Access: 1-800-735-2964

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

G&C APPROVED
Date: 9/3/14
Item # 20

July 15, 2014

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

REQUESTED ACTION

100% Federal funds

Authorize the Department of Health and Human Services, Division of Public Health Services, to enter into an agreement with the Foundation for Healthy Communities, Vendor #154533-B001, 125 Airport Road, Concord, NH 03301, in an amount not to exceed $279,000, to assist Critical Access Hospitals to improve quality of care for Medicare beneficiaries, to be effective date of Governor and Council approval, through August 31, 2015.

Funds are available in the following account for SFY 2015, and are anticipated to be available in SFY 2016 upon the availability and continued appropriation of funds in the future operating budgets, 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.

05-95-90-902010-2218 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY, & PERFORMANCE, HOSPITAL FLEX PROGRAM

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2015	102-500731	Contracts for Prog Svc	90076000	215,000
SFY 2016	102-500731	Contracts for Prog Svc	90076000	64,000
			Total	$279,000

EXPLANATION

Funds in this agreement will be used to provide evidence-based practices to assist the Critical Access Hospitals to improve quality and performance across the range of activities to ensure quality of care for Medicare beneficiaries in Critical Access Hospitals, ensure the financial viability of Critical Access Hospitals in order to support local access to care for Medicare beneficiaries, and develop and sustain systems of care between Critical Access Hospitals and other community health services in order to provide comprehensive care for Medicare beneficiaries.

The contractor will 1) work with Critical Access Hospitals on quality improvement projects; 2) work with Critical Access Hospitals on financial and operational improvement projects; 3) assist with the development of statewide systems of care focused on improving trauma, heart attack and stroke

patient outcomes, and assist Critical Access Hospitals and their Public Health Networks with their community needs assessments.

According to the New Hampshire definition of rural, approximately 37% of the population and 84% of the landmass in New Hampshire is considered rural. As with most rural populations, those within New Hampshire tend to be proportionately older, are more likely to be dependent upon Medicaid or Medicare, or are uninsured, and reside in areas designated as Health Professional Shortage Areas or Medically Underserved Areas. New Hampshire residents in rural communities face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals. New Hampshire's scenic rivers, mountain ranges, lakes and agricultural lands define the state's culture and geography but also create boundaries and barriers to the resources that improve health. Many New Hampshire residents depend on family and friends to get to and from grocery stores, work, medical facilities, and community events. Access to oral, mental, primary, specialty and/or reproductive health care can be a significant challenge, whether it's a few blocks or several hours away.

Although there are some statistics that show health benefits for rural residents, the majority of the differences identified show adverse health related measures in New Hampshire's rural areas. Some of the most notable differences are in the demographic characteristics of the rural residents, which impacts health status and access. Rural residents of the state are significantly older, poorer, and less educated than non-rural residents. These factors have all been shown to impact health status and access. Rural residents are also far more likely to be unemployed or out of the labor force and rural workers are more likely to be self-employed or to work in industries where health insurance benefits are less available.

These insurance patterns were reflected in the inpatient payer mix, and even more prominently in the payer mix for visits to hospital emergency departments. The majority of the uninsured were in employed families, however rural residents are less likely to have an employer sponsored health insurance option. Rural residents are also less likely to be insured for dental services. Birth records show that rural pregnant women have higher maternal tobacco use, maternal alcohol use, and are more likely to be under the age of twenty, unmarried and have Medicaid paid births. Resident death records show that rural residents are more likely to die in an accident or from suicide than other NH residents. In addition, rural residents are more likely to be hospitalized for injuries than other NH residents.

Although New Hampshire's population is slowly growing, it is also aging. 35.6% of the population is over age 50; about 20% are over 60; and over 9% are over 70. The Carsey Institute estimates that the population of those 65 and over will double in the next 20 years. New Hampshire will move from ranking 37 to 17 in terms of elderly population by 2030. These age structure shifts are not occurring evenly. Northern and central New Hampshire already contains a substantially larger proportion of residents age 65 and over than do other parts of the state. Much of this is a function of aging in place among current residents of these regions, coupled with a continuing loss of young adults. The senior population is much more likely to live in poverty and have significant medical and social services needs than those under 55. What's more, the majority of NH seniors live in the northern, rural areas of the State where – as previously stated - there are significant access barriers to health care.

Should Governor and Executive Council not authorize this Request, this will result in the discontinuation of program initiatives in developing and sustaining creative, effective access to quality health care services in rural NH communities.

The Foundation for Healthy Communities was selected for this project through a competitive bid process. A Request for Proposals was posted on The Department of Health and Human Services' web site from May 28, 2014 through June 25, 2014. In addition, a bidder's conference was held on June 11, 2014

One proposal was received in response to the Request for Proposals. Four reviewers who work internal and external to the Department reviewed the proposals. The reviewers represent seasoned public health administrators and managers who have between 11 to 34 years' experience managing agreements with vendors for various public health programs. Each reviewer was selected for the specific skill set they possess and their experience. Their decision followed a thorough discussion of the strengths and weaknesses to the proposals. The final decision was made through consensus scoring. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to extend for two (2) additional year(s), contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Council.

The following performance measures will be used to measure the effectiveness of the agreement:

- Number and percent of change in state reporting by Critical Access Hospitals on at least one Medicare Beneficiary Quality Improvement Project outpatient measure
- Number of Critical Access Hospitals in state reporting Hospital Consumer Assessment of Healthcare Providers and Systems data
- Percent improvement for Critical Access Hospitals in days in Accounts Receivable, based on gross revenue
- Number of Critical Access Hospitals engaged in regional and/or national ST segment elevation myocardial infarction/stroke programs.
- Number of Critical Access Hospitals that have completed a community needs assessment, including the development of strategies to address identified needs

Area served: Statewide.

Source of Funds: 100% Federal Funds from the US Department of Health and Human Services, Health Resources and Services Administration.

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

Respectfully submitted,

José Thier Montero, MD, MHCDS
Director

Approved by:
Nicholas A. Toumpas
Commissioner

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

NH Medicare Rural Hospital Flexibility Program
RFP Name

15-DHHS-DPHS-RHPC-03
RFP Number

Reviewer Names

1. Curtis Metzger, Program Manager, 11 years experience
2. Melinda Merrell, Director Hospital Program, SC Office of Rural Health, 11 years experience
3. Dolores Cooper, Financial Manager, 34 Years Experience
4. Shelley Swanson, Administrator, 21 Years Experience

Bidder Name	Pass / Fail	Maximum Points	Actual Points
1. Foundation for Healthy Communities	Pass	175	165
2. 0			

FORM NUMBER P-37 (version 1/09)

Subject: NH Medicare Rural Hospital Flexibility Program

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Foundation for Healthy Communities		**1.4 Contractor Address** 125 Airport Road Concord, NH 03301	
1.5 Contractor Phone Number 603-415-4275	**1.6 Account Number** 05-95-90-901010-2218-102 500731	**1.7 Completion Date** 08/31/2015	**1.8 Price Limitation** $279,000
1.9 Contracting Officer for State Agency Brook Dupee, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature		**1.12 Name and Title of Contractor Signatory** Shawn LaFrance, Executive Director	

1.13 Acknowledgement: State of NH, County of Hemmack

On 7/15/14 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] Noreen M. Cremin Notary Public ~~My Commission Expires: June 5, 2018~~ June 5, 2018

1.13.2 Name and Title of Notary or Justice of the Peace

Noreen M. Cremin Program & Grants Manager

1.14 State Agency Signature	**1.15 Name and Title of State Agency Signatory** Brook Dupee, Bureau Chief
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: Megan Yeple-Attorney	On: 7/23/14
1.18 Approval by the Governor and Executive Council	
By:	On:

SCOPE OF SERVICES

1. Covered Populations and Services

The Contractor will use evidence based practices to assist the Critical Access Hospitals (CAHS) to improve quality and performance across the range of activities described below, especially as these activities pertain to Medicare beneficiaries.

2. Minimum Required Services Service Delivery Activities–Stage 1

The following objectives are directed from the Federal Medicare Rural Hospital Flexibility Grant Program (i.e., Flex Program) guidance.

2.1. Objective:

Encourage Critical Access Hospital (CAHs) to publicly report data to Hospital Compare (federal quality reporting system: http://www.medicare.gov/hospitalcompare/search.html) on relevant process of care quality measures for inpatient and outpatient care, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey results.

Activities:

- Provide technical assistance to foster robust participation in Medicare Beneficiary Quality Improvement Project (MBQIP) Phases I and II and to use the identified measures (section 3.5) to target specific interventions within New Hampshire Critical Access Hospital (CAHs).
- Provide technical assistance to the 13 Critical Access Hospitals to ensure continued reporting of data to Hospital Compare.
- Provide technical assistance to the 13 Critical Access Hospitals to expand the number of measures reported under Phase I and II of Medicare Beneficiary Quality Improvement Project (MBQIP).

2.2. Objective:

Support CAHs in implementing activities to address patient safety, transitions between settings or unnecessary hospital readmissions.

Activities:

- Provide technical assistance to the Critical Access Hospitals to define a project or projects that assist them with quality improvement in patient safety, care transitions, or the reduction of unnecessary hospital readmissions in conjunction with relevant measures defined by Medicare, regulatory bodies, or hospital initiatives.

2.3. Objective:

Support Critical Access Hospitals and communities in developing collaborative projects/initiatives to address unmet health and health service needs.

Activities:

- Provide financial and technical assistance to one Critical Access Hospital and their Public Health Network (PHN) to conduct a community needs assessment and/or implement recommended activities identified by their community needs assessment based on best practice interventions.

3. Minimum Required Services/Service Delivery Activities–Stage 2

3.1. Objective:

Encourage Critical Access Hospital (CAHs) to publicly report data to Hospital Compare (federal quality reporting system: http://www.medicare.gov/hospitalcompare/search.html) on relevant process of care quality measures for inpatient and outpatient care, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey results.

Activities:

- Provide technical assistance to facilitate the identification of at least one specific measure to have reported by all CAHs.

3.2. Objective:

Support CAHs in implementing activities to address patient safety, transitions between settings or unnecessary hospital readmissions.

Activities:

- Provide technical assistance to the CAHs to implement at least one project that assists them with quality improvement in patient safety, care transitions, or the reduction of unnecessary hospital readmissions in conjunction with relevant measures defined by Medicare, regulatory bodies, or hospital initiatives.

3.3. Objective:

Support CAHs and communities in developing collaborative projects/initiatives to address unmet health and health service needs.

Activities:

- Provide financial and technical assistance to another CAH and their Public Health Network (PHN) to conduct a community needs assessment and/or implement recommended practice activities identified by their community needs assessment.

4. Delegation and Subcontractors- Fiscal Agent Activities Stage 1

4.1. New England Rural Health Roundtable (NERHRT)

Execute a subcontract in the amount of $50,000 with the New England Rural Health Round Table (NERHRT) to coordinate participation of New Hampshire small rural hospitals in a multi-state, multi-hospital rural Institute for Healthcare Improvement (IHI) network through the New England Rural Hospital Performance Improvement Initiative (NEPI).

Background: The New England Performance Improvement (NEPI) network, consisting of Critical Access Hospitals and additional small rural hospitals, state hospital associations, the New England Rural Health Round Table (NERHRT), and state Flex Programs from ME, VT, MA, and NH provides coordinated resources for CAHs across the northern New England region. In Federal Fiscal Year 2013, NEPI will continue to support ongoing professional education for CAH professionals through the Institute for Healthcare Improvement (IHI).

These educational programs may include but are not limited to:

- Open School,
- Leadership Quality Improvement (LQI) training,
- Patient Care Processes (various programs available), or
- Processes to Support Care (various programs available).

NEPI will ensure that at least one certification program is offered to CAHs and provide preparatory course and exam enrollment assistance.

1. Support CAH participation in quality reporting and benchmarking initiatives other than Hospital Compare, Support CAH participation in national Quality Improvement training or capacity building programs
    a. Support ongoing professional education for CAH professionals through the Institute for Healthcare Improvement (IHI). Programs may include but are not limited to: Open School, Leadership Quality Improvement (LQI) training , Patient Care Processes(various programs available), or Processes to Support Care(various programs available)
2. Support continued education for CAH professionals through certification programs such as Certified Professional in Healthcare Quality (CPHQ), Certified Professional in Patient Safety (CPPS), and/or Certified Professional in Healthcare Risk Management (CPHRM).
3. Provide leadership and funding support for NEPI's regional collaborative infrastructure and projects.
4. Convene a Performance Improvement session at the 2014 New England Rural Health Round Table Annual Symposium
5. Support continued access to useful information and resources through the NEPI web page on NERHRT website.
6. Create a strategic document for NEPI to guide the collaborators in planning for the next five years.
7. Develop a regional Technology Plan to identify strategies to foster long-distance education, training and access to quality improvement best practices

4.2. Financial Improvement Network

Provide the Financial Improvement Network (FIN) with services to identify areas for improvement to increase a Critical Access Hospital (CAH) staff's ability to better manage their revenue cycles; to foster financial integrity of pricing, charity care and bad debt policies; to increase hospital revenue and cash flow; to better serve patients and customers by informing them upfront of financial obligations; to improve hospital business and operational processes; and to build department manager accountability for CAH financial performance.

4.3. Operational Improvements

Identify areas for improvement for operational performance. Support may include technical assistance, educational programs/seminars, user group meetings, and consultation provided, facilitated or funded by the State Flex Program.

4.4. ST segment elevation myocardial infarction (STEMI)/Stroke Development Activities

Execute a contract with an appropriate vendor to promote ST segment elevation myocardial infarction (STEMI) which is a type of heart attack and stroke system development activities. Support the work of the statewide STEMI/Stroke Planning Advisory Group toward the goal of a statewide STEMI/Stroke system.

4.5. Trauma Registry

Execute a contract with a vendor identified by the New Hampshire Department of Safety, Bureau of Emergency Medical Services (EMS) and the Division of Public Health Services to provide consultant staffing resources to 6 CAHs and provide ongoing assistance with the implementation and training for the statewide trauma registry.

In year 2 of this contract services will advance the workplan above and complement the work described in Stage 2, pending federal funding and terms of the grant.

5. Delegation and Subcontractors- Fiscal Agent Activities Stage 2

5.1. Financial Improvement Network

Extend Stage 1 activities to provide the Financial Improvement Network (FIN) with services to increase a Critical Access Hospital (CAH) staff's ability to better manage their revenue cycles; to foster financial integrity of pricing, charity care and bad debt policies; to increase hospital revenue and cash flow; to better serve patients and customers by informing them upfront of financial obligations; to improve hospital business and operational processes; and to build department manager accountability for CAH financial performance.

Activities: During Stage 2 we expect implementation of strategies to address areas for improvement defined in Stage 1.

5.2. Operational Improvements

Extend Stage 1 activities to support CAHs in implementing interventions for improving operational performance. Support may include technical assistance, educational programs/seminars, user group meetings, and consultation provided, facilitated or funded by the State Flex Program.

Activities: During Stage 2 we expect implementation of strategies to address areas for improvement defined in Stage 1.

5.3. Hypertension Outcomes Toolkit

Execute a contract with a vendor to be identified by the Division of Public Health Services to develop a training module and toolkit to improve hypertension outcomes for primary care in CAH communities.

5.4. Trauma Registry

Extend a contract with a vendor to be identified by New Hampshire Department of Safety, Bureau of Emergency Medical Services (EMS) and the Division of Public Health Services to provide consultant staffing resources to 7 CAHs and provide ongoing assistance with the implementation and training for the statewide trauma registry.
Activities: Complete development and training on the statewide trauma registry.

6. Compliance Requirements

1. As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of Limited English Proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, the Contractor must submit a detailed description of the language assistance services they will provide to persons with Limited English Proficiency to ensure meaningful access to their programs and/or services, within 10 days of the contract effective date.

2. The Contractor shall attend meetings with representatives from Rural Health and Primary Care and/or other state officials to report on program progress and financial accountability.

3. The Contractor shall provide written reports on progress on a semi-annual and annual basis, as well as at the end of the contract. The reports shall outline progress on all deliverables, goals, objectives, and performance measures, and define any problems with attaining desired results.

7. Workplan

The contractor will be required to provide a work plan that demonstrates their plan for the contract required activities. The work plan must be submitted within 30 days of the effective date of the contract. The work plan will be used to assure progress towards meeting the performance measures and the overall program objectives and goals. At intervals specified by the Department of Health and Human Services (DHHS), the selected bidder will report on their progress towards meeting the performance measures, and overall program goals and objectives to demonstrate they have met the minimum required services for the proposal.

8. Performance Indicators/Measures

These performance indicators will apply to stage one and stage two activities.

Performance Indicators for 3.2.1.

1. Total number of Critical Access Hospitals reporting data on at least one Medicare Beneficiary Quality Improvement Project (MBQIP)inpatient measure
2. Total number of CAHs in state reporting data on at least one MBQIP outpatient measure
3. Number and percent of change in state reporting by CAHs on at least one MBQIP outpatient measure
4. Number of CAHs in state reporting Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data
5. Number of new CAHs reporting HCAHPS data this budget year
6. Number of CAHs in state implementing a Quality Improvement (QI) project based on Hospital Compare data

Performance Indicators for 3.2.2.

1. Number and percent of CAHs participating in a patient safety, care transitions, and/or readmissions project
2. Number of CAHs with improvement in one or more measure due to participation in a Q project.

Exhibit A

Performance Indicators for 3.2.3.

1. Number of CAHs receiving support and/or Technical Assistance (TA) to support them in conducting community health needs assessments
2. Number of CAHs that have completed a community needs assessment (including the development of strategies to address identified needs)

Performance Indicators for 3.3.1.

1. Number and percent of CAHs participating in a patient safety, care transitions, and/or readmissions project
2. Number of CAHs with improvement in one or more measure due to participation in a QI project.
3. Report number of seminars and workshops sponsored and percentage of participating in Institute for Healthcare Improvement (IHI) programming.
4. Offer at least one certification program to CAH and provide prep course and exam enrollment assistance (systems and financial) number of courses offered; number of CAH enrolled in at least one course; number of participants who complete course; number of participants who take exam
5. Provide leadership and funding support for New England Performance Improvement ('s) regional collaborative infrastructure and projects. Report number of NEPI meetings held; number of participants in NEPI project, number of workplan activities addressed; number of projects engage in; number of CAH reached by NEPI
6. Convene a Performance Improvement session at the 2014 New England Rural Health Round Table Annual Symposium number of participants in NEPI session; number of symposium attendees from CAHs
7. Support continued access to useful information and resources through the NEPI web page on New England Rural Health Round Table (NERHRT) website. Report number of resources posted on NEPI web page on NERHRT website; number of new resources identified and posted; number of CAH reached by outreach and marketing effort by NEPI project members; number of page hits; inventory of CAH resources available on website.
8. Create a strategic document for NEPI to guide the collaborators in planning for the next five years. Report number of planning sessions; number of feedback forms from CAH identifying their learning needs
9. Develop a regional Technology Plan to identify strategies to foster long-distance education, training and access to quality improvement best practices. Include evaluation of existing long-distance learning programs; number of feedback forms from CAH identifying their learning needs.

Performance Indicators for 3.4.2.

1. Number of CAHs receiving Flex-funded financial consultations
2. Percent improvement in bad debt as a per cent of gross charges and/or net patient revenue
3. Number and percent of CAHs completing analyses
4. Improvement in point of service collections as a percent of total revenue
5. Percent reduction in claims review and denial rates
6. Percent improvement in days in Accounts Receivable (AR), based on gross revenue
7. Percent change in gross revenue captured
8. Percent change in number of clean claims
9. Percent change in the reduction of denials

Performance Indicators for 3.4.3.

1. Number of CAHs receiving Flex-funded operational consultations.
2. Number of seminars and workshops sponsored;
3. The number of CAHs attending each seminar and/or workshop.
4. The number of total participants in each seminar and/or workshop

5. Total cost of seminars and workshops
6. Average cost per seminar
7. Average cost per workshop

Performance Indicators for 3.4.4.
1. Number of Critical Access Hospitals engaged in regional and/or national ST segment elevation myocardial infarction (STEMI)/stroke programs.
2. Number of meetings with stakeholders to develop STEMI/stroke systems.
3. Development of solutions to STEMI/stroke system problems.

Performance Indicators for 3.4.5
1. Contract executed
2. Number of workshops sponsored;
3. The number of CAHs staff attending each seminar and/or workshop.
4. The number of total participants in each seminar and/or workshop
5. Total cost of seminars and workshops
6. Average cost per workshop

9. Staffing

The Contractor shall maintain staffing to fulfill the roles and responsibilities to support activities of this project. The Contractor shall address the details to the following requirements to ensure adequate staffing is provided.

1. Provide sufficient staff to perform all tasks specified in this contract. The Contractor shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely fashion.

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

3. The Contractor shall develop a Staffing Contingency Plan, after receiving contract award, including but not limited to:
   a. The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the Agreement;
   b. Allocation of additional resources to the Agreement in the event of inability to meet any performance standard;
   c. Discussion of time frames necessary for obtaining replacements;
   d. Bidder's capabilities to provide, in a timely manner, replacement staff with comparable experience; and
   e. The method of bringing replacement staff up-to-date regarding the activities of this project.

4. Include staffing models that will be used by the subcontractors, if applicable.

Exhibit B

Method and Conditions Precedent to Payment

1) Funding Sources:

   a. $215,000 = 100% federal funds from the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.241, Federal Award Identification Number (FAIN), H54RH00022, SFY 2015.

   b. $ 64,000 = 100% federal funds from the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.241, Federal Award Identification Number (FAIN), H54RH00022, SFY 2016.

   $279,000 Total

2) The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.

   a. Payment for said services shall be made as follows:

      The Contractor will submit an invoice in a form satisfactory to the State by the twentieth working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement. The final invoice shall be due to the State no later than thirty (30) days after the contract Completion Date.

   b. The invoice must be submitted to:

      Department of Health and Human Services
      Division of Public Health Services
      Email address: DPHScontractbilling@dhhs.state.nh.us

3) The Contractor agrees to use and apply all contract funds from the State for direct and indirect costs and expenses including, but not limited to, personnel costs and operating expenses related to the Services, as detailed in Exhibit B-1 – SFY 2015 and Exhibit B-1 – SFY 2016 Budgets. Allowable costs and expenses shall be determined by the State in accordance with applicable state and federal laws and regulations. The Contractor agrees not to use or apply such funds for capital additions or improvements, entertainment costs, or any other costs not approved by the State. DHHS funding may not be used to replace funding for a program already funded from another source.

4) This is a cost-reimbursement contract based on an approved budget for the contract period. Reimbursement shall be made monthly based on actual costs incurred during the previous month.

Exhibit B

5) Payment will be made by the State agency subsequent to approval of the submitted invoice and if sufficient funds are available in the Service category budget line items submitted by the Contractor to cover the costs and expenses incurred upon compliance with reporting requirements and performance and utilization review. Contractors will keep detailed records of their activities related to DHHS-funded programs and services.

6) Contractors are accountable to meet the scope of services. Failure to meet the scope of services may jeopardize the funded contractor's current and/or future funding. Corrective action may include actions such as a contract amendment or termination of the contract. The contracted organization shall prepare progress reports, as required.

7) The Contractor shall have written authorization from the State prior to using contract funds to purchase any equipment with a cost in excess of three hundred dollars ($300) and with a useful life beyond one year.

8) Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

SPECIAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

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

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

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

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

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

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

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

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

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

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

DEPARTMENT: NH Department of Health and Human Services.

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

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

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

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

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

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

REVISIONS TO GENERAL PROVISIONS

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

   4. CONDITIONAL NATURE OF AGREEMENT.

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

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

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

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

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

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

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

3. Extension:

   This agreement has the option for a potential extension of up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Council.

4. Insurance

   Subparagraph 14.1.1 of the General Provisions of this contract is deleted and the following subparagraph is added:

   14.1.1 Comprehensive general liability against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $1,000,000 per occurrence and umbrella liability coverage in the amount of $1,000,000 per occurrence.