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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

Lori A. Weaver
Commissioner

Henry D. Lipman
Director

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

June 4, 2025

Her Excellency, Governor Kelly A. Ayotte
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to amend an existing contract with Delta Dental Plan of New Hampshire, Inc. (VC#174101), Concord. NH, to continue providing dental services to eligible and enrolled Medicaid members aged 21 and older through New Hampshire's Medicaid Care Management Program by exercising a contract renewal option,by increasing the price limitation by $19,531,716 from $50,531,712 to $70,063,428 and extending the completion date from March 31, 2026, to March 31, 2028, effective July 1, 2025 upon Governor and Council approval. 72% Federal Funds. 28% General Funds.

The original contract was approved by Governor and Council on November 2, 2022, item #9A, amended on October 18, 2023, item #21, amended on June 26, 2024, item #18A and most recently amended on February 26, 2025, item #13. The original contract included an option to extend for two years which the Department is pursuing to ensure stability of service access as the program develops. The vendor, Delta Dental Plan of New Hampshire, Inc., has succeeded in building out a provider network that enables the Department's access standards to be met and transitioning vendors at this juncture could potentially be disruptive to the level of access that members experience today.

The Centers for Medicare and Medicaid Services (CMS) generally requires that managed care rate certifications must be done on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments.

Funds are anticipated to be available in the following accounts for State Fiscal Years 2026 upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

05-95-47-470010-43080000- HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES, ADULT DENTAL PROGRAM

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	**Increase / (Decrease)**	**Revised Budget**
2023	101-500728	Dental Providers	47017100	$2,947,145		$2,947,145

2024	101-500728	Dental Providers	47017100	$11,788,580		$11,788,580
2025	101-500728	Dental Providers	47017100	$7,979,493		$7,979,493
2026	101-500728	Dental Providers	47017100	$0	$8,655,102	$8,655,102
2027	101-500728	Dental Providers	47017100	$0	TBD	TBD
2028	101-500728	Dental Providers	47017100	$0	TBD	TBD
			Sub-total	$22,715,218	$8,655,102	$31,370,320

05-95-47-470010-23580000- HEALTH AND SOCIAL SERVICES. HEALTH AND HUMAN SVCS, DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES, NH GRANITE ADV HEALTH CARE TRUST FUND

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount	**Increase / (Decrease)**	**Revised Budget**
2023	101-500728	Dental Providers	47017120	$3,749,805		$3,749,805
2024	101-500728	Dental Providers	47017120	$14,999,219		$14,999,219
2025	101-500728	Dental Providers	47017120	$9,067,470		$9,067,470
2026	101-500728	Dental Providers	47017120	$0	$10,876,614	$10,876,614
2027	101-500728	Dental Providers	47017120	$0	TBD	TBD
2028	101-500728	Dental Providers	47017120	$0	TBD	TBD
			Sub-total	$27,816,494	$10,876,614	$38,693,108
			Total Funds	$50,531,712	$19,531,716	$70,063,428

EXPLANATION

The purpose of this request is to update the program costs for the period of July 1, 2025, through June 30, 2026, rating period based largely on changes associated with emerging utilization of program services and to ensure a level of funding that supports the vendor being able to provide services up to the minimum dental loss ratio. This request also seeks to extend the contract completion date by two years, using the option to extend from the original contract approval. At this juncture of program development, it could potentially be disruptive to the level of access that members experience today if we do not exercise the option.

The Adult Dental Program has served over 21,000 unique members since the beginning of the program, with the recent complete month of April showing an 18% increase in monthly claims billed compared to the initial month of the program. There are currently 190 unique providers contracted in the network. The program continues to utilize mobile dental services with

weekend appointments to address service demand where network access support is needed and over 1,800 unique members have been treated at mobile events to date.

The contract requires a minimum dental loss ratio of 85%, meaning that at least 85% of the paid capitation must be spent on dental services. After the first contract year of 14 months, and with claims runout, the Department recouped funds due to results of the dental loss ratio being less than 85%. The funds returned for that period will total $17,192,439 ($12,890,385 in Federal funds and $4,302,054 in State funds.)

The Department will continue to monitor the Contractor's performance by:

- Operationalizing Exhibit O: Quality and Oversight Reporting Requirements - the performance monitoring program.
- Levying financial penalties through its Exhibit N: Liquidated Damages Matrix, when appropriate.
- Weekly review of data on network recruitment efforts, service access metrics, and impacts of the mobile dental services unit deployed in areas of relative access gaps to deliver covered services.
- Use of the External Quality Review Contractor for contractual and quality requirements specified in the Contract and required by CMS regulations; incentives for program performance, and a provider Alternative Payment Model (APM).
- Development of an evaluation demonstrating the impact of this program on emergency department utilization and the broader cost, quality, and clinical outcomes throughout the managed care program.
- Meeting regularly with Delta Dental leadership and other staff to provide. contract oversight and discuss plan performance.

To draw a federal match on dental capitation rates, the Department must secure CMS approval of the actuarial rate filing. Should the Governor and Council not authorize this specific request, the Department may not be able to draw matching federal funds and would need to negotiate another amendment which would incur additional actuarial contract costs, put at risk the achievement of a CMS rate certification, and potentially cause a temporary gap in coverage.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number #93.778, FAIN #2505NH5MAP

Respectfully submitted,

Ann Ch. N. Landry *For:*

Lori A. Weaver
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY

New Hampshire DoIT

27 Hazen Drive | Concord, NH | 03301
Fax: (603) 271-1516 | TDD: (800) 753-2964
doit.nh.gov

Denis Goulet, *Commissioner*

June 4, 2025

Lori A. Weaver, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Weaver:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a contract amendment with the Delta Dental Plan of New Hampshire, Inc. of Concord, NH, as described below and referenced as DoIT No. 2023-025D.

The purpose of this request is to update the program costs for the period of July 1, 2025, through June 30, 2026, rating period based largely on changes associated with emerging utilization of program services and to ensure a level of funding that supports the vendor being able to provide services up the minimum dental loss ratio.

The Total Price Limitation shall increase by $19,531,716 for a New Total Price Limitation of $70,063,428, effective upon Governor and Council approval from July 1, 2025, through March 31, 2028.

A copy of this letter must accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/RA
DoIT #2023-025D

cc: Ken Gagne, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #4

This Amendment to the Medicaid Care Management Dental Services contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Delta Dental Plan of New Hampshire, Inc. ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on November 2, 2022 (Item #9A), as amended on October 18, 2023 (Item #21), June 26, 2024 (Item #18A), and most recently on February 26, 2025 (Item #13) 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, pursuant to Form P-37, General Provisions, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; 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 to amend as follows:

1. Form P-37, General Provisions, Block 1.7., Competition Date, to read:

   March 31, 2028

2. Form P-37, General Provisions, Block 1.8., Price Limitation, to read:

   $70,063,428

3. Modify Exhibit B, Scope of Services, by replacing it in its entirety with Exhibit B-Scope of Services-Amendment #4, which is attached hereto and incorporated by reference herein. Modifications to Exhibit B are outlined below:

4. Modify Exhibit B, Scope of Services, by removing all references of the Withhold and Incentive Program and replacing with Withhold Program.

5. Modify Exhibit B, Scope of Services, Section 4.3.1.4.3.6.1., to read:

   4.3.1.4.3.6.1. The DO shall post on its website and advise the Member within ten (10) calendar days following the MCO's receipt of a valid enrollment file from the Department, but no later than seven (7) calendar days after the effective date of enrollment in paper or electronic form that the Member Handbook is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. [42 CFR 438.10(g)(3)(i)-(iv)]

6. Modify Exhibit B, Scope of Services, Section 4.3.1.4.3.6.2., to read:

   4.3.1.4.3.6.2. The DO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information. The DO shall provide the Member Handbook information by email after obtaining the Member's agreement to receive the information electronically. [42 CFR 438.10(g)(3)(i)-(iv)]

7. Modify Exhibit B, Scope of Services, Section 4.4.5.7., to read:

   4.4.5.7. The DO shall meet the timeframes above for ninety-eight percent (98%) of requests for expedited appeals.

8. Modify Exhibit B, Scope of Services, Section 4.8.7., to read:

   4.8.7. Reserved

9. Modify Exhibit B, Scope of Services, Section 5.4.1., to read:

   5.4.1 The Department shall institute a withhold arrangement through which an actuarially sound

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percentage of the DO's risk adjusted Capitation Payment will be recouped from the DO and be available for distribution upon meeting specific criteria.

10. Modify Exhibit N Liquidated Damages Matrix, by replacing it in its entirety with Exhibit N Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

11. Modify Exhibit C, Payment Terms; Section 2.2, to read:

2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit B Scope of Services. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category who enroll with this Contractor for covered services. Capitation rates were developed based on a 12-month period through June 30, 2026 the end of State Fiscal Year (SFY) 2026

Capitation payment rates are as follows:

Rate Cell Cohort	Rate Cell Name	Age	Base Category of Eligibility Code	Waiver Special Eligibility Code	Nursing Home Level of Care	July 1,2025 - June 30,2026	Priority Ranking - Detailed level
CHTDA 1	Qualified Waiver Population - Base Rate	21+	Any Full Medicaid Eligible category including MGIA and MGIM	AA, AB, AC, AD, BB, BC, BE, DE, ED, EE, EC, EF, EG	N	$22.33	10
CHTDA 2	Qualified Waiver Population - Denture Rate	21+	Any Full Medicaid Eligible category including MGIA or MGIM	AA, AB, AC, AD, BB, BC, BE, DE, ED, EE, EC, EF, EG	N	$0.65	11
CHTDA 3	Non-Qualified Waiver Population NF - Base Rate	21+	Any Full Medicaid Eligible category not MGIA or MGIM	N	L2, L3, L4, L6	$22.33	20
CHTDA 4	Non-Qualified Waiver Population NF - Denture Rate	21+	Any Full Medicaid Eligible category not MGIA or MGIM	N	L2, L3, L4, L6	$0.65	21
CHTDA 5	Non-Qualified Waiver Population (STD MCAID)	21+	Any Full Medicaid Eligible category not MGIA or MGIM	N	N	$20.56	30
CHTDA 6	Non-Qualified Waiver Population (Mcaid Expansion)	21+	MGIA, MGIM	N	N	$17.11	40

For each of the subsequent years of the Agreement, actuarially sound per member per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

Any rate adjustments shall be subject to the availability of State appropriations.

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All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be effective upon July 1, 2025 upon Governor and 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

6/5/2025
Date

DocuSigned by:
Henry D. Lipman
CF5D44D4F70D4E4...

Name: Henry D. Lipman
Title: Medicaid Director

Delta Dental Plan of New Hampshire, Inc.

6/5/2025
Date

DocuSigned by:
Tom Raffio
BD6D9ED927BE41D...

Name: Tom Raffio
Title: President + CEO/Northeast Delta Dental

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

OFFICE OF THE ATTORNEY GENERAL

6/6/2025
Date

DocuSigned by:
Robyn Guarino
748734844941460...
Name: Robyn Guarino
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:

Medicaid Care Management Dental Services

EXHIBIT B – AMENDMENT #4

SCOPE OF SERVICES

1 INTRODUCTION

1.1 Purpose

1.1.1 This Dental Medicaid Care Management Agreement is a comprehensive full risk prepaid capitated Agreement that sets forth the terms and conditions for the Dental Organization's (DO) participation in the New Hampshire (NH) Dental Medicaid Care Management (DMCM) program.

1.2 Term

1.2.1 The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed DMCM Agreement or, if the DO does not have health maintenance organization (HMO) licensure in the State of New Hampshire by the New Hampshire Insurance Department on the date of Governor and Executive Council approval, the date the DO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.2 If the DO fails to obtain HMO licensure within thirty (30) calendar days of Governor and Executive Council approval, this Agreement shall become null and void without further recourse to the DO.

1.2.3 The Program Start Date shall begin April 1, 2023.

1.2.4 The DO's participation in the DMCM program is contingent upon approval by the Governor and Executive Council, the DO's successful completion of the Readiness Review process as determined by the Department, and obtaining HMO licensure in the State of New Hampshire as set forth above.

1.2.5 The DO is solely responsible for the cost of all work during the Readiness Review and undertakes the work at its sole risk.

1.2.6 If at any time the Department determines that any DO will not be ready to begin providing services on the DMCM Program Start Date, April 1, 2023, at its sole discretion, the Department may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the DO.

2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 Abuse

Provider practices that are inconsistent with generally accepted business or dental practices that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or dental services that are not medically necessary or that fail to meet professionally recognized standards for dental care; or recipient practices that result in unnecessary cost to the Medicaid program

2.1.2 Adults with Special Health Care Needs

Members who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

This includes, but is not limited to Members with: Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); a Severe Mental Illness (SMI), Serious Emotional Disturbance (SED), Intellectual and/or Developmental Disability (I/DD), Substance Use Disorder diagnosis; or chronic pain.

2.1.3 Advance Directive

As applicable, written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of New Hampshire, relating to the provision of health care when a Member is incapacitated. [42 CFR 489.100]

2.1.4 Adverse Action

The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure of the DO to act on a grievance or an appeal within the time limits defined in this Agreement.

2.1.5 Agreement

A Contract duly executed and legally binding.

2.1.6 Americans with Disabilities Act (ADA)

A civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.[1]

2.1.7 Alternative Payment Model (APM)

A payment approach that gives added incentive payments to provide high-quality cost-efficient care.

2.1.8 Alternative Payment Model Implementation Plan

A DO's plan for meeting the APM requirements described in this Agreement. A program developed, operated, and maintained by the DO that meets the criteria contained in this Agreement related to Utilization Management. The

[1] The Americans with Disability Act National Network, "What is the Americans with Disabilities Act"

DO Utilization Management Program shall include defined structures, policies, and procedures for Utilization Management.

2.1.9 Appeal Process

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

2.1.10 Automatic Assignment (or Auto-Assign)

The enrollment of an eligible Medicaid recipient, for whom enrollment is mandatory, in a DO chosen by the Agency or its agent, and/or the assignment of a new enrollee to a PDP chosen by the DO.

2.1.11 Auxiliary Aids

Services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy, the benefits of programs or activities conducted by the DO.

Such aids include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDDs), interpreters, note takers, written materials, and other similar services and devices.

2.1.12 Capitation Payment

The monthly payment by the Department to the DO for each Member enrolled in the DO's plan for which the DO provides Covered Services under this Agreement.

Capitation payments are made only for Medicaid-eligible Members and retained by the DO for those Members. The Department makes the payment regardless of whether the Member receives services during the period covered by the payment. [42 CFR 438.2]

2.1.13 Care Coordination/Case Management

A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a member's dental health needs using communication and all available resources to promote quality cost-effective outcomes. Proper case management occurs across a continuum of care, addressing the ongoing individual needs of a member rather than being restricted to a single practice setting. For purposes of this Agreement, "care coordination" and "case management" are the same.

2.1.14 Care Manager

A qualified and trained individual who is hired directly by the DO or a provider in the MCO's network (a "Participating Provider"), who is primarily responsible for providing Care Coordination and Care Management services as defined by this Agreement.

2.1.15 Case Management

Service provided for supervising or coordinating the provision of initial and primary dental care to members; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.

2.1.16 Centers for Medicare & Medicaid Services (CMS)

The federal agency within the United States Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare programs

2.1.17 Choices for Independence (CFI)

Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

The CFI waiver is also known as HCBS for the Elderly and Chronically Ill (HCBS-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and Covered Services are identified in He-E 801.

2.1.18 Clean Claim

A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for Fraud or Abuse, or a claim under review for medical necessity pursuant to 42 CFR 447.45(b).

2.1.19 Cold Call Marketing

Any unsolicited personal contact by the DO or its designee, with a potential Member or a Member with another contracted DO for the purposes of Marketing. [42 CFR 438.104(a)]

2.1.20 Confidential Information and Confidential Data

The definition for this term is located in Exhibit K: DHHS Information Security Requirements.

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

Family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of health care.

2.1.22 Continuity of Care

Provision of continuous care for chronic or acute medical conditions through Member transitions between: facilities and home; facilities; Providers; service areas; managed care contractors; Marketplace, Medicaid fee-for-service (FFS) or private insurance and managed care arrangements.

2.1.23 Continuous Quality Improvement (CQI)

Systematic process of identifying, describing, and analyzing strengths and weaknesses and then testing, implementing, learning from, and revising solutions.

2.1.24 Copayment

Monetary amount that a Member pays directly to a Provider at the time a Covered Service is rendered.

2.1.25 Corrective Action Plan (CAP)

Plan that the DO completes and submits to the Department to identify and respond to any issues and/or errors in instances where it fails to comply with Department requirements.

2.1.26 Cost Sharing

A monetary amount that a Member pays directly to a Provider at the time a Covered Service is rendered.

2.1.27 Covered Services

Health care services as defined by the Department and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, including In Lieu of Services and Value-Added Services authorized by the Department.

2.1.28 Cultural Competence

The level of knowledge-based skills required to provide effective clinical care to members of particular ethnic or racial groups.

2.1.29 Data

Department records, files, forms, electronic information and other documents or information, in either electronic or paper form, that will be used /converted by the Vendor during the contract term, that may be defined as "Confidential Data" within Exhibit K: DHHS Information Security Requirements.

2.1.30 Data Breach

The definition for this term is located in Attachment 2 – Exhibit K: DHHS Information Security Requirements.

2.1.31 Dental Home

A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible, and coordinated way.

2.1.32 Dental or Oral Disease or Condition

A disease or condition of the oral cavity, including but not limited to: dental caries, gingivitis, periodontitis, oral and pharyngeal cancer, salivary and oral mucosal conditions, malocclusion, congenital anomaly, injury or trauma to

oral facial structures, and any other dental or oral disease or condition including manifestation of systemic disease and effects of certain medications and other medical treatments.

2.1.33 Dental Organization (DO)

An entity that has a certificate of authority from the NH Insurance Department (NHID) and who contracts with the Department under a comprehensive risk Agreement to provide covered dental care services to eligible Members under the DMCM program. This term also includes any subcontracted entity which provides dental managed care services in accordance with this Agreement.

2.1.34 Dental Quality Alliance (DQA)

Organization responsible to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.

2.1.35 Dental Risk Assessment

The process of collecting information from a person about hereditary, lifestyle, and environmental factors to determine specific diseases or conditions for which the person is at risk.

2.1.36 Dentist

An individual who holds a valid and active license to practice dentistry or dental surgery in full force and effect pursuant to the applicable laws of the State in which the service is furnished.

2.1.37 Determinants of Health

A wide range of factors known to have an impact on healthcare, ranging from socioeconomic status, education and employment, to one's physical environment and access to healthcare.

2.1.38 Disenrollment

The discontinuation of a Member's entitlement to receive Covered Services under the terms of this Agreement, and deletion from the approved list of members furnished by the Department.

2.1.39 DO Data Certification

Encounter Data submitted to the Department, which must be certified by one of the following:

- The DO Dental Contract Manager;
- The DO Dental Director; or
- An individual who has delegated authority to sign for, and who reports directly to, the DO Contract Manager or Dental Director.

2.1.40 DO Quality Assessment and Performance Improvement (QAPI) Program

An ongoing and comprehensive program for the Covered Services the DO furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program. [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]

2.1.41 Dual-Eligible Members

Members who are eligible for both Medicare and Medicaid.

2.1.42 Emergency Dental Condition

A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions may include severe pain, hemorrhage, acute infection, traumatic injury to teeth and surrounding tissue, or unusual swelling of the face or gums.

2.1.43 Emergency Dental Services

Those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingiva, alveolar bone), jaws, and tissues of the oral cavity.

2.1.44 Emergency Medical Condition

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

2.1.45 Emergency Services

Covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition. [42 CFR 438.114(a)]

2.1.46 Encounter Data

A record of Covered Services provided to a DO Member. An "encounter" is an interaction between a patient and a provider (DO, rendering dentist, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient. Encounter Data is considered to be Confidential Data as defined in Exhibit K: DHHS Information Security Requirements.

2.1.47 Enrollment

The process by which a person becomes a Member of the DO's plan through the Department.

2.1.48 Equal Access

All Members have the same access to all Providers and Covered Services.

2.1.49 Exclusion Lists

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

2.1.50 External Quality Review (EQR)

The analysis and evaluation described in 42 CFR 438.350 by an External Quality Review Organization (EQRO) detailed in 42 CFR 438.364 of aggregated information on quality, timeliness, and access to Covered Services that the DO or its Subcontractors furnish to Medicaid recipients.

2.1.51 Facility

Any premises (a) owned, leased, used, or operated directly or indirectly by or for the DO or its affiliates for purposes related to this Agreement; or (b) maintained by a Subcontractor to provide Covered Services on behalf of the DO.

2.1.52 Federally Qualified Health Centers (FQHCs)

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

2.1.53 Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or State law.

2.1.54 Granite Advantage Members

Members who are covered under the NH Granite Advantage waiver, which includes individuals in the Medicaid new adult eligibility group, covered under Title XIX of the Social Security Act who are adults, aged nineteen (19) up to and including sixty-four (64) years, with incomes up to and including one hundred and thirty-eight percent (138%) of the federal poverty level (FPL) who are not pregnant, not eligible for Medicare and not enrolled in NH's Health Insurance Premium Payment (HIPP) program.

2.1.55 Grievance Process

The procedure for addressing Member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.56 Home and Community Based Services (HCBS)

The waiver of Sections 1902(a)(10) and 1915(c) of the Social Security Act, which permits the federal Medicaid funding of LTSS in non-institutional settings for Members who reside in the community or in certain community

alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility (ICF). This includes services provided under the HCBS-CFI waiver program, Developmental Disabilities (HCBS-DD) waiver program, Acquired Brain Disorders (HCBS-ABD) waiver program, and In Home Supports (HCBS-I) waiver program.

2.1.57 Hospital-Acquired Conditions and Provider Preventable Conditions

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

2.1.58 Implementation

The process for making the System fully operational for processing the Data.

2.1.59 In Lieu Of Services

An "In Lieu Of Service" means an alternative service or setting that the Department has approved as medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan.

A Member cannot be required by the DO to use the alternative service or setting. Any In Lieu Of Service shall be authorized by the Department, either via the Department's issuance of prospective identification of approved In Lieu of Services or through an agreement reached between the Department and the DO.

The utilization and actual cost of In Lieu Of Services shall be taken into account in developing the component of the capitation rates that represents the Medicaid State Plan Covered Services, unless a statute or regulation explicitly requires otherwise.

2.1.60 Incomplete Claim

A claim that is denied for the purpose of obtaining additional information from the Provider.

2.1.61 Indian Health Care Provider (IHCP)

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

2.1.62 Licensed

A facility, equipment, or an individual that has formally met State, county, and local requirements, and has been granted a license by a local, State, or federal government entity.

2.1.63 Limited English Proficiency (LEP)

Member's primary language is not English and the Member may have limited ability to read, write, speak or understand English.

2.1.64 List of Excluded Individuals and Entities (LEIE)

A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, medical health care providers, patients, and others relating to parties excluded from participation in Medicare, Medicaid, and all other federal medical health care programs.

2.1.65 Long Term Services and Supports (LTSS)

Nursing facility services, all four of NH's Home and Community Based Care waivers, and services provided to children and families through the Division for Children, Youth and Families (DCYF).

2.1.66 Managed Care Information System (MCIS)

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

Means an entity that has a certificate of authority from the NH Insurance Department (NHID) and who contracts with the Department under a comprehensive risk Agreement to provide health care services to eligible Members under the Medicaid Care Management (MCM) managed care program.

2.1.67 Marketing

Any communication from the DO to a potential Member, or Member who is not enrolled in that DO, that can reasonably be interpreted as intended to influence the Member to enroll with the DO or to either not enroll, or disenroll from another the Department contracted DO. [42 CFR 438.104(a)]

2.1.68 Marketing Materials

Materials that are produced in any medium, by or on behalf of the DO that can be reasonably interpreted as intended as Marketing to potential Members. Written or printed Member materials (including Member ID cards),

may be distributed to Members in a digital format as permissible under state and federal laws and regulations. [42 CFR 438.104(a)(ii)]

2.1.69 Medicaid Dental Director

The State Medicaid Dental Director of NH DHHS.

2.1.70 Medicaid Management Information System (MMIS)

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

2.1.71 Medicaid State Plan

An agreement between a State and the Federal government describing how that State administers its Medicaid and CHIP programs. It gives an assurance that a State will abide by Federal rules and may claim Federal matching funds for its program activities. The State plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the State.

2.1.72 Medical Loss Ratio (MLR)

The proportion of premium revenues spent on clinical services and quality improvement, calculated in compliance with the terms of this Agreement and with all federal standards, including 42 CFR 438.8(b).

2.1.73 Medically Necessary

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

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the Member's illness, injury, disease, or its symptoms;
- Not primarily for the convenience of the Member or the Member's family, caregiver, or health care Provider;
- No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the Member's illness, injury, disease, or its symptoms; and
- Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].

2.1.74 Member

An individual who is enrolled in managed care through a DO having an Agreement with the Department. [42 CFR 438.2]

2.1.75 Member Advisory Board

A group of Members that represents the Member population, established and facilitated by the DO. The Member Advisory Board shall adhere to the requirements set forth in this Agreement.

2.1.76 Member Encounter Confidential Data(Encounter Data)

The information relating to the receipt of any item(s) or service(s) by a Member, under this Agreement, between the Department and an DO that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

2.1.77 Member Handbook

A handbook based upon the Model Member Handbook developed by the Department and published by the DO that enables the Member to understand how to effectively use the DMCM program in accordance with this Agreement and 42 CFR 438.10(g).

2.1.78 National Committee for Quality Assurance (NCQA)

The organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

2.1.79 NCQA Credentialing Accreditation

DO credentialing and re-credentialing accreditation obtained from the NCQA that provides a framework for organizations to implement industry best practices that help them accurately and efficiently credential and re-credential health care professionals.

2.1.80 Non-Covered Service

A service that is not a benefit under either the Medicaid State Plan or the DO.

2.1.81 Non-Emergency Medical Transportation (NEMT)

Transportation services arranged by the DO and provided free of charge to Members who are unable to pay for the cost of transportation to Provider offices and facilities for Medically Necessary care and services covered by the Medicaid State Plan, regardless of whether those Medically Necessary services are covered by the DO.

2.1.82 Non-Participating Provider

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

2.1.83 Non-Symptomatic Office Visits

Office visits available from the Member's Dental Provider (DP) or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, diagnostic, preventive, and restorative services.

2.1.84 Non-Urgent, Symptomatic Office Visits

Office visits available from the Member's Dental Provider (DP) or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of oral health related signs or symptoms not requiring immediate attention, but that require monitoring.

2.1.85 Overpayments

Any amount received to which the Provider is not entitled. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.

2.1.86 Participating Provider

A dentist, licensed to practice dentistry in the State of New Hampshire who contracts with the DO to provide specialized covered dental services to the DO's Members.

2.1.87 Performance Improvement Project (PIP)

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

2.1.88 Physician or Dental Group

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

2.1.89 Physician Incentive Plan

Any compensation arrangement between the DO and Providers that apply to federal regulations found at 42 CFR 422.208 and 42 CFR 422.210, as applicable to Medicaid managed care on the basis of 42 CFR 438.3(i).

2.1.90 Post-Stabilization Services

Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition. [42 CFR 438.114; 422.113]

2.1.91 Practice Guidelines

Evidence-based clinical guidelines adopted by the DO that are in compliance with 42 CFR 438.236 and with URAC's requirements for health plan accreditation. The Practice Guidelines shall be based on valid and

reasonable clinical evidence or a consensus of Providers in the particular field, shall consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

2.1.92 Prescription Drug Monitoring Program (PDMP)

The program operated by the NH Office of Professional Licensure and Certification that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in NH.

2.1.93 Primary Care Provider (PCP)

A provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the Continuity of Member Care. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All federal requirements applicable to primary care physicians shall also be applicable to PCPs as the term is used in this Agreement.

2.1.94 Primary Dental Provider (PDP)

An appropriately licensed general dentist who furnishes to Members comprehensive, coordinated, and readily-accessible dental care including: dental health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

2.1.95 Prior Authorization

The process by which the Department, the DO, or another DO participating in the DMCM program, whichever is applicable, authorizes, in advance, the delivery of Covered Services based on factors, including but not limited to medical necessity, cost-effectiveness, and compliance with this Agreement.

2.1.96 Priority Population

A population that is most likely to have Care Management needs and be able to benefit from Care Management. The following groups are considered Priority Populations under this Agreement: Adults with Special Health Care Needs, including, but not limited to, Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain; Members receiving services under HCBS waivers; Members identified as those with rising risk; individuals with high unmet resource needs; pregnant women with Substance Use Disorder; intravenous drug users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use; individuals who have been in the ED for an overdose event in the last twelve (12) months; recently incarcerated individuals; and other Priority Populations as determined by the DO and/or the Department.

2.1.97 Program Start Date

The date when the DO is responsible for coverage of Covered Services to its Members in the DMCM program, contingent upon Agreement approval by

the Governor and Executive Council and the Department's determination of successful completion of the Readiness Review period.

2.1.98 Provider Directory

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

2.1.99 Qualified Bilingual/Multilingual Staff

An employee of the DO who is designated by the DO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the DO that they are proficient in speaking and understanding spoken English and at least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

2.1.100 Qualified Interpreter for a Member with a Disability

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

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

2.1.101 Qualified Interpreter for a Member with LEP

An interpreter who, via a remote interpreting service or an on-site appearance adheres to generally accepted interpreter ethics principles, including Member confidentiality; has demonstrated proficiency in speaking and understanding spoken English and at least one (1) other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

2.1.102 Qualified Translator

A translator who adheres to generally accepted translator ethics principles, including Member confidentiality; has demonstrated proficiency in writing and understanding written English and at least one (1) other written language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. [45 CFR 92.4, 45 CFR 92.101]

2.1.103 Qualifying APM

An APM approved by the Department as consistent with the standards specified in this Agreement and in any subsequent Department guidance, including the Department Medicaid APM Strategy.

2.1.104 Quality

The degree to which a DO increases the likelihood of desired dental health outcomes of its members through its structural and operational characteristics and through the provision of dental health services that are consistent with current professional knowledge.

2.1.105 Quality Improvement (QI)

The process of monitoring that the delivery of dental health care services is available, accessible, timely, and medically necessary. The DO must have a quality improvement program (QI program) that includes standards of excellence. It also must have a written quality improvement plan (QI plan) that draws on its quality monitoring to improve dental health care outcomes for members.

2.1.106 Referral Provider

A Provider, who is not the Member's PDP or PCP, to whom a Member is referred for Covered Services.

2.1.107 Risk Scoring and Stratification

Means the methodology to identify Members who are part of a Priority Population for Care Management and who should receive a Comprehensive Assessment. The DO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level including details regarding the algorithm and data sources used to identify eligible Member for Care Management.

2.1.108 Rural Health Clinic (RHC)

A clinic located in an area designated by the Department as rural, located in a federally designated medically underserved area, or has an insufficient number of physicians, which meets the requirements under 42 CFR 491.

2.1.109 Second Opinion

The opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the DO has permitted the Member to consult, at no cost to the Member. [42 CFR 438.206(b)(3)]

2.1.110 Software

All Custom, Open Source, IaaS, SaaS and/or COTS Software and/or applications provided by the Contractor under the Agreement.

2.1.111 Specifications

Refer to Contract Exhibit P-37: General Provisions Section 12 – Assignment, Delegation, Subcontracts.

2.1.112 State

The State of New Hampshire and any of its agencies.

2.1.113 State Data

All Data created or in any way originating with the State, and all Data that is the output of computer processing of or other electronic manipulation of any Data that was created by or in any way originated with the State, whether such Data or output is stored on the State's hardware, the Contractor's hardware or exists in any system owned, maintained or otherwise controlled by the State or by the Contractor not defined as "Confidential Data" within Exhibit K: DHHS Information Security Requirements

2.1.114 Subcontract

Any separate contract or written arrangement between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Agreement.

2.1.115 Subcontractor

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

2.1.116 System

All Software, specified hardware, and interfaces and extensions, integrated and functioning together in accordance with the Specifications.

2.1.117 Term

The duration of this Agreement.

2.1.118 Third Party Liability (TPL)

The legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan.

By law, all other available third party resources shall meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

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

2.1.119 Transitional Care Management

The responsibility of the DO to manage Covered Services care transitions for all Members moving from one clinical setting to another or from a clinical

setting to home, to prevent unplanned or unnecessary ED visits or adverse health outcomes. [42 CFR 438.208(b)(2)(i)]

2.1.120 Transportation

An appropriate means of conveyance furnished to a Member to obtain Covered Services.

2.1.121 URAC Health Plan Accreditation

DO accreditation obtained from URAC based on measurement, reporting and monitoring requirements of accreditation to promote continuous quality improvement.

2.1.122 Urgent, Symptomatic Office Visits

Office visits, available from the Member's Primary Dental Provider (PDP) or another Provider within forty-eight (48) hours, for the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

2.1.123 Utilization Management

The criteria of evaluating the necessity, appropriateness, and efficiency of Covered Services against established guidelines and procedures.

2.1.124 Value-Added Services

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

2.1.125 Verification

Supports the confirmation of authority to enter a computer system application or network.

2.1.126 Willing Provider

A Provider credentialed as a qualified treatment provider according to the requirements of the Department and the DO, who agrees to render services as authorized by the DO and to comply with the terms of the DO's Provider Agreement, including rates and policy manual.

2.1.127 Withhold

The actuarially sound amount retained as a percent of the DO's risk adjusted total Capitation for a rating period which is withheld annually and may be available for distribution to the DO in future contract years upon meeting specific performance criteria.

2.1.128 Work Plan

Documentation that details the activities for the Project created in accordance with the Contract. The plan and delineation of tasks, activities and events to be performed and Deliverables to be produced under the

Project as specified in Appendix B: Business/Technical Requirements and Deliverables. The Work Plan must include a detailed description of the Schedule, tasks/activities, Deliverables, critical events, task dependencies, and the resources that would lead and/or participate on each task.

2.2 Acronym List

2.2.1 ABD means Acquired Brain Disorder.

2.2.2 ADA means Americans with Disabilities Act.

2.2.3 ADT means Admission, Discharge and Transfer.

2.2.4 AIDS means Acquired Immune Deficiency Syndrome.

2.2.5 APM means Alternative Payment Model.

2.2.6 ASC means Accredited Standards Committee.

2.2.7 ASL means American Sign Language.

2.2.8 CAHPS means Consumer Assessment of Healthcare Providers and Systems.

2.2.9 CAP means Corrective Action Plan.

2.2.10 CARC means Claim Adjustment Reason Code.

2.2.11 CDT means The American Dental Association's Current Dental Terminology

2.2.12 CFI means Choices for Independence.

2.2.13 CFR means Code of Federal Regulations.

2.2.14 CHIS means Comprehensive Health Care Information System.

2.2.15 CMS means Centers for Medicare & Medicaid Services.

2.2.16 COB means Coordination of Benefits.

2.2.17 COBA means Coordination of Benefits Agreement.

2.2.18 CQI means Continuous Quality Improvement.

2.2.19 DD means Developmental Disability.

2.2.20 DEA means Drug Enforcement Administration.

2.2.21 DHHS means New Hampshire Department of Health and Human Services.

2.2.22 DMCM means Dental Medicaid Care Management

2.2.23 DO means Dental Organization.

2.2.24 DOB means Date of Birth.

2.2.25 DOD means Date of Death.

2.2.26 DOJ means (New Hampshire or United States) Department of Justice.

2.2.27 ECI means Elderly and Chronically Ill.

2.2.28 ED means Emergency Department.

2.2.29 EDI means Electronic Data Interchange.

2.2.30 EFT means Electronic Funds Transfer.

2.2.31 EOB means Explanation of Benefits.

2.2.32 EQR means External Quality Review.

2.2.33 EQRO means External Quality Review Organization.

2.2.34 ERISA means Employees Retirement Income Security Act of 1974.

2.2.35 EST means Eastern Standard Time.

2.2.36 ETL means Extract, Transformation and Load.

2.2.37 FCA means False Claims Act.

2.2.38 FFATA means Federal Funding Accountability & Transparency Act.

2.2.39 FFS means Fee-for-Service.

2.2.40 FPL means Federal Poverty Level.

2.2.41 FQHC means Federally Qualified Health Center.

2.2.42 HEDIS means Healthcare Effectiveness Data and Information Set

2.2.43 HIV means Human Immunodeficiency Virus.

2.2.44 HMO means Health Maintenance Organization.

2.2.45 HRSA means Health Resources and Services Administration for the United States Department of Health and Human Services.

2.2.46 I/T/U means Indian Tribe, Tribal Organization, or Urban Indian Organization.

2.2.47 IBNR means Incurred But Not Reported.

2.2.48 ID means Intellectual Disabilities.

2.2.49 IHCP means Indian Health Care Provider.

2.2.50 IHS means Indian Health Service.

2.2.51 IVR means Interactive Voice Response.

2.2.52 LEIE means List of Excluded Individuals & Entities.

2.2.53 LEP means Limited English Proficiency.

2.2.54 LTSS means Long-Term Services and Supports.

2.2.55 MCIS means Managed Care Information System.

2.2.56 MCM means Medicaid Care Management.

2.2.57 MFCU means Medicaid Fraud Control Unit, Office of Attorney General.

2.2.58 MLR means Medical Loss Ratio.

2.2.59 MMIS means Medicaid Management Information System.

2.2.60 NCPDP means National Council for Prescription Drug Programs.

2.2.61 NCQA means National Committee for Quality Assurance.

2.2.62 NEMT means Non-Emergency Medical Transportation.

2.2.63 NH means New Hampshire.

2.2.64 NHID means New Hampshire Insurance Department.

2.2.65 NPI means National Provider Identifier.

2.2.66 NPPES means National Plan and Provider Enumeration System.

2.2.67 OIG means Office of the Inspector General for the United States Department of Health and Human Services.

2.2.68 PCP means Primary Care Provider.

2.2.69 PDP means Primary Dental Provider.

2.2.70 PDMP means Prescription Drug Monitoring Program.

2.2.71 PIP means Performance Improvement Plan.

2.2.72 POS means Point of Service.

2.2.73 QAPI means Quality Assessment and Performance Improvement.

2.2.74 QI means Quality Improvement.

2.2.75 QM means Quality Management.

2.2.76 QOS means Quality of Service.

2.2.77 RARC means Reason and Remark Codes.

2.2.78 RFP means Request for Proposal.

2.2.79 RHC means Rural Health Clinic.

2.2.80 RHC means Rural Health Clinic.

2.2.81 SFY means State Fiscal Year.

2.2.82 SHIP means State's Health Insurance Assistance Program.

2.2.83 SIU means Special Investigations Unit.

2.2.84 SMART means Specific, Measurable, Attainable, Realistic, and Time Relevant.

2.2.85 SMDL means State Medicaid Director Letter.

2.2.86 SNF means Skilled Nursing Facility.

2.2.87 SSADMF means Social Security Administration Death Master File.

2.2.88 SSAE means Statement on Standards for Attestation Engagements.

2.2.89 SSI means Supplemental Security Income.

2.2.90 SSN means Social Security Number.

2.2.91 TAP means Technical Assistance Publication.

2.2.92 TDD means Telecommunication Device for Deaf Persons.

2.2.93 TPL means Third Party Liability.

2.2.94 TTY means Teletypewriter.

2.2.95 UM means Utilization Management.

2.2.96 URAC means the unabbreviated name of the health plan accreditation organization.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

3.1.1.1 The DO shall provide a comprehensive risk-based, capitated program for providing dental services to Members enrolled in the DMCM program and who are enrolled in the DO.

3.1.1.2 The DO shall provide for all aspects of administrating and managing such program and shall meet all service and delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the DMCM program.

3.1.2 Representation and Warranties

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

3.1.2.2 The DO acknowledges that, in being awarded this Agreement, the Department has relied upon all representations and warrants made by the DO in its response to the Department's Request for Proposal (RFP) as referenced in Exhibit M- The DO Proposal by Reference including any addenda, with respect to delivery of Medicaid managed care covered dental services and affirms all representations made therein.

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

3.1.2.4 The DO shall not take advantage of any errors and/or omissions in the RFP or the resulting Agreement and amendments.

3.1.2.5 The DO shall promptly notify the Department of any such errors and/or omissions that are discovered.

3.1.2.6 This Agreement shall be signed and dated by all parties, and is contingent upon approval by Governor and Executive Council.

3.1.3 Program Management Plan

3.1.3.1 The DO shall develop and submit a Program Management Plan for the Department's review and approval.

3.1.3.2 The DO shall provide the initial Program Management Plan to the Department for review and approval at the beginning of the Readiness Review period; in future years, any modifications to the Program Management Plan shall be presented for prior approval to the Department at least sixty (60) calendar days prior to the coverage year.

3.1.4 The Program Management Plan shall:

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

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

3.1.4.3 Describe how the DO shall ensure timely notification to the Department regarding:

3.1.4.3.1 Expected or unexpected interruptions or changes that impact DO policy, practice, operations, Members or Providers,

3.1.4.3.2 Correspondence received from the Department on emergent issues and non-emergent issues; and

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

3.1.4.4 On an annual basis, the DO shall submit to the Department either a certification of "no change" to the Program Management Plan or a revised Program Management Plan together with a redline that reflects the changes made to the Program Management Plan since the last submission.

3.1.5 Key Personnel Contact List

3.1.5.1 The DO shall submit a Key Personnel Contact List to the Department that includes the positions and associated information indicated in Section 3.1.16.1 (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the DMCM program.

3.1.5.2 Thereafter, the DO shall submit an updated Contact List immediately upon any Key Personnel staff changes.

3.1.6 Agreement Elements

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

3.1.6.1.1 General Provisions, Form Number P-37

3.1.6.1.2 Exhibit A: Revisions to Standard Agreement Provisions.

3.1.6.1.3 Exhibit B: Scope of Services

3.1.6.1.4 Exhibit C: Payment Terms

3.1.6.1.5 Exhibit D: Certification Regarding Drug Free Workplace Requirements

3.1.6.1.6 Exhibit E: Certification Regarding Lobbying

3.1.6.1.7 Exhibit F: Certification Regarding Debarment, Suspension, and Other Responsibility Matters

3.1.6.1.8 Exhibit G: Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections

3.1.6.1.9 Exhibit H: Certification Regarding Environmental Tobacco Smoke

3.1.6.1.10 Exhibit I: Health Insurance Portability Act Business Associate Agreement

3.1.6.1.11 Exhibit J: Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.

3.1.6.1.12 Exhibit K: DHHS Information Security Requirements.

3.1.6.1.13 Exhibit L: DO Implementation Plan

3.1.6.1.14 Exhibit M: DO Proposal submitted in response to RFP-2023-DMS-06-MEDIC, by reference.

3.1.6.1.15 Exhibit N: Liquidated Damages Matrix

3.1.6.1.16 Exhibit O: Quality and Oversight Reporting Requirements:

3.1.6.1.17 Exhibit P: DO Program Oversight Plan

3.1.6.1.18 Exhibit Q: DoIT Technical Requirements Workbook

3.1.7 Delegation of Authority

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

3.1.8 Authority of the New Hampshire Insurance Department

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

3.1.8.2 The DO is subject to all applicable laws and rules (and as subsequently amended) including but not limited to RSA 420-B; Managed Care Law and Rules RSA. 420-J; RSA 420-F and N.H. Administrative Rules Chapter Ins 2700; compliance with Bulletin INSNO. 12-015-AB, and further updates made by the NHID; and the NH Comprehensive Health Care Information System (CHIS) Confidential Data reporting submission under NHID rules/bulletins.

3.1.9 Time of the Essence

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

3.1.10 CMS Approval of Agreement and Any Amendments

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

3.1.10.2 This Agreement submission shall be considered complete for CMS's approval if:

3.1.10.2.1 All pages, appendices, attachments, etc. were submitted to CMS; and

3.1.10.2.2 Any documents incorporated by reference (including but not limited to State statute, regulation, or other binding document, such as a Member Handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS.

3.1.10.3 As part of this Agreement, the Department shall submit to CMS for review and approval the DO rate certifications concurrent with the review and approval process for this Agreement. [42 CFR 438.7(a)]

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

3.1.11 Cooperation With Other Vendors and Prospective Vendors

3.1.11.1 This is not an exclusive Agreement and the Department may award simultaneous and/or supplemental contracts for work related to the Agreement, or any portion thereof. The DO shall reasonably cooperate with such other vendors, and shall not knowingly or negligently commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place Members at risk.

3.1.11.2 The DO is required to notify the Department within twelve (12) hours of a report by a Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the DO, its subcontractor or a Provider.

3.1.11.3 For the purpose of this Agreement, a serious criminal offense should be defined to include murder, arson, rape, sexual assault, assault, burglary, kidnapping, criminal trespass, or attempt thereof.

3.1.11.4 The DO's notification shall be to a member of senior management of the Department such as the Commissioner, Deputy Commissioner, Associate Commissioner, Medicaid Director, Deputy Medicaid Director, or Medicaid Dental Director.

3.1.12 Renegotiation and Re-Procurement Rights

3.1.12.1 Renegotiation of Agreement

3.1.12.1.1 Notwithstanding anything in the Agreement to the contrary, the Department may at any time during the Term exercise the option to notify the DO that the Department has elected to renegotiate certain terms of the Agreement.

3.1.12.1.2 Upon the DO's receipt of any notice pursuant to this Section.

3.1.12.1.3 3.1.12 (Renegotiation and Re-Procurement Rights) of the Agreement, the DO and the Department shall undertake good faith negotiations of the subject terms of the Agreement, and may execute an amendment to the Agreement subject to approval by Governor and Executive Council.

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

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

3.1.12.2.2 The Department shall give the DO ninety (90) calendar days' notice of intent to replace another DO participating in the DMCM program or to add an additional DO or other contractors to the DMCM program.

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

3.1.13 Organization Requirements

3.1.13.1 General Organization Requirements

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

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

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

3.1.13.2 Articles

3.1.13.2.1 The DO shall provide, by the beginning of each Agreement year and at the time of any substantive changes, written assurance from DO's legal counsel that the DO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.1.13.3 Ownership and Control Disclosures

3.1.13.3.1 The DO shall submit to the Department, in compliance with Exhibit K: Information Security Requirements, the name of any persons or entities with an ownership or control interest in the DO that:

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

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

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

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

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

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

3.1.13.3.2.3. Tax identification number(s) of any corporation;

3.1.13.3.2.4. Information on whether an individual or entity with an ownership or control interest in the DO is related to

another person with ownership or control interest in the DO as a spouse, parent, child, or sibling;

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

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

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

3.1.13.3.2.8. Certification by the MCO's CEO that the information provided in this Section 3.1.13.3 (Ownership and Control Disclosures) to DHHS is accurate to the best of his or her information, knowledge, and belief.

3.1.13.3.3 The DO shall disclose the information set forth in this Section 3.1.13.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to DHHS at the following times:

3.1.13.3.3.1. At the time of Agreement execution;

3.1.13.3.3.2. When the Provider or disclosing entity submits a Provider application;

3.1.13.3.3.3. When the Provider or disclosing entity executes a Provider agreement with the Department;

3.1.13.3.3.4. Upon request of the Department during the revalidation of the Provider enrollment; and

3.1.13.3.3.5. Within thirty-five (35) calendar days after any change in ownership of the disclosing entity. [Section

1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)]

3.1.13.4 The Department shall review the ownership and control disclosures submitted by the DO and any Subcontractors. [42 CFR 438.602(c); 42 CFR 438.608(c)]

3.1.13.5 The DO shall be fined in accordance with Exhibit N: Liquidated Damages Matrix for any failure to comply with ownership disclosure requirements detailed in this Section.

3.1.13.6 Change in Ownership or Proposed Transaction

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

3.1.13.7 Prohibited Relationships

3.1.13.7.1 Pursuant to Section 1932(d)(1)(A) of the Social Security Act (42 USC 1396u-2(d)(1)(A)), the DO shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the DO's equity who has been, or is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.610(a)(1)-(2); 42 CFR 438.610(c)(2); Exec. Order No. 12549]

3.1.13.7.2 The DO shall not have an individual:

3.1.13.7.2.1. With a direct or indirect ownership or control interest of 5 percent (5%) or more in the entity or with an ownership or control interest, as defined in section 1124(a)(3) of the Social Security Act, in that entity; or

3.1.13.7.2.2. Who is an officer, director, agent, or managing employee as defined in section 1126(b) of the Social Security Act. The term "agent" shall include non-officer, non-director, non-managing employees as defined in section 1126(b) and subcontractors for the purposes of this section to the extent required by CMS or other federal authority; or

3.1.13.7.2.3. Who no longer has a direct or indirect ownership or control interest of 5 percent (5%) or more in the entity or with an ownership or control interest in that entity as defined in section 1124(a)(3)of the Social Security Act due to a transfer of such ownership or control to an immediate family member or member of the household as defined in 1128(j) of the Social Security Act who continues to maintain a direct or indirect ownership or control interest of 5% or more in the entity; and

3.1.13.7.2.4. Has been convicted of any offense in Sections 1128(a) or 1128(b)(1)-(3) of the Social Security Act, to the extent required by CMS or other federal authority; or

3.1.13.7.2.5. Has been excluded from participation under a program under title XVIII or under a State health care program; or

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

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

3.1.13.7.4 Within five (5) calendar days of discovery, the DO shall provide written disclosure to the Department, and Subcontractors shall provide written disclosure to the DO, which shall provide the same to the Department, of any individual or entity (or affiliation of the individual or entity) who/that is debarred, suspended, or otherwise excluded from participating

in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or prohibited affiliation under 42 CFR 438.610. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1-2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1-4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549]

3.1.13.7.5 If the Department learns that the DO has a prohibited relationship with an individual or entity that (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the DO has relationship with an individual who is an affiliate of such an individual; (ii) is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, the Department may:

3.1.13.7.5.1. Terminate the existing Agreement with the DO;

3.1.13.7.5.2. Continue an existing Agreement with the DO unless the HHS Secretary directs otherwise;

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

3.1.13.8 Background Checks

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

3.1.13.8.2 The DO or its Subcontractors shall conduct background checks upon hire and monthly exclusion

checks on all employees (or contractors and their employees) to ensure that the DO and Subcontractors do not employ or contract with any individual or entity, in accordance with Prohibited Relationship provisions in Section 3.1.13.7 of this Agreement, on an Exclusion List who are:

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

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

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

3.1.13.8.3 In addition, the DO or its Subcontractor shall conduct screenings upon hire and monthly of its employees (except its directors and officers), and contractors and DO Subcontractors' contractor employees (except its directors and officers) to ensure that none of them appear on:

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

3.1.13.8.3.2. The System of Award Management;

3.1.13.8.3.3. The list maintained by the Office of Foreign Assets Control; and

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

3.1.13.8.4 The DO shall certify to the Department annually that it or its Subcontractors performs screenings upon

hire and monthly thereafter against the Exclusion Lists and that neither the DO nor its Subcontractors, including contractor employees of DO Subcontractors, have any employees, directly or indirectly; with:

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

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

3.1.13.8.4.3. Any individual or entity excluded from Medicare, Medicaid or NH participation by the Department per the Department system of record;

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

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

3.1.13.8.5 In the event that the DO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the DO unable to certify as required under this Section 3.1.13.8 (Background Checks) or Section 3.1.13.3 (Ownership and Control Disclosures) above, then the DO should notify the Department in writing and shall begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program.

3.1.13.8.6 The DO shall maintain documentation to ensure screenings have been completed by Subcontractors and reviewed by the DO monthly.

3.1.13.9 Conflict of Interest

3.1.13.9.1 The DO shall ensure that safeguards, at a minimum equal to federal safeguards (41 USC 423), are in

place to guard against conflict of interest. [Section 1932(d)(3) of the Social Security Act; SMDL 12/30/97]. The DO shall report transactions between the DO and parties in interest to the Department and any other agency as required, and make it available to DO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.1.13.9.2 The DO shall report to the Department and, upon request, to the HHS Secretary, the HHS Inspector General, and the Comptroller General a description of transactions between the DO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

3.1.13.9.3 Any sale or exchange, or leasing of any property between the DO and such a party;

3.1.13.9.4 Any furnishing for consideration of goods, services (including management services), or facilities between the DO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and

3.1.13.9.5 Any lending of money or other extension of credit between the DO and such a party. [Section 1903(m)(4)(A) of the Social Security Act; Section 1318(b) of the Social Security Act]

3.1.14 Compliance With State and Federal Laws

3.1.14.1 General Requirements

3.1.14.1.1 The DO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.1.14 (Compliance with State and Federal Laws).

3.1.14.1.2 The DO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]

3.1.14.1.3 The DO shall comply, at a minimum, with the following:

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

Related rules: Title 42 Chapter IV of the Code of Federal Regulations;

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

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

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

3.1.14.1.3.5. State administrative rules and laws pertaining to confidentiality;

3.1.14.1.3.6. American Recovery and Reinvestment Act;

3.1.14.1.3.7. Title VI of the Civil Rights Act of 1964;

3.1.14.1.3.8. The Age Discrimination Act of 1975;

3.1.14.1.3.9. The Rehabilitation Act of 1973;

3.1.14.1.3.10. Title IX of the Education Amendments of 1972 (regarding education programs and activities);

3.1.14.1.3.11. The ADA;

3.1.14.1.3.12. 42 CFR Part 2– Confidentiality of Substance Use Disorder Patient Records;

3.1.14.1.3.13. Section 1557 of the Affordable Care Act; and [42 CFR438.3(f)(1); 42 CFR 438.100(d)]

3.1.14.1.3.14. HIPAA Public Law 104-191 (1996); 45 CFR 160, 162 and, 164.

3.1.14.1.4 The DO shall comply with all aspects of the Department Sentinel Event Policy PR 10-01, effective September 2010, and any subsequent versions and/or amendments;

3.1.14.1.5 The DO shall cooperate with any investigation of a Sentinel event, including involvement in the Sentinel Event Review team, and provide any information requested by the Department to conduct the Sentinel Event Review;

3.1.14.1.6 The DO shall report to the Department within twenty-four (24) hours any time a sentinel event occurs with one of its Members. This does not replace the DO's responsibility to notify the appropriate authority if the DO suspects a crime has occurred;

3.1.14.1.7 The DO shall comply with all statutorily mandated reporting requirements, including but not limited to, RSA 161-F:42-54 and RSA 169-C:29;

3.1.14.1.8 In instances where the time frames detailed in the Agreement conflict with those in the Department Sentinel Event Policy, the policy requirements will prevail.

3.1.14.2 Non-Discrimination

3.1.14.2.1 The DO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.1.15.1 and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. [42 CFR 438.3(d)(4)]

3.1.14.3 Reporting Discrimination Grievances

3.1.14.3.1 The DO shall forward to the Department copies of all grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability or gender identity for review and appropriate action within three (3) business days of receipt by the DO.

3.1.14.3.2 Failure to submit any such grievance within three (3) business days may result in the imposition of liquidated damages as outlined in Section 5.5.2. (Liquidated Damages).

3.1.14.4 Americans with Disabilities Act

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

3.1.14.4.2 The ADA compliance plan shall be sufficient to determine the specific actions that shall be taken to remove existing barriers and/or to accommodate the needs of Members who are qualified individuals with a disability.

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

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

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

3.1.14.4.6 The DO shall survey Participating Providers of their compliance with the ADA using a standard survey document that shall be provided by the Department. Completed survey documents shall be kept on file

by the DO and shall be available for inspection by the Department.

3.1.14.4.7 The DO shall, in accordance with Exhibit G (Certification Regarding ADA Compliance), annually submit to the Department a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the ADA, that it has complied with this Section 3.1.14.4.7 (Americans with Disabilities Act) of the Agreement, and that it has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the DO's knowledge.

3.1.14.4.8 The DO warrants that it shall hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the DO to be in compliance with the ADA.

3.1.14.4.9 Where applicable, the DO shall abide by the provisions of Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. Section 794, regarding access to programs and facilities by people with disabilities.

3.1.14.5 Non-Discrimination in Employment

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

3.1.14.5.2 The DO shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.1.14.5.3 Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

3.1.14.5.4 The DO agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

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

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

3.1.14.5.7 The DO shall comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.1.14.5.8 The DO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and shall permit access to its books, records, and accounts by the Department and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.1.14.5.9 The DO shall include the provisions described in this Section 3.1.14.5 (Non-Discrimination in Employment) in every contract with a Subcontractor or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions shall be binding upon each Subcontractor or vendor.

3.1.14.5.10 The DO shall take such action with respect to any contract with a Subcontractor or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance, provided, however, that in the event the DO becomes involved in, or is

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

3.1.14.6 Non-Compliance

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

3.1.14.7 Changes in Law

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

3.1.15 Subcontractors

3.1.15.1 DO Obligations

3.1.15.1.1 The DO shall maintain ultimate responsibility for adhering to, and otherwise fully complying with the terms and conditions of this Agreement, notwithstanding any relationship the DO may have with the Subcontractor, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by the DO.

3.1.15.1.2 For the purposes of this Agreement, such work performed by any Subcontractor shall be deemed performed by the DO. [42 CFR 438.230(b)]

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

3.1.15.1.4 The DO, regardless of its written agreements with any Subcontractors, maintains ultimate responsibility for complying with this Agreement.

3.1.15.1.5 The DO shall have oversight of all Subcontractors' policies and procedures for compliance with the False Claims Act (FCA) and other State and federal laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

3.1.15.2 Contracts with Subcontractors

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

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

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

3.1.15.2.1.3. Term of the agreement, methods of extension, and termination rights;

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

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

3.1.15.2.1.6. In accordance with Prohibited Relationship provisions in Section 3.1.13.7.

3.1.15.3 Requirements for the Subcontractor

3.1.15.3.1 Provided that DM makes timely payments to the DO under this Agreement to hold harmless the Department and its employees, and all Members served under the terms of this Agreement in the event of non-payment by the DO.

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

3.1.15.4 Requirements that provide that:

3.1.15.4.1 [Amendment #1] The DO, the Department, NH Medicaid Fraud Control Unit (MFCU), NH Department of Justice (DOJ), U.S. DOJ, the OIG, and the Comptroller General or their respective designees shall have the right at any time to inspect and audit any records or documents, ~~evaluate, and inspect,~~ and that it shall make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under this Agreement; [42 CFR 438.230(c)(3)(i) & (ii); 42 CFR 438.3(k)]

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

3.1.15.4.3 [Amendment #1] The DO, the Department, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an inspection and audit any records or documents at any time if the Department, MFCU, NH DOJ, U.S. DOJ, the OIG, and the Comptroller General or their respective designee determines that there is a reasonable possibility of fraud, potential Member harm or similar risk. [42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k)]

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

3.1.15.4.5 Require Subcontractor to submit ownership and controlling interest information as required by

Section 3.1.13.3 (Ownership and Control Disclosures);

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

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

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

3.1.15.4.6.3. An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Subcontractor or Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)];

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

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

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

3.1.15.4.6.7. A provision for revoking delegation of activities or obligations, or imposing other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the DO or the Department;

3.1.15.4.6.8. Subcontractor's agreement to comply with the ADA, as required by Section 3.1.14.4 (Americans with Disabilities Act) above;

3.1.15.4.6.9. Include provisions of this Section 3.1.15.2 (Contracts with Subcontractors) in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965;

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

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

3.1.15.4.6.12. Require any Subcontractor to comply with any other provisions specifically required under this Agreement or the

applicable requirements of 42 CFR 438. [42 CFR 438.230]

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

3.1.15.4.8 If any of the DO's activities or obligations under this Agreement are delegated to a Subcontractor:

3.1.15.4.8.1. The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the DO and the Subcontractor; and

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

3.1.15.4.9 Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire.

3.1.15.5 Notice and Approval

3.1.15.5.1 The DO shall submit all Subcontractor agreements and Subcontractor Provider agreements to the Department, for review at least sixty (60) calendar days prior to the anticipated implementation date of that Subcontractor agreement, any time there is a renewal or extension amendment to a Subcontractor agreement already reviewed by the Department or there is a substantial change in scope or terms of the Subcontractor agreement.

3.1.15.5.2 The DO remains responsible for ensuring that all Agreement requirements are met and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.1.15.5.3 The DO shall notify the Department of any change in Subcontractors and shall submit a new

Subcontractor agreement for review sixty (60) calendar days prior to the start date of the new Subcontractor agreement.

3.1.15.5.4 Review by the Department of a Subcontractor agreement does not relieve the DO from any obligation or responsibility regarding the Subcontractor and does not imply any obligation by the Department regarding the Subcontractor or Subcontractor agreement.

3.1.15.5.5 The Department may grant a written exception to the notice requirements of this Section 3.1.15.5 (Notice and Approval) if, in the Department's reasonable determination, the DO has shown good cause for a shorter notice period.

3.1.15.5.6 The DO shall notify the Department within five (5) business days of receiving notice from a Subcontractor of its intent to terminate a Subcontractor agreement.

3.1.15.5.7 The DO shall notify the Department of any material breach by Subcontractor of an agreement between the DO and the Subcontractor that may result in the DO being non-compliant with or violating this Agreement within one (1) business day of validation that such breach has occurred.

3.1.15.5.8 The DO shall take any actions directed by the Department to cure or remediate said breach by the Subcontractor.

3.1.15.6 DO Oversight of Subcontractors

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

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

3.1.15.6.2.1. Prior to any delegation, the DO shall evaluate the prospective Subcontractor's ability to perform the Social Security activities to be delegated;

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

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

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

3.1.15.6.4 If the DO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the DO shall notify the Department within seven (7) calendar days and require the Subcontractor to develop a CAP. The DO shall provide the Department with a copy of the Subcontractor's CAP within thirty (30) calendar days upon the Department request, which is subject to the Department approval [42 CFR 438.230 and 42 CFR Section 438.3]

3.1.16 Staffing

3.1.16.**1** Key Personnel

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

3.1.16.1.2 DO Contract Manager: The DO shall designate a Contract Manager to work directly with the department. The Contract Manager shall be a full-time employee of the DO with day-to-day authority to revise processes or procedures and assign additional resources as needed to maximize the efficiency and effectiveness of services required under this Agreement. The DO shall meet during normal working hours in person, or by telephone, at the request of the Department representatives to discuss the status of the Agreement, DO performance, benefits to the State, necessary

revisions, reviews, reports, and planning. The Contract Manager shall be physically located in New Hampshire.

3.1.16.1.3 DO Dental Director: The DO shall have a full-time dentist with an active unencumbered license in the State of New Hampshire and physically located in the State of New Hampshire, to serve as dental director for this Agreement who has day-to-day authority to manage the clinical aspects of this Agreement, including responsibility for the proper provision of medically necessary Covered Services to members. The DO Dental Director shall be closely involved in the monitoring of provider network development, retention and adequacy; program integrity; quality; utilization management and utilization review; proper corrective action; site visits; credentialing processes; and Performance Improvement Projects (PIPS). The dental director cannot be designated to serve in any other non-administrative position.

3.1.16.1.4 Dental Records Review Coordinator: The DO shall have a designated person, qualified by training and experience, to ensure compliance with the dental records requirements as described in this Agreement. The dental records review coordinator shall maintain dental record standards and direct dental record reviews according to the terms of this Agreement.

3.1.16.1.5 Data Processing and Data Reporting Coordinator: The DO shall have a designated person trained by the Compliance Officer and experienced in Confidential Data processing, Confidential Data reporting, and claims resolution, as required, to ensure that computer system reports the DO provides to the Department and its agents are accurate.

3.1.16.1.6 QI Coordinator and Prior Authorization Coordinator: The DO shall have designated persons, qualified by training and experience in QI and UM and who hold the appropriate clinical certification/license.

3.1.16.1.7 Grievance System Coordinator: The DO shall have a designated person, qualified by training and experience, to process and resolve complaints, grievances, and appeals, and be responsible for the grievance system.

3.1.16.1.8 Compliance Officer: The DO shall have a designated person qualified by training and experience in health care or risk management, to oversee a fraud and abuse program to prevent and detect potential fraud and abuse activities pursuant to State and federal rules and regulations, and carry out the provisions of the compliance plan, including fraud and abuse policies and procedures, investigating unusual incidents, and implementing corrective action.

3.1.16.1.9 Case Management Staff: The DO shall have sufficient case management staff, qualified by training, experience, and certification/licensure to conduct the DO's case management functions.

3.1.16.1.10 Claims/Encounter Manager: The DO shall have a designated person qualified by training and experience to oversee claims and encounter Confidential Data submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

3.1.16.1.11 Provider Support Representatives: The DO shall have sufficient provider support staff to educate and assist Participating Providers in working with utilization management programs including, but not limited to, prior authorization requests, electronic billing, compliance initiatives, or other program requirements.

3.1.16.1.12 Information Security Officer: The DO shall have sufficient staff with required information security expertise to meet all DHHS Information Security Requirements.

3.1.16.1.13 Information Technology Officer: The DO shall have sufficient staff with required information security expertise to meet all information technology requirements and that computer systems operate in an accurate and timely manner.

3.1.16.1.14 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.1.16.1.14.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement

meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.1.16.2 Other DO Required Staff

3.1.16.2.1 Fraud, Waste, and Abuse Staff: The DO shall establish a Special Investigations Unit (SIU), which shall be comprised of experienced fraud, waste and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein.

3.1.16.2.2 At a minimum, the SIU shall have at least two (2) fraud, waste and abuse investigators and one (1) Fraud, Waste and Abuse Coordinator.

3.1.16.2.3 The DO shall adequately staff the SIU to ensure that the DO meets Agreement provisions of Section 5.3.2 (Fraud, Waste and Abuse).

3.1.16.3 On-Site Presence

3.1.16.3.1 The DO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this Section 5.3.2 of the Agreement means that the DO's personnel identified below regularly reports to work in the State of New Hampshire:

3.1.16.3.1.1. DO Contract Manager;

3.1.16.3.1.2. DO Dental Director;

3.1.16.3.1.3. Network Management Director;

3.1.16.3.1.4. Provider Relations Manager;

3.1.16.3.1.5. Provider Support Representatives;

3.1.16.3.1.6. Grievance Coordinator; and

3.1.16.3.1.7. Fraud, Waste, and Abuse Coordinator

3.1.16.3.2 Upon the Department's request, DO required staff who are not located in New Hampshire shall travel to New Hampshire for in-person meetings.

3.1.16.3.3 The DO shall provide to the Department for review and approval key personnel and qualifications no later than sixty (60) calendar days prior to the start of the program.

3.1.16.3.4 The DO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by the Department, which approval shall not be unreasonably withheld.

3.1.16.3.5 The Department may grant a written exception to the notice requirements of this section if, in the Department's reasonable determination, the DO has shown good cause for a shorter notice period.

3.1.16.4 General Staffing Provisions

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

3.1.16.4.2 The DO shall ensure that all staff receive appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement.

3.1.16.4.3 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 inspection.

3.1.16.4.4 All key personnel shall be generally available during Department hours of operation and available for in-person or video conferencing meetings as requested by the Department.

3.1.16.4.5 The DO key personnel, and others as required by the Department, shall, at a minimum, be available for monthly in-person meetings in NH with the Department.

3.1.16.4.6 The DO shall make best efforts to notify the Department at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

3.1.16.4.7 If a member of the DO's key personnel is to be replaced for any reason while the DO is under

Agreement, the DO shall inform the Department within seven (7) calendar days, and submit a transition plan with proposed alternate staff to the Department for review and approval, for which approval shall not be unreasonably withheld.

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

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

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

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

4 PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.1 Overview of Covered Populations

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

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

4.1.1.3 All beneficiaries age 21 and over shall be eligible for the adult dental benefit in accordance with RSA 126-A:5.

4.1.2 Overview of Covered Services

4.1.2.1 The DO shall provide Covered Services for all DO Members, as described in this Agreement.

4.1.2.2 The DO shall provide, at a minimum, all Covered Services identified in the following matrix, and all Covered Services in accordance with the CMS-approved Medicaid State Plan and

Alternative Benefit Plan State Plan. The DO shall cover services consistent with 45 CFR 92.207(b).

4.1.2.2.1 Diagnostic and preventive dental services including an annual comprehensive oral examination, necessary x-rays or other imaging, prophylaxis, topical fluoride, oral hygiene instruction, behavior management and smoking cessation counseling, and other as determined by the annual update of Current Dental Terminology (CDT) codes D0100-D0999 and D1000-D1999.

4.1.2.2.2 Comprehensive restorative dental services necessary to prevent or treat oral health conditions.

4.1.2.2.3 Limited periodontic dental services.

4.1.2.2.4 Oral surgery dental services necessary to relieve pain, eliminate infection or prevent imminent tooth loss.

4.1.2.2.5 Transportation to dental appointments.

4.1.2.2.6 Support for oral health through care management and care coordination.

4.1.2.2.7 $1,500 yearly limit on dental services, with the exception of preventive services.

4.1.2.2.8 Removable prosthodontic coverage for the following individuals who qualify for services under the following criteria:

4.1.2.2.8.1. Developmental Disability (DD) Waiver.

4.1.2.2.8.2. Acquired Brain Disorder (ABD) Waiver.

4.1.2.2.8.3. Choices for Independence (CFI) Waiver.

4.1.2.2.8.4. Nursing facility residents.

4.1.2.2.9 Cost sharing of 10% of the fees for the services for each visit, with the exception of diagnostic and preventive services, for individuals above 100% Federal Poverty Level (FPL) and up to 5% of annual household income.

4.1.2.3 While the DO may provide a higher level of service and cover more services than required by the Department (as described in Section 4.1.3 (Covered Services Additional Provisions)), the DO shall, at a minimum, cover the services identified at least up to the

limits in Section 4.1.2.2 of this Agreement. [42 CFR 438.210(a)(1)-(3), (4)(i), (5) (i)-(ii)(A)-(C) and (b).

4.1.3 Covered Services Additional Provisions

4.1.3.1 Nothing in this Section 4.1.3 shall be construed to limit the DO's ability to otherwise voluntarily provide any other services in addition to the Covered Services required to be provided under this Agreement.

4.1.3.2 The DO shall seek written approval from the Department, bear the entire cost of the service, and the utilization and cost of such voluntary services shall not be included in determining capitation rates.

4.1.3.3 All Covered Services shall be provided in accordance with 42 CFR 438.210 and 42 CFR 438.207(b). The DO shall ensure there is no disruption in service delivery to Members or Providers as the DO transitions these services into Medicaid managed dental care from FFS.

4.1.3.4 The DO shall adopt written policies and procedures to verify that Covered Services are actually provided. [42 CFR 455.1(a)(2)]

4.1.4 In Lieu Of Services

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

4.1.4.1.1 The Department determines that the alternative service or setting is a medically appropriate and cost-effective substitute;

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

4.1.4.1.3 The In Lieu Of Service has been authorized by the Department; and

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

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

4.1.4.3 For the DO to obtain approval for In Lieu Of Services not authorized by the Department, the DO shall submit an In Lieu Of

Service request to the Department for each proposed In Lieu of Service not yet authorized.

4.1.4.4 The DO shall monitor the cost-effectiveness of each approved In Lieu of Service by tracking utilization and expenditures and submit an annual update providing an evaluation of the cost-effectiveness of the alternative service during the previous twelve (12) months, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.5 Telemedicine

4.1.5.1 The DO shall comply with provisions of RSA 167:4(d) by providing access to dental telehealth services to Members in certain circumstances.

4.1.5.2 The DO shall develop a dental telehealth services clinical coverage policy and submit the policy to the Department during Readiness Review for approval. Covered dental telehealth services modalities shall comply with all local, State and federal laws including the HIPAA, record retention requirements, Exhibit K: Information Security Requirements and the Exhibit Q: IT Requirements Workbook.

4.1.5.3 The clinical policy shall include security requirements which demonstrate how each covered teledental modality complies with Exhibit K, Information Security Requirements.

4.1.6 Non-Participating Indian Health Care Providers

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

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

4.1.7 Moral and Religious Grounds

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

4.1.7.2 If the DO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the DO shall furnish information about the services it does not cover to the Department with its

application for a Medicaid contract and any time thereafter when it adopts such a policy during the Term of this Agreement. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(b)(1)(i)(A)(1)-(2)]

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

4.1.8 Cost Sharing

4.1.8.1 Any cost sharing imposed on Medicaid Members shall be in accordance with NH's Medicaid Cost Sharing State Plan Amendment and Medicaid FFS requirements pursuant to 42 CFR 447.50 through 42 CFR 447.57. [Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act; 42 CFR 438.108; 42 CFR 447.50-57.

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

4.1.8.2.1 A copayment equal to 10% of the cost of the treatment rendered at a dental appointment, excluding preventive services, up to 5% of annual household income shall be required at each dental visit for Covered Services.

4.1.8.3 The following services are exempt from cost-sharing:

4.1.8.3.1 Preventive services,

4.1.8.3.2 Pregnancy-related services,

4.1.8.3.3 Services resulting from potentially preventable events, and,

4.1.8.3.4 Members are exempt from Copayments when:

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

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

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

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

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

4.1.8.3.4.6. The Member is receiving hospice care; or

4.1.8.3.4.7. The Member is an American Indian/Alaska Native.

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

4.1.9 Emergency Services

4.1.9.1 The DO shall cover and pay for Emergency Services at rates that are no less than the equivalent Department FFS rates if the Provider that furnishes the services has an agreement with the DO. [Section 1932(b)(2)(A) of the Social Security Act; 42 CFR 438.114(b)]

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

4.1.9.3 The DO shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating Provider.

4.1.9.4 The DO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the Department FFS system in place at the time the service was provided. [SMDL 3/31/06; Section 1932(b)(2)(D) of the Social Security Act]

4.1.9.5 The DO shall not deny treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition.

4.1.9.6 The DO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the DO

instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A-B)].

4.1.9.7 The DO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

4.1.9.8 The DO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, DO, or the Department of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. [42 CFR 438.114(d)(1)(i-ii)]

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

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

4.1.10 Post-Stabilization Services

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

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

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

4.1.10.1.3 Administered to maintain, improve or resolve the Member's stabilized condition without pre-authorization, and regardless of whether the Member obtains the services within the DO network if:

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

4.1.10.1.3.2. The DO cannot be contacted; or

4.1.10.1.3.3. The DO representative and the treating physician cannot reach an agreement concerning the Member's care and an DO provider is not available for consultation. In this situation, the DO shall give the treating physician the opportunity to consult with an DO provider, and the treating physician may continue with care of the patient until an DO provider is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

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

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

4.1.10.3.1 The DO provider with privileges at the treating hospital assumes responsibility for the Member's care;

4.1.10.3.2 The DO provider assumes responsibility for the Member's care through transfer;

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

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

4.1.11 Value-Added Services

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

4.1.11.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The DO may elect to add Value-Added Services not specified in the Agreement at the DO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The DO shall

submit to the Department an annual list of the Value-Added Services being provided.

4.1.12 Non-Emergency Medical Transportation (NEMT)

4.1.12.1 The DO shall provide the most cost-effective and least expensive mode of transportation to secure Covered Services for its Members. However, the DO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The DO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements.

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

4.1.12.2.1 Does not have a valid driver's license;

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

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

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

4.1.12.3 The DO shall make good faith effort to achieve a fifty percent (50%) rate of total NEMT one-way rides provided by the DO through the Family and Friends Mileage Reimbursement Program.

4.1.12.4 If no car is owned or available, the Member shall use public transportation if:

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

4.1.12.4.2 The Provider is less than one half mile from the bus route; and

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

4.1.12.5 Exceptions the above public transportation requirement are:

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

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

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

4.1.12.5.3.1. Pregnant or up to six (6) weeks post-partum;

4.1.12.5.3.2. Moderate to severe respiratory condition with or without an oxygen dependency;

4.1.12.5.3.3. Limited mobility (walker, cane, wheelchair, amputee, etc.);

4.1.12.5.3.4. Visually impaired;

4.1.12.5.3.5. Developmentally delayed;

4.1.12.5.3.6. Significant and incapacitating degree of mental illness; or

4.1.12.5.3.7. Other exception by Provider approval only.

4.1.12.6 If public transportation is not an option, the DO shall ensure that the Member is provided transportation from a transportation Subcontractor.

4.1.12.6.1 For NEMT driver services, excluding public transit drivers, the DO shall ensure:

4.1.12.6.1.1. Background checks are performed for all NEMT drivers;

4.1.12.6.1.2. Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

4.1.12.6.1.3. Each such individual driver has a valid driver's license;

4.1.12.6.1.4. Each such provider has in place a process to address any violation of a State drug law; and

4.1.12.6.1.5. Each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider. [Consolidated

Appropriations Act, 2021 (Public Law 116-260), Division CC, Title II, Section 209].

4.1.12.7 The DO, through their sole responsibility to provide transportation for their Members, shall assure that ninety-five percent (95%) of all Member scheduled rides for Covered Services are delivered within fifteen (15) minutes of the scheduled pick-up time.

4.1.12.8 The DO shall provide reports to the Department related to NEMT requests, authorizations, trip results, service use, late rides, and cancellations, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.2 Member Enrollment and Disenrollment

4.2.1 Eligibility

4.2.1.1 The Department has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether the individual shall be enrolled in the DMCM program. The DO shall comply with eligibility decisions made by the Department.

4.2.1.2 The DO and its Subcontractors shall ensure that ninety-nine percent (99%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. The DO shall make the Department aware, within one (1) business day, of unsuccessful uploads that go beyond twenty-four (24) hours.

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

4.2.1.4 To ensure appropriate Continuity of Care, For Members transitioning from another DO, the Department shall also provide such claims Confidential Data as well as available encounter information regarding the Member supplied by other DOs, as applicable.

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

4.2.2 Enrollment

4.2.2.1 The DO shall accept all Members who were assigned to the DO by the Department. The DO shall accept for automatic re-enrollment Members who were disenrolled due to a loss of

Medicaid eligibility for a period of two (2) months or less. [42 CFR 438.56(g)]

4.2.2.2 When assigning a PDP, the DO shall include the following methodology, if information is available: Member claims history; family member's PDP assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.2.3 Non-Discrimination

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

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

4.2.3.3 The DO shall not discriminate in enrollment, disenrollment, and re-enrollment against individuals on the basis of health status or need for health care services. [42 CFR 438.3(q)(4)]

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

4.2.3.5 In accordance with RSA 354-A and all other relevant State and federal laws, the DO shall not discriminate on the basis of gender identity.

4.2.4 Disenrollment

4.2.4.1 Member Disenrollment Request

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

4.2.4.1.1.1. The Member moves out of State;

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

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

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

4.2.4.1.1.4. The DO does not cover the service the Member seeks because of moral or religious objections. [42 CFR 438.56(d)(2)(i-ii)].

4.2.4.1.2 For Member disenrollment requests "with cause" as described in Sections 4.2.5.1.1.1 through 4.2.5.1.1.4 of this Agreement, the Member shall first seek redress through the DO's grievance system.

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

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

4.2.4.1.3.2. Once every twelve (12) months;

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

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

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

4.2.4.1.4 The DO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period. The notice shall

include an explanation of all of the Member's disenrollment rights as specified in this Agreement. [42 CFR 438.56(f)]

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

4.2.4.1.6 The DO shall furnish all relevant information to the Department for its determination regarding disenrollment, within three (3) business days after receipt of the Department's request for information.

4.2.4.1.7 Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the Member files the request.

4.2.4.1.8 If the Department fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e); 42 CFR 438.56(d)(3); 42 CFR 438.3(q); 42 CFR 438.56(c)]

4.2.4.2 DO Disenrollment Request

4.2.4.2.1 The DO shall submit involuntary disenrollment requests to the Department with proper documentation for the following reasons:

4.2.4.2.1.1. Member has established out of State residence;

4.2.4.2.1.2. Member death;

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

4.2.4.2.1.4. Fraudulent use of the Member identification card; or

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

4.2.4.2.1.6. The DO shall not request disenrollment because of:

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

4.2.4.2.1.8. The Member's utilization of medical services;

4.2.4.2.1.9. The Member's diminished mental capacity;

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

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

4.2.4.2.1.12. If an DO is requesting disenrollment of a Member, the DO shall:

4.2.4.2.1.12.1 Specify the reasons for the requested disenrollment of the Member; and

4.2.4.2.1.12.2 Submit a request for involuntary disenrollment to the Department along with documentation and justification, for review.

4.2.4.2.1.12.3 Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month

in which the DO files the request.

4.2.4.2.1.12.4 If the Department fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e)]

4.3 Member Services

4.3.1 Member Information

4.3.1.1 The DO shall perform the Member Services responsibilities contained in this Agreement for all Members.

4.3.1.2 Primary Dental Provider Information

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

4.3.1.3 Member Identification Card

4.3.1.3.1 The DO shall issue a hardcopy identification card to all New Members within ten (10) calendar days following the DO's receipt of a valid enrollment file from the Department, but no later than seven (7) calendar days after the effective date of enrollment.

4.3.1.3.2 The identification card shall include, but is not limited to, the following information and any additional information shall be approved by the Department prior to use on the identification card:

4.3.1.3.2.1. The Member's name;

4.3.1.3.2.2. The Member's DOB;

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

4.3.1.3.2.4. The name of the DO;

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

4.3.1.3.2.6. How to file an appeal or grievance.

4.3.1.3.2.7. The DO shall reissue a Member identification card if:

4.3.1.3.2.7.1 A Member reports a lost card;

4.3.1.3.2.7.2 A Member has a name change; or

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

4.3.1.4 Member Handbook

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

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

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

4.3.1.4.3.1. A table of contents;

4.3.1.4.3.1.1 How to access Auxiliary Aids and services, including additional information in alternative formats or languages [42 CFR 438.10(g)(2)(xiii-xvi),

	42 CFR 438.10(d)(5)(i-iii)];
4.3.1.4.3.1.2	[Amendment #1:] The Department developed definitions, including but not limited to: appeal, Copayment, durable medical equipment, Emergency Dental Condition, emergency medical condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, Medically Necessary, network, Non-Participating Provider, Participating Provider, PDP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

4.3.1.4.3.1.3	The medical necessity definitions used in determining whether services will be covered;
4.3.1.4.3.1.4	A reminder to report to the Department any change of address;
4.3.1.4.3.1.5	Information and guidance as to how the Member can effectively use the managed care program [42 CFR 438.10(g)(2)];
4.3.1.4.3.1.6	A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)].
4.3.1.4.3.1.7	Non-Participating Providers and Cost Sharing on any benefits carved out and provided by DHHS [42 CFR 438.10(g)(2)(i)-(ii)];
4.3.1.4.3.1.8	Information on how to report suspected fraud or abuse [42 CFR 438.10(g)(2)(xiii)-(xvi)];
4.3.1.4.3.1.9	Information explaining that, in the case of a counseling or referral service that the DO does not cover because of moral or religious objections, the DO shall inform Members that the service is not covered and how Members

can obtain information from DHHS about how to access those services [42 CFR 438.10(g)(2)(ii)(A)-(B), 42 CFR 438.102(b)(2)];

4.3.1.4.3.2. Appointment procedures;

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

4.3.1.4.3.2.2 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the DO's toll-free telephone line and website, the toll-free telephone number for Member Services, and the toll-free telephone number for any other unit providing services directly to Members [42 CFR 438.10(g)(2)(xiii)-(xvi)];

4.3.1.4.3.2.3 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long

	Term Care Ombudsman;
4.3.1.4.3.2.4	The policies and procedures for disenrollment;
4.3.1.4.3.2.5	Cost Sharing requirements [42 CFR 438.10(g)(2)(viii)];
4.3.1.4.3.2.6	A description of utilization review policies and procedures used by the DO;
4.3.1.4.3.2.7	A Statement that additional information, including information on the structure and operation of the DO plan and Provider Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];
4.3.1.4.3.2.8	Information on how to report suspected fraud or abuse [42 CFR 438.10(g)(2)(xiii)-(xvi)];
4.3.1.4.3.2.9	Information about the role of the PDP and information about choosing and changing a PDP, as applicable under the DMCM program;
	Non-Participating Providers and Cost Sharing on any benefits carved out and provided by the Department [42 CFR 438.10(g)(2)(i)-(ii)];

4.3.1.4.3.2.10 How to exercise Advance Directives [42 CFR 438.10(g)(2)(xii), 42 CFR 438.3(j)];

4.3.1.4.3.2.11 Advance Directive policies which include a description of current State law. [42 CFR 438.3(j)(3)]; and

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

4.3.1.4.3.3. Benefits;

4.3.1.4.3.3.1 How and where to access any Covered Services, including NEMT services [42 CFR 438.10(g)(2)(i)-(ii), (vi)-(vii)].

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

4.3.1.4.3.3.3 How Transportation is provided for any benefits carved out of this Agreement and provided by the Department [42 CFR 438.10(g)(2)(i)-(ii)];

4.3.1.4.3.3.4 Information explaining that, in the case of a counseling or referral service that the DO does not cover

because of moral or religious objections, the DO shall inform Members that the service is not covered and how Members can obtain information from the Department about how to access those services [42 CFR 438.10(g)(2)(ii)(A)-(B), 42 CFR 438.102(b)(2)];

4.3.1.4.3.3.5 How emergency care is provided, including:

4.3.1.4.3.3.6 The extent to which, and how, after hours and emergency coverage are provided;

4.3.1.4.3.3.7 What constitutes an Emergency Dental Service and an Emergency Dental Condition;

4.3.1.4.3.3.8 The fact that Prior Authorization is not required for Emergency Services; and

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

4.3.1.4.3.4. Service Limitations;

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

4.3.1.4.3.4.2 A description of all pre-certification, Prior Authorization criteria,

or other requirements for treatments and services;

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

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

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

4.3.1.4.3.5. Rights and Responsibilities:

4.3.1.4.3.5.1 Member rights and protections, outlined in Section 4.3.1.7 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the DO. [42 CFR 438.100(b)(2)(i-vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)].

4.3.1.4.3.5.2 Grievances, appeals, and State fair hearings procedures and timeframes;

4.3.1.4.3.5.3 The right to file grievances and appeals;

4.3.1.4.3.5.4 The requirements and timeframes for filing grievances or appeals;

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

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

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

4.3.1.4.3.6. Member Handbook Dissemination

4.3.1.4.3.6.1 [Amendment #4] The DO shall post on its website and advise the Member within ten (10) calendar days following the MCO's receipt of a valid enrollment file from the Department, but

no later than seven (7) calendar days after the effective date of enrollment in paper or electronic form that the Member Handbook is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost~~make available a printed hardcopy of the Member Handbook to new Members within ten (10) calendar days following the DO's receipt of a valid enrollment file from the Department, but no later than seven (7) calendar days after the effective date of enrollment~~. [42 CFR 438.10(g)(3)(i)-(iv)]

4.3.1.4.3.6.2 [Amendment #4] The DO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information~~shall advise the Member in paper or electronic form that the Member Handbook information is available on the internet, and include~~

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

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

4.3.1.4.3.6.4 Information contained in the Member Handbook;

4.3.1.4.3.6.5 Information on how to file grievances and appeals;

4.3.1.4.3.6.6 Information on the DO's Provider network for all Provider types covered under this Agreement (e.g., Dentists, dental specialists):

4.3.1.4.3.6.6.1. Names and any group affiliations;

4.3.1.4.3.6.6.2. Street addresses;

4.3.1.4.3.6.6.3. Office hours;

4.3.1.4.3.6.6.4. Telephone numbers;

4.3.1.4.3.6.6.5. Website (whenever web presence exists);

4.3.1.4.3.6.6.6. Specialty (if any),

4.3.1.4.3.6.6.7. Description of accommodations offered for people with

	disabilities;
4.3.1.4.3.6.7	The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office,
4.3.1.4.3.6.8	Gender of the Provider;
4.3.1.4.3.6.9	Identification of Providers that are not accepting new Members; and
4.3.1.4.3.6.10	Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi)-(vii)]
4.3.1.4.3.6.11	The DO shall produce a revised Member Handbook, or an insert, informing Members of changes to Covered Services, upon the Department notification of any change in Covered Services, and at least thirty (30) calendar days prior to the effective date of such change.
4.3.1.4.3.6.12	The DO shall use Member notices, as applicable, in accordance with the model notices developed by the

Department. [42 CFR 438.10(c)(4)(ii)] For any change that affects Member rights, filing requirements, time frames for grievances, appeals, and State fair hearings, availability of assistance in submitting grievances and appeals, and toll-free numbers of the DO grievance system resources, the DO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. The DO shall also notify all Members of their disenrollment rights, at a minimum, annually. The DO shall utilize notices that describe transition of care policies for Members and potential Members. As applicable, this includes notification of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the Member can access those services. [42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4); 42 CFR 438.62(b)(3)]

4.3.1.5 Provider Directory

4.3.1.5.1 The DO shall publish a Provider Directory that shall be reviewed by the Department prior to initial publication and distribution. The DO shall submit the draft Provider Directory and all substantive changes to the Department for review.

4.3.1.5.2 The following information shall be in the DO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., Dentists, dental specialists, FQHC's, RHC's):

4.3.1.5.2.1. Names and any group affiliations;

4.3.1.5.2.2. Street addresses;

4.3.1.5.2.3. Office hours;

4.3.1.5.2.4. Telephone numbers;

4.3.1.5.2.5. Website (whenever web presence exists);

4.3.1.5.2.6. Specialty (if any),

4.3.1.5.2.7. Gender;

4.3.1.5.2.8. Description of accommodations offered for people with disabilities;

4.3.1.5.2.9. The cultural and linguistic capabilities of Participating Providers, including languages (including ASL) offered by the Participating Provider or a skilled medical interpreter at the Provider's office;

4.3.1.5.2.10. Hospital affiliations (if applicable);

4.3.1.5.2.11. Board certification (if applicable);

4.3.1.5.2.12. Identification of Participating Providers that are not accepting new patients; and

4.3.1.5.2.13. Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(h)(1)(i-viii); 42 CFR 438.10(h)(2)]

4.3.1.5.3 The DO shall send a letter to New Members within ten (10) calendar days following the DO's receipt of a valid enrollment file from the Department, but no later than seven (7) calendar days after the effective

date of enrollment directing the Member to the Provider Directory on the DO's website and informing the Member of the right to a printed version of the Provider Directory upon request.

4.3.1.5.4 The DO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.4(Practice Guidelines and Standards). [42 CFR 438.236(c)]

4.3.1.5.5 The DO shall notify all Members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the DO's website in a machine readable file and format as specified by CMS.

4.3.1.5.6 The DO shall update the paper copy of the Provider Directory at least monthly if the DO does not have a mobile-enabled electronic directory, or quarterly, if the DO has a mobile-enabled, electronic provider directory; and shall update an electronic directory no later than thirty (30) calendar days after the DO receives updated provider information. [42 CFR 438.10(h)(3-4)].

4.3.1.5.7 The DO shall post on its website a searchable list of all Participating Providers. At a minimum, this list shall be searchable by Provider name, specialty, location, and whether the Provider is accepting new Members.

4.3.1.5.8 The DO shall update the Provider Directory on its website within seven (7) calendar days of any changes. The DO shall maintain an updated list of Participating Providers on its website in a Provider Directory.

4.3.1.5.9 Thirty (30) calendar days after the effective date of this Agreement or ninety (90) calendar days prior to the Program Start Date, whichever is later, the DO shall develop and submit the draft website Provider Directory template to the Department for review; thirty (30) calendar days prior to Program Start Date the DO shall submit the final website Provider Directory.

4.3.1.5.10 Upon the termination of a Participating Provider, the DO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify Members who received their primary care from, or

was seen on a regular basis by, the terminated Provider. [42 CFR 438.10(f)(1)]

4.3.1.6 Language and Format of Member Information

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

4.3.1.6.2 The DO shall use the Department developed definitions consistently in any form of Member communication. The DO shall develop Member materials utilizing readability principles appropriate for the population served.

4.3.1.6.3 The DO shall provide all enrollment notices, information materials, and instructional materials relating to Members and potential Members in a manner and format that may be easily understood and readily accessible in a font size no smaller than twelve (12) point. [42 CFR 438.10(c)(1), 42 CFR 438.10(d)(6)(i-iii)]

4.3.1.6.4 The DO's written materials shall be developed in compliance with all applicable communication access requirements at the request of the Member or prospective Member at no cost.

4.3.1.6.5 Information shall be communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or LEP.

4.3.1.6.6 The DO shall inform Members that information is available in alternative formats and how to access those formats. [42 CFR 438.10(d)(3), 42 CFR 438.10(d)(6)(i-iii)]

4.3.1.6.7 The DO shall make all written Member information available in English, Spanish, and any other State-defined prevalent non-English languages of DMCM Members. [42 CFR 438.10(d)(1)]

4.3.1.6.8 All written Member information critical to obtaining services for potential members shall include at the bottom, taglines printed in a conspicuously visible font size, and in the non-English languages prevalent among DMCM Members, to explain the availability of written translation or oral

interpretation, and include the toll-free and teletypewriter (TTY/TDD) telephone number of the DO's Member Services Center. [42 CFR 438.10(d)(3)]

4.3.1.6.9 The large print tagline must be printed in a conspicuously visible font size, and shall include information on how to request Auxiliary Aids and services, including materials in alternative formats. Upon request, the DO shall provide all written Member and potential enrollee critical to obtaining services information in large print with a font size no smaller than eighteen (18) point. [42 CFR 438.10(d)(2-3), 42 CFR 438.10(d)(6)(i-iii)]

4.3.1.6.10 Written Member information shall include at a minimum:

4.3.1.6.10.1. Provider Directories;

4.3.1.6.10.2. Member Handbooks;

4.3.1.6.10.3. Appeal and grievance notices; and

4.3.1.6.10.4. Denial and termination notices.

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

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

4.3.1.6.13 The DO shall provide Auxiliary Aids such as TTY/TDD and ASL interpreters free of charge to Members or potential Members who require these services. [42 CFR 438.10(d)(4)]

4.3.1.6.14 The DO shall take into consideration the special needs of Members or potential Members with disabilities or LEP. [42 CFR 438.10(d)(5)(i)-(iii)]

4.3.1.7 Member Rights

4.3.1.7.1 The DO shall have written policies which shall be included in the Member Handbook and posted on

the DO website regarding Member rights, such that each Member is guaranteed the right to:

4.3.1.7.1.1. Receive information on the DMCM program and the DO to which the Member is enrolled;

4.3.1.7.1.2. Be treated with respect and with due consideration for their dignity and privacy and the confidentiality of their PHI and PI as safeguarded by State rules and State and federal laws;

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

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

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

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

4.3.1.7.1.7. Request and receive any DO's written Physician Incentive Plans;

4.3.1.7.1.8. Request and receive a Second Opinion; and

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

4.3.1.8 Member Communication Supports

4.3.1.8.1 During the Readiness Review period, the DO shall provide a blueprint of its website for review by the Department.

4.3.1.9 Member Call Center

4.3.1.9.1 The DO shall operate a toll-free call center Monday through Friday. The DO shall submit the holiday calendar to the Department for review and approval ninety (90) calendar days prior to the end of each calendar year.

4.3.1.9.2 The DO shall ensure that the Member Call Center have a call line that is in compliance with requirements set forth in Section 4.3 (Member Services), works efficiently to resolve issues, and is adequately staffed with qualified personnel who are trained to accurately respond to Members. At a minimum, the Member Call Center shall be operational:

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

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

4.3.1.9.2.3. During major program transitions, additional hours and capacity shall be accommodated by the DO.

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

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

4.3.1.9.3.2. Average Speed of Answer: Eighty-five percent (85%) of calls shall be answered with live voice within thirty (30) seconds; and

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

4.3.1.9.4 The DO shall coordinate its Member Call Center with the Department Customer Service Center, and the Member Service Line, at a minimum, and includes the development of a warm transfer protocol for Members.

4.3.1.10 Welcome Call

4.3.1.10.1 The DO shall make a welcome call or an interactive voice recognition (IVR) call to each new Member within thirty (30) calendar days of the Member's enrollment in the DO, and include a means for the Member to request immediate live DO representative support during the welcome call.

4.3.1.10.2 In accordance with applicable law, the DO will communicate with Members by text, email, phone or other digital or electronic communications.

4.3.1.10.3 The welcome call shall, at a minimum:

4.3.1.10.3.1. Assist the Member in selecting a PDP or confirm selection of a PDP;

4.3.1.10.3.2. Arrange for a wellness visit with the Member's PDP (either previously identified or selected by the Member from a list of available PDPs), which shall include:

4.3.1.10.3.3. Development of a health, wellness and care plan;

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

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

4.3.1.10.3.6. Answer any other Member questions about the DO;

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

4.3.1.10.3.8. Remind Members to report to the Department any change of address, as Members shall be liable for premium payments paid during period of ineligibility.

4.3.1.10.3.9. Regardless of the completion of the welcome call, the DO shall complete

Health Risk Assessment Screenings as required in 4.15.2.2.

4.3.1.11 Member Hotline

4.3.1.11.1 The DO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays.

4.3.1.11.2 The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for Members to leave messages.

4.3.1.11.3 The DO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day.

4.3.1.11.4 The DO may substitute a live answering service in place of an automated system.

4.3.2 Program Website

4.3.2.1 The DO shall develop a website, in compliance with Section 7.7 (Website and Social Media) in this Agreement, to provide general information about the DO's program, its Participating Provider network, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance and Appeal Processes.

4.3.2.2 The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit N: Liquidated Damages Matrix.

4.3.2.3 If the DO chooses to provide required information electronically to Members, it shall:

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

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

4.3.2.3.3 Be consistent with content and language requirements;

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

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

4.3.2.4 The DO program content included on the website shall be:

4.3.2.4.1 Written in English and Spanish;

4.3.2.4.2 Culturally appropriate;

4.3.2.4.3 Appropriate to the reading literacy of the population served; and

4.3.2.4.4 Geared to the health needs of the enrolled DO program population.

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

4.3.3 Marketing

4.3.3.1 The DO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The DO shall submit all DO Marketing material to the Department for approval before distribution.

4.3.3.2 The Department shall identify any required changes to the Marketing Materials within thirty (30) calendar days. If the Department has not responded to a request for review by the thirtieth calendar day, the DO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i)-(ii), 42 CFR 438.104(b)(1)(iv)-(v)]

4.3.3.3 The DO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

4.3.3.4 The DO Marketing Materials shall not contain false or materially misleading information. The DO shall not offer other insurance products as inducement to enroll.

4.3.3.5 The DO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or the Department. The DO's Marketing Materials shall not contain any written or oral assertions or Statements that:

4.3.3.5.1 The recipient shall enroll in the DO in order to obtain benefits or in order not to lose benefits; or

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

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

4.3.4 Member Engagement Strategy

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

4.3.5 Member Advisory Board

4.3.5.1 Representation on the Member Advisory Board shall draw from and be reflective of the DO membership to ensure accurate and timely feedback on the DMCM program.

4.3.5.2 The Member Advisory Board shall meet at least four (4) times per year.

4.3.5.3 The Member Advisory Board shall meet in-person or through interactive technology, including but not limited to a conference call or webinar and provide Member perspective(s) to influence the DO's QAPI program changes (as further described in Section 4.11.2 (Quality Assessment and Performance Improvement Program).

4.3.5.4 All costs related to the Member Advisory Board shall be the responsibility of the DO.

4.3.6 In-Person Regional Member Meetings

4.3.6.1 The DO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the DO can ask questions and obtain feedback from Members.

4.3.6.2 Regional meetings shall be held at least twice each Agreement year in demographically different locations in NH. The DO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the DO shall use alternate technologies as available for all meetings.

4.3.6.3 The DO may utilize remote technologies for regional Member meetings.

4.3.6.4 The DO shall accommodate in-person and remote technologies for regional Member meetings.

4.3.7 Cultural and Accessibility Considerations

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

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

4.3.8 Cultural Competency Plan

4.3.8.1 In accordance with 42 CFR 438.206, the DO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and translators in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.3.8.2 The Cultural Competency Plan shall describe how the Participating Providers, and systems within the DO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity.

4.3.8.3 The DO shall work with the Department Office of Health Equity to address cultural and linguistic considerations.

4.3.9 Communication Access

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

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

4.3.9.3 The DO shall adhere to certain quality standards in delivering language assistance services, including using only Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member

with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators.

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

4.3.9.4.1 Require a Member with LEP to provide their own interpreter;

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

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

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

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

4.3.9.4.6 Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.101(b)(2)]

4.3.9.5 The DO shall ensure interpreter services are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and DO services, exclusive of inpatient services.

4.3.9.6 The DO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e. will provide meaningful access) for all Members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.3.9.7 Accordingly, the DO shall provide the most appropriate interpretation service possible under the circumstances. In all

cases, the DO shall provide interpreter services when deemed clinically necessary by the Provider of the encounter service.

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

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

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

4.3.9.8.3 A clear, audible transmission of voices; and

4.3.9.8.4 Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. [45 CFR 92.101(b)(3)]

4.3.9.9 The DO shall bear the cost of interpretive services and communication access, including ASL interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

4.3.9.10 The DO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.3.9.11 If the Member declines free interpretation services offered by the DO, the DO shall have a process in place for informing the Member of the potential consequences of declination with the assistance of a competent interpreter to assure the Member's understanding, as well as a process to document the Member's declination.

4.3.9.12 Interpreter services shall be offered by the DO at every new contact. Every declination requires new documentation by the DO of the offer and decline.

4.3.9.13 The DO shall comply with applicable provisions of federal laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which

prohibits the DO from discriminating on the basis of race, color, or national origin.

4.3.9.14 As clarified by Executive Order 13166, Improving Access to Services for Persons with LEP, and resulting agency guidance, national origin discrimination includes discrimination on the basis of LEP. To ensure compliance with Title VI of the Civil Rights Act of 1964, the DO shall take reasonable steps to ensure that LEP Members have meaningful access to the DO's programs.

4.3.9.15 Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The DO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the DO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.3.9.16 Digital, video, and phone interpretation services must comply with Exhibit K: Information Security Requirements and Exhibit Q: IT Requirements Workbook.

4.4 Member Grievances and Appeals

4.4.1 General Requirements

4.4.1.1 The DO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The DO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, State law as applicable, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.4.1.2 The DO shall provide to the Department a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for the Department's review and approval during the Readiness Review period. Any proposed changes to the Grievance System shall be reviewed by the Department thirty (30) calendar days prior to implementation.

4.4.1.3 The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a Medicaid service, the DO shall handle the grievance or appeal in accordance with this Agreement.

4.4.1.4 In the event the DO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a

Medicare service, the DO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

4.4.1.5 The DO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The DO shall:

4.4.1.5.1 Provide Members with all reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.4.1.5.2 Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member or authorized Provider requests expedited resolution [42 CFR 438.406(b)(1); 42 CFR 438.228(a)];

4.4.1.5.3 Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making [42 CFR 438.406(b)(2)(i); 42 CFR 438.228(a)];

4.4.1.5.4 Ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 438.406(b)(2)(iii); 42 CFR 438.228(a)];

4.4.1.5.5 Ensure that, if deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the Member's condition or disease:

4.4.1.5.5.1. An appeal of a denial based on lack of medical necessity;

4.4.1.5.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

4.4.1.5.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A-C); 42 CFR 438.228(a)].

4.4.1.5.6 Ensure that Members are permitted to file appeals and State fair hearings after receiving notice that an adverse action is upheld [42 CFR 438.402(c)(1); 42 CFR 438.408].

4.4.1.6 The DO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

4.4.1.7 The DO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contact or Subcontract. The information shall include, but is not limited to:

4.4.1.7.1 The Member's right to file grievances and appeals and requirements and timeframes for filing;

4.4.1.7.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.4.1.7.3 The availability of assistance with filing;

4.4.1.7.4 The toll-free numbers to file oral grievances and appeals;

4.4.1.7.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the DO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.4.1.7.6 The Provider's right to appeal the failure of the DO to pay for or cover a service.

4.4.1.8 The DO shall make available training to Providers in supporting and assisting Members in the Grievance System.

4.4.1.9 The DO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)]

4.4.1.10 At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the Member, the dates received, the dates of each review, the dates of the grievance or appeal, the resolution and the date of resolution. [42 CFR 438.416(b)(1-6)]

4.4.1.11 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the DO shall provide reports on all actions related to Member grievances and appeals, including all matters handled

by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.4.1.12 The DO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The DO shall regularly review appeals Confidential Data for process improvement which should include but not be limited to reviewing:

4.4.1.12.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

4.4.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.4.1.13 The DO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.4.2 Grievance Process

4.4.2.1 The DO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.4.2.2 The DO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the DO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.4.2.3 The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.4.2.3.1 The quality of care or services provided;

4.4.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.4.2.3.3 Failure to respect the Member's rights;

4.4.2.3.4 Dispute of an extension of time proposed by the DO to make an authorization decision;

4.4.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

4.4.2.3.6 Members who believe the DO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.4.2.4 The DO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the DO receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the DO does not have all the information necessary to make the decision, for ninety-eight percent (98%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

4.4.2.5 The DO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.4.2.5.1 If the Member requests the extension; or

4.4.2.5.2 If the DO shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

4.4.2.6 If the DO extends the timeline for a grievance not at the request of the Member, the DO shall:

4.4.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.4.2.6.2 Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1)

4.4.2.7 If the Member requests disenrollment, then the DO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month in which the Member requests disenrollment. [42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)]

4.4.2.8 The DO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.4.2.9 Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.4.3 Appeal Process

4.4.3.1 The DO shall develop, implement, and maintain an Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the DO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The

DO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.4.3.2 The DO shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal orally or in writing of any DO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.4.3.3 The DO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's State. [42 CFR 438.406(b)(6)]

4.4.3.4 The DO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the DO's notice of action. [42 CFR 438.402(c)(2)(ii)]

4.4.3.5 The DO shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

4.4.3.6 If the Department receives a request to appeal an action of the DO, the Department shall forward relevant information to the DO and the DO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.4.3.7 The DO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.4.3.8 The DO shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The DO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.4.3.9 [Amendment #1] The DO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, ~~including medical records, and any other documents and records considered during the Appeal Process~~ free of charge prior ~~to the resolution~~ and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b-c)]

4.4.3.10 The DO may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

4.4.3.11 The DO shall resolve one hundred percent (98%) of standard Member appeals within thirty (30) calendar days from the date the

appeal was filed with the DO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.4.3.12 The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

4.4.3.13 Members who believe the DO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.4.3.14 If the DO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the DO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.4.4 Actions

4.4.4.1 The DO shall permit the appeal of any action taken by the DO. Actions shall include, but are not limited to the following:

4.4.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.4.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.4.4.1.3 Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)];

4.4.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.4.4.1.5 Untimely service authorizations;

4.4.4.1.6 Failure of the DO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.4.4.1.7 At such times, if any, that the Department has an Agreement with fewer than two (2) DOs, for a rural area resident with only one (1) DO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.4.5 Expedited Appeal

4.4.5.1 The DO shall develop, implement, and maintain an expedited appeal review process for appeals when the DO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously

jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function: [42 CFR 438.410(a)]

4.4.5.2 The DO shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

4.4.5.3 The DO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the DO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.4.5.4 The DO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the DO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The DO shall also make reasonable efforts to provide oral notice.

4.4.5.5 The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

4.4.5.6 If the DO extends the timeframes not at the request of the Member, it shall:

4.4.5.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within two (2) calendar days of the DO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.4.5.6.2 Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision;

4.4.5.6.3 Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-iii); 42 CFR 438.408(b)(2)-(3)]

4.4.5.7 [Amendment #4] The DO shall meet the timeframes above for ~~one hundred~~ ninety-eight percent (98%) of requests for expedited appeals.

4.4.5.8 The DO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.4.5.9 If the DO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

4.4.5.10 The Member has a right to file a grievance regarding the DOs denial of a request for expedited resolution. The DO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.4.6 Content of Notices

4.4.6.1 The DO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.4.6.2 The DO shall utilize URAC compliant model notices for all adverse actions and appeals. DO adverse action and appeal notices shall be submitted for the Department review during the Readiness Review process. Each notice of adverse action shall contain and explain:

4.4.6.2.1 The action the DO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.4.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

4.4.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the DO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b-c)];

4.4.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.4.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.4.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits [42 CFR 438.404(b)(6)].

4.4.6.3 The DO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.4.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by DMCM Members (as defined by the State per 42 CFR 438.10(d));

4.4.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.4.6.3.3 Notices shall use easily understood language and format, and shall be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members shall be informed that information is available in alternative formats and how to access those formats.

4.4.6.4 The DO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.4.6.4.1 The Member has died;

4.4.6.4.2 The Member submits a signed written Statement requesting service termination;

4.4.6.4.3 The Member submits a signed written Statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.4.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

4.4.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.4.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.4.7 Timing of Notices

4.4.7.1 For termination, suspension or reduction of previously authorized Medicaid Covered Services, the DO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the DO has verified facts that the action should be taken because of probable fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.4.7.2 In accordance with 42 CFR 438.404(c)(2), the DO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.4.7.3 For standard service authorization denials or partial denials, the DO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services. [42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3)] An extension of up to an additional fourteen (14) calendar days is permissible, if:

4.4.7.3.1 The Member, or the Provider, requests the extension; or

4.4.7.3.2 The DO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.4.7.4 When the DO extends the timeframe, the DO shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i)] Under such circumstance, the DO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii)]

4.4.7.5 For cases in which a Provider indicates, or the DO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the DO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours

after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.4.7.6 The DO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the DO justifies a need for additional information and how the extension is in the Member's interest.

4.4.7.7 The DO shall provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. [42 CFR 438.404(c)(5)]

4.4.8 Continuation of Benefits

4.4.8.1 The DO shall continue the Member's benefits if:

4.4.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.4.8.1.1.1. Within ten (10) calendar days of the DO mailing the notice of action, or

4.4.8.1.1.2. The intended effective date of the DO's proposed action;

4.4.8.1.1.3. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.4.8.1.1.4. The services was ordered by an authorized Provider;

4.4.8.1.1.5. The authorization period has not expired;

4.4.8.1.1.6. The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

4.4.8.1.1.7. The Member requests extension of benefits, orally or in writing. [42 CFR 438.420(a); 42 CFR 438.420(b)(1-5); 42 CFR 438.402(c)(2)(ii)]

4.4.8.2 If the DO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.4.8.2.1 The Member withdraws the appeal, in writing;

4.4.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the DO

mails an adverse DO decision regarding the Member's DO appeal;

4.4.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.4.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]

4.4.8.3 If the final resolution of the appeal upholds the DO's action, the DO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.4.8.4 A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.4.9 Resolution of Appeals

4.4.9.1 The DO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.4.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the DO does not have all the information necessary to make the decision, unless the DO notifies the Member that an extension is necessary to complete the appeal.

4.4.9.1.2 The DO may extend the timeframes up to fourteen (14) calendar days if:

4.4.9.1.2.1. The Member requests an extension, orally or in writing, or

4.4.9.1.2.2. The DO shows that there is a need for additional information and the DO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

4.4.9.1.3 If the DO extends the timeframes not at the request of the Member then it shall:

4.4.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.4.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.4.9.2 Under no circumstances may the DO extend the appeal determination beyond forty-five (45) calendar days from the day the DO receives the appeal request even if the DO does not have all the information necessary to make the decision.

4.4.9.3 The DO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.4.9.4 The DO shall include a written Statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.4.9.5 For notice of an expedited resolution, the DO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.4.9.6 For appeals not resolved wholly in favor of the Member, the notice shall:

4.4.9.6.1 Include information on the Member's right to request a State fair hearing;

4.4.9.6.2 How to request a State fair hearing;

4.4.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.4.9.6.4 Inform the Member that the Member may be held liable for the amount the DO pays for services received while the hearing is pending, if the hearing decision upholds the DO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.4.10 State Fair Hearing

4.4.10.1 The DO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.4.10.2 The parties to the State fair hearing include the DO as well as the Member and their representative or the representative of a deceased Member's estate.

4.4.10.3 The DO shall ensure that Members are informed, at a minimum, of the following:

4.4.10.3.1 That Members shall exhaust all levels of resolution and appeal within the DO's Grievance System prior to filing a request for a State fair hearing with the Department; and

4.4.10.3.2 That if a Member does not agree with the DO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the DO's notice of the resolution of the appeal. [42 CFR.408(f)(2)]

4.4.10.4 If the Member requests a fair hearing, the DO shall provide to the Department and the Member, upon request, within three (3) business days, all DO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.4.10.5 A Member may request an expedited resolution of a State fair hearing if the Administrative Appeals Unit (AAU) determines that the time otherwise permitted for a State fair hearing could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, and:

4.4.10.5.1 The DO adversely resolved the Member's appeal wholly or partially; or

4.4.10.5.2 The DO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.4.10.6 If the Member requests an expedited State fair hearing, the DO shall provide to the Department and the Member, upon request within twenty-four (24) hours, all DO-held documentation related to the appeal, including but not limited to any transcript(s),

records, or written decision(s) from Participating Providers or delegated entities.

4.4.10.7 If the AAU grants the Member's request for an expedited State fair hearing, then the AAU shall resolve the appeal within three (3) business days after the Unit receives from the DO the case file and any other necessary information. [He-W 506.09(g)]

4.4.10.8 The DO shall appear and defend its decision before the Department AAU. The DO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the DO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the DO shall provide all necessary support to the Department for the duration of the appeal at no additional cost.

4.4.10.9 The Department AAU shall notify the DO of State fair hearing determinations. The DO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the DO's decision. The DO shall not object to the State intervening in any such appeal.

4.4.11 Effect of Adverse Decisions of Appeals and Hearings

4.4.11.1 If the DO or the Department reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the DO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.4.11.2 If the DO or the Department reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal or State fair hearing were pending, the DO shall pay for those services. [42 CFR 438.424(b)]

4.4.12 Survival

4.4.12.1 The obligations of the DO to fully resolve all grievances and appeals, including but not limited to providing the Department with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

4.5 Provider Appeals

4.5.1 General

4.5.1.1 The DO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the DO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

4.5.1.2 The DO shall provide to the Department a complete description of its Provider Appeals Process, in writing, including all policies and procedures, notices and forms, of its proposed Provider Appeals Process for the Department's review and approval during the Readiness Review period.

4.5.1.3 Any proposed changes to the Provider Appeals Process shall be approved by the Department at least thirty (30) calendar days in advance of implementation.

4.5.1.4 The DO shall clearly articulate its Provider Appeals Process in the DO's Provider manual, and reference it in the Provider agreement.

4.5.1.5 The DO shall ensure its Provider Appeals Process complies with the following general requirements:

4.5.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.5.1.5.2 Ensures that the decision makers involved in the Provider Appeals Process and their subordinates were not involved in previous levels of review or decision making of the Provider's adverse action;

4.5.1.5.3 Ensures that decision makers take into account all comments, documents, records, and other information submitted by the Provider to the extent such materials are relevant to the appeal; and

4.5.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

4.5.2 Provider Adverse Actions

4.5.2.1 The Provider shall have the right to file an appeal with the DO and utilize the Provider Appeals Process for any adverse action, in accordance with RSA 126-A:5, VIII, except for Member appeals or grievances described in Section 4.4 (Member Grievances and Appeals). The Provider shall have the right to file an appeal within thirty (30) calendar days of the date of the DO's notice of adverse action to the Provider. Reasons may include, but are not limited to:

4.5.2.1.1 Action against the Provider for reasons related to program integrity;

4.5.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when the Department, MFCU or other government agency has required the DO to terminate such agreement;

4.5.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.5.2.1.4 Violation of the agreement between the DO and the Provider.

4.5.2.2 The DO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the DO's Provider Appeals Process or State fair hearing, the DO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.5.3 Provider Appeal Process

4.5.3.1 The DO shall provide written notice to the Provider of any adverse action, and include in its notice a description of the basis of the adverse action, and the right to appeal the adverse action.

4.5.3.2 Providers shall submit a written request for an appeal to the DO, together with any evidence or supportive documentation it wishes the DO to consider, within thirty (30) calendar days of:

4.5.3.2.1 The date of the DO's written notice advising the Provider of the adverse action to be taken; or

4.5.3.2.2 The date on which the DO should have taken a required action and failed to take such action.

4.5.3.3 The DO shall be permitted to extend the decision deadline by an additional thirty (30) calendar days to allow the Provider to submit evidence or supportive documentation, and for other good cause determined by the DO.

4.5.3.4 The DO shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider Appeal.

4.5.3.5 The DO may offer peer-to-peer review support, with a like clinician, upon request, for Providers who receive an adverse decision from the DO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.5.3.6 The DO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period

not less than ten (10) years. At a minimum, log records shall include:

4.5.3.6.1 General description of each appeal;

4.5.3.6.2 Name of the Provider;

4.5.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.5.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.5.3.7 If the DO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the DO's Appeals Process and may initiate a State fair hearing.

4.5.4 DO Resolution of Provider Appeals

4.5.4.1 The DO shall provide written notice of resolution of ninety-five percent (95%) Provider appeal (Resolution Notice) within thirty (30) calendar days from either the date the DO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the DO.

4.5.4.2 The Resolution Notice shall include, without limitation:

4.5.4.2.1 The DO's decision;

4.5.4.2.2 The reasons for the DO's decision;

4.5.4.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.5.4.2.4 For overturned appeals, the DO shall take all steps to reverse the adverse action within ten (10) calendar days.

4.5.5 State Fair Hearing

4.5.5.1 The DO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.5.5.2 The parties to the State fair hearing include the DO as well as the Provider.

4.5.5.3 The Participating Provider shall exhaust the DO's Provider Appeals Process before pursuing a State fair hearing.

4.5.5.4 If a Participating Provider requests a State fair hearing, the DO shall provide to the Department and the Participating Provider, upon request, within three (3) business days, all DO-held

documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.5.5.5 The DO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the DO shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.5.5.6 The DO shall appear and defend its decision before the Department AAU. Nothing in this Agreement shall preclude the DO from representation by legal counsel.

4.5.5.7 The Department AAU shall notify the DO of State fair hearing determinations within sixty (60) calendar days of the date of the DO's Notice of Resolution.

4.5.5.8 The DO shall:

4.5.5.8.1 Not object to the State intervening in any such appeal;

4.5.5.8.2 Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the DO's Final Determination; and

4.5.5.8.3 Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.5.5.9 Reporting

4.5.5.9.1 The DO shall provide to the Department, as detailed in Exhibit O: Quality and Oversight Reporting Requirements, Provider complaint and appeal logs. [42 CFR 438.66(c)(3)]

4.6 Access

4.6.1 Provider Network

4.6.1.1 The DO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.6.1.2 The DO shall develop and maintain a statewide Participating Provider network that adequately meets all covered dental needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its network, the DO shall consider the following:

4.6.1.2.1 Current and anticipated NH Medicaid enrollment;

4.6.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH population;

4.6.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.6.1.2.4 The number of network Providers limiting NH Medicaid patients or not accepting new or any NH Medicaid patients;

4.6.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.6.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.6.1.2.7 The availability of screening systems, as well as the use of teledentistry, e-visits, and/or other evolving and innovative technological solutions, in compliance with Exhibit K: Information Security Requirements and Exhibit Q: IT Requirements Workbook;

4.6.1.2.8 Adequacy of the primary dental care network to offer each Member a choice of at least two (2) appropriate PDPs that are accepting new Medicaid patients;

4.6.1.2.9 Required access standards identified in this Agreement; and

4.6.1.2.10 Required access standards set forth by the NHID, including RSA. 420-J; and N.H. Code of Administrative Rules Ins 2700.

4.6.1.3 The DO shall meet the network adequacy standards included in this Agreement in all geographic areas in which the DO operates for all Provider types covered under this Agreement.

4.6.1.4 The DO shall ensure that services are as accessible to Members in terms of timeliness, amount, duration and scope as those that are available to Members covered by the Department under FFS Medicaid within the same service area.

4.6.1.5 The DO shall ensure Participating Providers comply with the accessibility standards of the ADA. Participating Providers shall demonstrate physical access, reasonable accommodations, and

accessible equipment for all Members including those with physical or cognitive disabilities. [42 CFR 438.206(c)(3)]

4.6.1.6 The DO shall demonstrate that there are sufficient Participating Indian Health Care Providers (IHCPs) in the Participating Provider network to ensure timely access to services for American Indians who are eligible to receive services. If Members are permitted by the DO to access out-of-state IHCPs, or if this circumstance is deemed to be good cause for disenrollment, the DO shall be considered to have met this requirement. [42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)]

4.6.1.7 The DO shall maintain an updated list of Participating Providers on its website in a Provider Directory, as specified in Section 4.3.1.5 (Provider Directory) of this Agreement.

4.7 Assurances of Adequate Capacity and Services

4.7.1 The DO's network shall have Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all Covered Services to meet the geographic standards in Section 4.7.3 (Time and Distance Standards), the timely provision of services requirements in Section 4.7.6 (Timely Access to Service Delivery), Equal Access, and reasonable choice by Members to meet their needs [42 CFR 438.207(a)].

4.7.2 The DO shall submit documentation to the Department, in the format and frequency specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, that fulfills the following requirements:

4.7.2.1 The DO shall give assurances and provide supporting documentation to the Department that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the Department's standards for access and timeliness of care. [42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)].

4.7.2.2 The DO offers an appropriate range of preventive, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.3 The DO demonstrates Equal Access to services for all populations in the DMCM program, as described in Section 4.7.6 (Timely Access to Service Delivery).

4.7.2.4 The DO shall submit documentation to the Department to demonstrate that it maintains an adequate network of Participating Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.7.2.4.1 During the Readiness Review period, prior to the Program Start Date;

4.7.2.4.2 Annually; and

4.7.2.4.3 At any time there has been a significant change (as defined by the Department) in the entity's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, geographic service area, or payments; and/or enrollment of a new population in the DO. [42 CFR 438.207(b-c)]

4.7.2.5 For purposes of providing assurances of adequate capacity and services, the DO shall base the anticipated number of Members on the "NH DMCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by the Department.

4.7.3 Time and Distance Standards

4.7.3.1 At a minimum, the DO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members. [42 CFR 438.68(b)(1)(i-viii); 42 CFR 438.68(b)(3)].

4.7.3.2 Geographic access standards are based on the following county groupings: "Rural", "Middle", and "Urban". Maximum travel distances or times are based on the service type, county, and specific zip code within the county as follows:

Geographic Access Standards	
Location	Requirement
Urban counties, including Strafford, Hillsborough, and Rockingham counties:	a. Ten miles or 15 minutes driving time for core services; b. Twenty miles or 30 minutes driving time for common services; and
Middle counties, including Merrimack, Belknap, Cheshire, Grafton, Carroll, and Sullivan counties:	a. Twenty miles or 40 minutes driving time for core services; b. Forty miles or 80 minutes driving time for common services; and
Rural counties, including Coos county:	a. Thirty miles or one hour driving time for core services; b. Eighty miles or 2 hours driving time for common services; and
• Core services: Dental diagnostic services; Dental preventive services; Dental restorative services	

Geographic Access Standards	
Location	Requirement
• Common Services: Dental adjunctive general services; Dental oral and maxillofacial surgery; Dental periodontics (limited coverage in NH Medicaid); Dental prosthodontics which are removable	

4.7.3.3 The DO shall report annually how specific provider types meet the time and distance standards for Members in each county within NH in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.3.4 The Department shall continue to assess where additional access requirements, whether time and distance or otherwise, shall be incorporated. The Department may provide additional guidance to the DO regarding its network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.4 Standards for Geographic Accessibility

4.7.4.1 The DO may request reasonable exceptions from the Agreement's network standards after demonstrating its efforts to contract a sufficient network of Participating Providers. The Department reserves the right to approve or disapprove these requests, at its discretion.

4.7.4.2 Should the DO be unable to contract a sufficient number of Participating Providers in accordance with the Agreement's Time and Distance Standards and Timely Access to Service Delivery Standards within thirty (30) days of the Program Start Date or at any time during the contract term, Liquidated Damages described in Section 5.5.2 (Liquidated Damages) and Exhibit N shall apply.

4.7.4.3 At any time the provisions of this section may apply, the DO shall ensure Members have reasonable access to Covered Services.

4.7.5 Exceptions

4.7.5.1 The DO may request exceptions, via a Request for Exception, from the network adequacy standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. [42 CFR 438.68(d)(1)] the Department may grant the DO an exception in the event that:

4.7.5.1.1 The DO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the DO are available to meet the network adequacy standards in this Agreement and as otherwise defined by the NHID and the Department;

4.7.5.1.2 The DO demonstrates, to the satisfaction of the Department, that the DO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the DO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.5.1.3 The DO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies reviewed and approved by the Department, but the DO shall not use telemedicine to meet the State's network adequacy standards unless the Department has specifically approved a Request for Exception.

4.7.5.1.4 The DO shall report on network adequacy and exception requests in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.6 Timely Access to Service Delivery

4.7.6.1 The DO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.6.2 The DO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)]

4.7.6.3 The DO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.6.4 The DO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.6.5 The DO's network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.6.6 The DO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.6.6.1 Non-Symptomatic Office Visits: (i.e., diagnostic, preventive, and restorative services) shall be available from the Member's PDP or another Provider within forty-five (45) calendar days.

4.7.6.6.2 Non-Urgent, Symptomatic Office Visits shall be available from the Member's PDP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of oral health related signs or symptoms not requiring immediate attention, but that require monitoring.

4.7.6.6.3 Urgent, Symptomatic Office Visits shall be available from the Member's PDP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.6.7 The DO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards.

4.7.6.7.1 The DO shall regularly monitor its network to determine compliance with timely access and shall provide an annual report to the Department documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v), in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.6.8 The DO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

4.7.7 Non-Participating Providers

4.7.7.1 If the DO's network is unable to provide necessary covered oral health services covered under the Agreement to a particular Member, the DO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the DO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.7.2 The DO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.7.3 The DO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.7.3.1 If the DO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the DO is not responsible for payment.

4.7.7.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider, the payment amount is a matter between the DO and the Non-Participating Provider.

4.7.7.4 The DO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

4.7.8 Access to Providers During Transitions of Care

4.7.8.1 The DO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.8.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.8.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.8.2 The DO shall permit that, in the instances when a Member transitions into the DO from FFS Medicaid, :

4.7.8.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition, the Member is permitted to continue seeing their Provider(s), regardless of whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first;

4.7.8.3 The DO shall permit that, in instances in which a Provider in good standing leaves an DO's network and:

4.7.8.3.1 The Member is in ongoing course of treatment, the Member is permitted to continue seeing their Provider(s),whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

4.7.8.4 The DO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the DO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition

plan shall describe how Members shall be identified by the DO and how Continuity of Care shall be provided.

4.7.8.5 The DO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.8.5.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.8.5.2 Are assigned to receive primary dental services from the terminated Provider.

4.7.8.6 The DO shall make a good faith effort to give written notice of termination of a contracted provider, as follows:

4.7.8.6.1 Written notice to the Department, the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination; and

4.7.8.6.2 Written notice to each Member who received their care from, or was seen on a regular basis by, the terminated provider, the later of:

4.7.8.6.2.1. Thirty (30) calendar days prior to the effective date of the termination; or

4.7.8.6.2.2. Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated provider.

4.7.8.7 The DO shall have a transition plan in place for affected Members described in Section 4.12.19.4 within three (3) calendar days prior to the effective date of the termination.

4.7.8.8 In addition to notification of the Department of provider terminations, the DO shall provide reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.8.9 If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the DO shall notify the Member in writing within seven (7) calendar days from the date the DO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.8.10 If the terminated Provider is a PDP to whom the DO Members are assigned, the DO shall:

4.7.8.10.1 Describe in the notice to Members the procedures for selecting an alternative PDP;

4.7.8.10.2 Explain that the Member shall be assigned to an alternative PDP if they do not actively select one; and

4.7.8.10.3 Ensure the Member selects or is assigned to a new PDP within thirty (30) calendar days of the date of notice to the Member.

4.7.8.11 If the DO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the DO.

4.7.8.12 The DO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers.

4.7.8.13 To minimize disruptions in care, the DO shall provide continuation of the terminating Provider's services for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Participating Provider without disruption of care, whichever is less.

4.7.9 Second Opinion

4.7.9.1 The DO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member. The DO shall clearly State its procedure for obtaining a Second Opinion in its Member Handbook. [42 CFR 438.206(b)(3)]

4.7.10 Provider Choice

4.7.10.1 The DO shall permit each Member to choose their Provider to the extent possible and appropriate. [42 CFR 438.3(l)]

4.8 Utilization Management

4.8.1 Policies and Procedures

4.8.1.1 The DO's policies and procedures related to the authorization of services shall be in compliance with all applicable laws and regulations including but not limited to 42 CFR 438.210 and RSA Chapter 420-E.

4.8.1.2 The DO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to dentists and dental specialists.

4.8.1.3 Amount, Duration, and Scope

4.8.1.3.1 The DO shall ensure that each service provided to adults is furnished in an amount, duration and scope that is no less than the amount, duration and scope

for the same services provided under FFS Medicaid. [42 CFR 438.210(a)(2)]

4.8.1.4 Written Utilization Management Policies

4.8.1.4.1 The DO shall develop, operate, and maintain a Utilization Management program that is documented through a program description and defined structures, policies, and procedures that are reviewed and approved by the Department. The DO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the DO's service area, and are consistent with the Practice Guidelines described in Section 4.8.4 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (the Department shall approve any changes to the clinical criteria before the criteria are utilized);

4.8.1.4.1.4. Are applied based on individual needs and circumstances (including social determinants of health needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of URAC Health Plan Accreditation.

4.8.1.4.2 The DO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are

licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs; and

4.8.1.4.2.2. The process used by the DO to preserve confidentiality of medical information.

4.8.1.4.3 Clinical review criteria and changes in criteria shall be communicated to Participating Providers and Members at least thirty (30) calendar days in advance of the changes.

4.8.1.4.4 The Utilization Management Program descriptions shall be submitted by the DO to the Department for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the DO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.8.1.4.6 The DO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The DO's written Utilization Management policies, procedures, and criteria shall be made available upon request to the Department, Participating Providers, and Members.

4.8.1.4.8 The DO shall provide the Medical Management Committee (or the DO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.66 (c)(7)]

4.8.2 Service Limit

4.8.2.1 The DO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.2.2 The DO may place appropriate limits on a service for utilization control, provided:

4.8.2.2.1 The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)].

4.8.3 Prior Authorization

4.8.3.1 The DO and, if applicable, its Subcontractors shall have in place and follow written policies and procedures as described in the Utilization Management policies for processing requests for initial and continuing authorizations of services and including conditions under which retroactive requests shall be considered.

4.8.3.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person-centered planning process. [42 CFR 438.210(b)(2)(iii)]

4.8.3.3 The DO shall work in good faith with the Department, as initiated by the Department, to adopt Prior Authorization form practices with consistent information and documentation requirements from Providers wherever feasible. Providers shall be able to submit the Prior Authorizations forms electronically, by mail, or fax.

4.8.3.4 The DO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.3.5 The DO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

4.8.3.6 The DO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.

4.8.3.7 The DO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.3.8 The DO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.3.9 The DO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.3.10 Compensation to individuals or entities that conduct Utilization Management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue

Medically Necessary services to any Member. [42 CFR 438.210(e)]

4.8.3.11 Medicaid State Plan services Prior Authorizations, in place at the time a Member transitions to an DO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.3.12 In the event that the Prior Authorization specifies a specific Provider, that DO shall continue to utilize that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the DO's network.

4.8.3.13 The DO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the DO issues new authorizations that address the Member's needs.

4.8.3.14 The DO shall ensure that Subcontractors or any other party performing utilization review are licensed in NH in accordance with Section 3.1.15.2 (Contracts with Subcontractors).

4.8.4 Practice Guidelines and Standards

4.8.4.1 The DO shall adopt evidence-based clinical Practice Guidelines. The Practice Guidelines adopted by the DO shall:

4.8.4.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

4.8.4.1.2 Consider the needs of the DO's Members,

4.8.4.1.3 Be adopted in consultation with Participating Providers, and

4.8.4.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1)-(3); 42 CFR 438.236(b)(4)]

4.8.4.2 The DO shall adopt Practice Guidelines consistent with the standards of care and evidence-based practices of specific professional specialty groups, as identified by the Department. These include, but are not limited to:

4.8.4.2.1 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adults, rated A or B;

4.8.4.3 The DO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force, provided that the DO meets all other Practice Guidelines requirements indicated within this Section 4.8.4 (Practice Guidelines and Standards) of the Agreement and that such

substitution is reviewed by the Department prior to implementation.

4.8.4.4 The DO shall disseminate Practice Guidelines to the Department and all affected Providers and make Practice Guidelines available, including but not limited to the DO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

4.8.4.5 The DO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the DO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.5 Medical Necessity Determination

4.8.5.1 The DO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.5.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

4.8.5.1.2 Addresses the extent to which the DO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.5.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.5.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.5.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.5.2 For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Definitions.

4.8.6 Notices of Coverage Determinations

4.8.6.1 The DO shall provide the requesting Provider and the Member with written notice of any decision by the DO to deny a service authorization request, or to authorize a service in an amount,

duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.6.2 Urgent Determinations and Continued/Extended Services

4.8.6.2.1 The DO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.6.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.6.2.1.2. In the case of such failure, the DO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request and shall advise the Member or Member's representative of the specific information necessary to make a determination.

4.8.6.2.1.3. The Member or Member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

4.8.6.2.1.4. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the DO's receipt of the specified additional information; or the end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.6.2.1.5. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

4.8.6.3 All Other Determinations

4.8.6.3.1 The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed fourteen (14) calendar days for ninety-five percent (95%) of requests after the receipt of a request.

4.8.6.3.2 An extension of up to fourteen (14) calendar days is permissible for non-diagnostic radiology determinations if the Member or the Provider requests the extension, or the DO justifies a need for additional information.

4.8.6.3.3 If an extension is necessary due to a failure of the Member or Member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the Member or Member's representative shall be given at least forty- five (45) calendar days from receipt of the notice within which to provide the specified information.

4.8.6.3.4 Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of:

4.8.6.3.4.1. The DO's receipt of the specified additional information; or

4.8.6.3.4.2. The end of the period afforded the Member or Member's representative

to provide the specified additional information.

4.8.6.3.4.3. When the DO extends the timeframe, the DO shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the DO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.8.6.3.5 Ninety-five percent (95%) of post service authorization determinations shall be made within thirty (30) calendar days of the date of filing. In the event the Member fails to provide sufficient information to determine the request, the DO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.6.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.6.3.7 Whenever there is an adverse determination, the DO shall notify the ordering Provider and the Member. For an adverse standard authorization decision, the DO shall provide written notification within three (3) calendar days of the decision.

4.8.6.3.8 The DO shall provide Utilization Management Confidential Data to include but not be limited to timely processing, results, and frequency of service

4.8.7 [Amendment #4] Reserved. ~~Advance Directives~~

4.8.7.1 ~~The DO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:20.~~

4.8.7.2 ~~The DO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.~~

4.8.7.3 ~~The DO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.~~

4.8.7.4 ~~The DO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1) (2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]~~

4.8.7.5 ~~The DO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1) (2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]~~

4.8.7.6 ~~The DO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1) (2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]~~

4.8.7.7 ~~The DO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.1.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]~~

4.8.7.8 ~~The DO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]~~

4.9 Member Education and Incentives

4.9.1 General Provisions

4.9.1.1 The DO shall develop and implement evidenced-based oral health wellness and prevention programs for its Members. The DO shall seek to promote and provide oral health wellness and prevention programming aligned with similar programs and services promoted by the Department. The DO shall also participate in other public health initiatives at the direction of the Department.

4.9.1.2 The DO shall provide Members with general and oral health information and provide services to help Members make informed decisions about their oral health care needs. The DO shall encourage Members to take an active role in shared decision-making.

4.9.1.3 The DO shall promote personal responsibility through the use of incentives and care management. The DO shall reward Members

for activities and behaviors that promote good oral health, health literacy and Continuity of Care. The Department shall review and approve all reward activities proposed by the DO prior to their implementation.

4.9.2 Member Oral Health Education

4.9.2.1 The DO shall develop and initiate a Member oral health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their oral health care.

4.9.2.2 The DO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3 Member Incentive Programs

4.9.3.1 The DO shall develop at least one (1) Member Healthy Behavior Incentive Program, as further described within this Section 4.9.3 (Member Incentive Programs) of the Agreement. The DO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the DOs and Providers described in Section 4.13 (Alternative Payment Models) of this Agreement as appropriate.

4.9.3.2 For all Member Incentive Programs developed, the DO shall provide to participating Members that meet the criteria of the DO-designed program cash or other incentives that:

4.9.3.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.3.2.2 Do not, in a given fiscal year for any one (1) Member, exceed a total monetary value of two hundred and fifty dollars ($250.00).

4.9.3.3 The DO shall submit to the Department for review and approval all Member Incentive Program plan proposals prior to implementation.

4.9.3.4 Within the plan proposal, the DO shall include adequate assurances, as assessed by the Department, that:

4.9.3.4.1 The program meets the requirements of the Social Security Act; and

4.9.3.4.2 The program meets the criteria determined by the Department as described in Section 4.9.3.6 (Healthy Behavior Incentive Programs).

4.9.3.5 The DO shall report to the Department, at least annually, the results of any Member Incentive Programs in effect in the prior twelve (12) months, including the following metrics and those indicated by the Department, in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.9.3.5.1 The number of Members in the program's target population, as determined by the DO;

4.9.3.5.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.3.5.3 The total value of the incentive payments;

4.9.3.5.4 An analysis of the statistically relevant results of the program; and

4.9.3.5.5 Identification of goals and objectives for the next year informed by the data.

4.9.3.6 Healthy Behavior Incentive Programs

4.9.3.6.1 The DO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.3.6.1.1. Incorporate incentives for Members who complete a Dental Risk Assessment Screening, in compliance with Section 4.10.2 of this Agreement (Dental Risk Assessment Screening); and/or

4.9.3.6.1.2. Support smoking cessation in collaboration with the Department's Division of Public Health New Hampshire Tobacco Cessation Program., Quitline.

4.10 Care Coordination and Care Management

4.10.1 General Requirements

4.10.1.1 The DO shall be responsible for the management, coordination, and Continuity of Care for all Members for purposes of treating a Dental or Oral Disease or Condition, and shall develop and maintain policies and procedures to address this responsibility.

4.10.1.2 The DO shall implement Care Coordination and Care Management procedures to ensure that each Member has an ongoing source of care appropriate to their needs, and include

confidentiality, consent, or informed consent. [42 CFR 438.208(b)]

4.10.1.3 The DO shall provide the services described in this Section 4.10 (Care Coordination and Care Management) for all Members who need Care Coordination and Case Management services regardless of their acuity level.

4.10.1.4 The DO shall perform Care Coordination and Care Management functions.

4.10.1.5 Care Coordination means the interaction with established local community-based Providers to address the dental needs of the Member.

4.10.1.6 Care Management means direct contact with a Member focused on the provision of various aspects of the Member's dental needs that shall enable the Member in achieving the best oral health outcomes.

4.10.1.7 The DO shall implement Care Coordination and Care Management in order to achieve the following goals:

4.10.1.7.1 Improve care of Members;

4.10.1.7.2 Improve oral health outcomes;

4.10.1.7.3 Improve Continuity of Care;

4.10.1.7.4 Reduce utilization of unnecessary Emergency Services;

4.10.1.7.5 Reduce unmet resource needs (related to social determinants of health);

4.10.1.7.6 Decrease total costs of care; and

4.10.1.7.7 Increase Member satisfaction with their health care experience.

4.10.1.8 The DO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PDPs, dental specialists; the process shall include, but not be limited to, the designation of a Care Manager who shall be responsible for leading the coordination of care.

4.10.1.9 The DO shall also implement procedures to coordinate services the DO furnishes to the Member with the services the Member receives in Medicaid FFS and Medicaid MCOs, as applicable. [42 CFR 438.208(b)(2)(iii)].

4.10.1.10 The DO shall provide care coordination support for Members who require oral health services not covered by this Agreement as they may receive services through other appropriate Medicaid, commercial or government health insurance programs. In such

cases, the DO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii)-(iv).

4.10.2 Dental Risk Assessment Screening

4.10.2.1 The Dental Risk Assessment Screening process shall identify the need for Care Coordination and Care Management services and the need for clinical and non-clinical services including referrals to specialists and community resources.

4.10.2.2 The DO shall conduct a Dental Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of DO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs. [42 CFR 438.208(c)(1)]

4.10.2.3 The Dental Risk Assessment screening tool developed by the DO shall be submitted to the Department for review and approval, as part of the Readiness Review process, and annually thereafter.

4.10.2.4 The Dental Risk Assessment Screening may be conducted by telephone, in person, or through completion of the form in writing by the Member. The DO shall make at least three (3) reasonable attempts to contact a Member at the phone number most recently reported by the Member. [42 CFR 438.208(b)(3)]

4.10.2.5 Documentation of the three (3) attempts shall be included in the DO electronic Care Management record. Reasonable attempts shall occur on not less than three (3) different calendar days, at different hours of the day including day and evening hours and after business hours. If after the three (3) attempts are unsuccessful, the DO shall send a letter to the Member's last reported residential address with the Dental Risk Assessment form for completion.

4.10.2.6 The DO may secure a delegate or Subcontract to engage Members to complete the Health Risk Assessment screening either telephonically or in-person in an agency office/clinic setting, during a scheduled home visit or medical appointment.

4.10.2.7 All completed Dental Risk Assessments shall be shared with the Member's assigned PDP for inclusion in the Member's dental

record and within seven (7) calendar days of completing the screening.

4.10.2.8 The DO shall report the number of Members who received a Dental Risk Assessment, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10.2.9 The DO shall share with the Department the results of any identification and assessment of that Member's needs to prevent duplication of activities. [42 CFR 438.208(b)(4)]

4.10.2.10 The DO shall report to the Department its performance against Dental Risk Assessment requirements, as described in Exhibit O: Quality and Oversight Reporting Requirements.

4.10.2.11 The DO shall ensure Member Dental Risk Assessment completion for at least twenty-five percent (25%) of the plan's membership.

4.10.2.12 The evidence-based Dental Risk Assessment Screening tool shall identify, at minimum, the following information about Members:

4.10.2.12.1 Demographics;

4.10.2.12.2 Chronic and/or acute conditions;

4.10.2.12.3 Chronic pain;

4.10.2.12.4 Tobacco Cessation needs; and

4.10.2.12.5 Other factors or conditions about which the DO shall need to be aware to arrange available interventions for the Member.

4.10.3 Initial Oral Health Visits

4.10.3.1 For all Members the DO shall support the Member to arrange an initial oral health visit with their PDP, either previously identified or selected by the Member from a list of available PDPs.

4.10.3.2 The initial oral health visit shall include appropriate assessments for the purpose of developing an oral health wellness and care plan.

4.10.4 Priority Populations

4.10.4.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs:

4.10.4.1.1 Adults with Special Health Care Needs, meaning those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related

services of a type or amount beyond that usually expected for Members of similar age;

4.10.4.1.2 This includes, but is not limited to Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain; and

4.10.4.1.3 Members receiving services under HCBS waivers.

4.10.5 Dental Care Coordination/Case Management

4.10.5.1 The DO shall formally designate a Care Manager that is primarily responsible for coordinating Covered Services and referral services for the Member.

4.10.5.2 The DO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.10.5.3 Care Managers shall remain conflict-free which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.

4.10.6 Prescription Drug Monitoring Program

4.10.6.1 The DO shall include in its Provider agreements the requirement that prescribers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

4.10.6.2 The DO shall monitor harmful prescribing rates and, at the discretion of the Department, may be required to provide ongoing updates on those Participating Providers who have been identified as overprescribing.

4.11 Quality Management

4.11.1 General Provisions

4.11.1.1 The DO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.11.1.2 The DO shall work in collaboration with the Department, Members and Providers to actively improve the quality of care provided to

Members, consistent with the DO's quality improvement goals and all other requirements of the Agreement.

4.11.1.3 The DO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the DO's quality improvement activities.

4.11.1.4 The DO shall support and comply with the most current version of the Quality Strategy for the DMCM program.

4.11.1.5 The DO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.11.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.11.1.5.2 Foster data-driven decision-making;

4.11.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.11.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.11.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

4.11.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.11.2 Quality Assessment and Performance Improvement Program

4.11.2.1 The DO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.11.2.2 The DO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the DO's governing body, and submitted to the Department for its review annually.

4.11.2.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the QAPI Plan shall contain, at a minimum, the following elements:

4.11.2.3.1 A description of the DO's organization-wide QAPI program structure;

4.11.2.3.2 The DO's annual goals and objectives for all quality activities, including but not limited to:

4.11.2.3.2.1. DHHS-required PIPs;

4.11.2.3.2.2. DHHS-required quality performance data;

4.11.2.3.2.3. DHHS-required quality reports; and

4.11.2.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.11.2.3.2.5. Mechanisms to detect both underutilization and overutilization of services; [42 CFR 438.330(b)(3)]

4.11.2.3.2.6. Mechanisms to assess the quality and appropriateness of care for Members with Special Health Care Needs (as defined by the Department in the quality strategy) [42 CFR 438.330(b)(4)] in order to identify any Ongoing Special Conditions of a Member that require a course of treatment or regular care monitoring; and

4.11.2.3.2.7. Mechanisms to assess and address disparities in the quality of, and access to, health care, based on age, race, ethnicity, sex, primary language, and disability status (defined as whether the individual qualified for Medicaid on the basis of a disability). [42 CFR 438.340(b)(6)]

4.11.2.4 The DO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the DO shall ensure that the QAPI program structure:

4.11.2.4.1 Is organization-wide, with clear lines of accountability within the organization;

4.11.2.4.2 Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, clinicians, and non-clinicians;

4.11.2.4.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-

clinical programs or initiatives and measurement activities; and

4.11.2.4.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

4.11.2.5 If the DO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the DO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by the Department or its designee upon request, and a summary of any functions that have been delegated to Subcontractor(s) shall be indicated within the DO's QAPI Plan submitted to the Department annually.

4.11.2.6 Additional detail regarding the elements of the QAPI program and the format in which it should be submitted to the Department is provided in Exhibit O: Quality and Oversight Reporting Requirements.

4.11.2.7 Performance Improvement Projects

4.11.2.7.1 The DO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.11.2.7.2 Throughout the contract period, the DO shall conduct at least one (1) clinical PIP that meets the following criteria [42 CFR 438.330 (d)(1)]:

4.11.2.7.2.1. **At least (1) clinical PIP shall focus on improving quality performance in an area that the DO performed lower than the fiftieth (50th) percentile nationally, as otherwise indicated by the Department.

4.11.2.7.2.2. If the DO's individual experience is not reflected in the most recent EQRO technical report, the DO shall incorporate a PIP in an area that the DOs participating in the DMCM program at the time of the most recent EQRO technical report performed below the seventy-fifth (75th) percentile.

4.11.2.7.2.3. Should no quality measure have a lower than seventy-fifth (75th) percentile performance, the DO shall focus the PIP on one (1) of the areas for which its performance (or, in the

event the DO is not represented in the most recent report) was lowest.

4.11.2.7.3 The DO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.11.2.7.3.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.11.2.7.3.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.11.2.7.3.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.11.2.7.3.4. Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.11.2.7.4 Each PIP shall be approved by the Department and shall be completed in a reasonable time period so as to generally permit information on the success of PIPs in the aggregate to produce new information on quality of care every year.

4.11.2.7.5 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the DO shall include in its QAPI Plan, to be submitted to the Department annually, the status and results of each PIP conducted in the preceding twelve (12) months and any changes it plans to make to PIPs or other DO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.11.2.7.6 At the sole discretion of the Department, the PIPs may be delayed in the event of a public health emergency.

4.11.2.8 Member Experience of Care Survey

4.11.2.8.1 The DO shall be responsible for administering the Consumer Assessment of Healthcare Providers and

Systems (CAHPS) survey on an annual basis, including the CAHPS Dental Plan Survey (Adult Version or later version) as specified by the Department.

4.11.2.8.2 The DO shall obtain the Department approval of instruments prior to fielding the CAHPS surveys.

4.11.2.9 Quality Measures

4.11.2.9.1 The DO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with Exhibit O: Quality and Oversight Reporting Requirements [42 CFR 438.330(b)(2); 42 CFR 438.330(c)(1) and (2); 42 CFR 438.330(a)(2)]:

4.11.2.9.1.1. CMS Adult Core Set of Health Care Quality Measures for Medicaid, as specified by the Department;

4.11.2.9.1.2. The DO shall include supplemental Confidential Data in HEDIS measures identified in Exhibit O: Quality and Oversight Reporting Requirements for URAC or NCQA Accreditation and reporting through Interactive Confidential Data Submission System.

4.11.2.9.1.3. The DO shall report Member level Confidential Data for audited HEDIS measures as identified in Exhibit O: Quality and Oversight Reporting Requirements.

4.11.2.9.1.4. All available CAHPS measures and sections and additional supplemental questions defined by the Department;

4.11.2.9.1.5. Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)];

4.11.2.9.1.6. Select measures to monitor DO Member and Provider operational quality and Care Coordination efforts;

4.11.2.9.1.7. Select measures specified by the Department as priority measures for use in assessing and addressing local challenges to high-quality care and access;

4.11.2.9.1.8. Measures indicated by the Department as a requirement for fulfilling CMS waiver requirements; and

4.11.2.9.1.9. Measures indicated by the Department as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.11.2.9.2 The DO shall report all quality measures in accordance with Exhibit O: Quality and Oversight Reporting Requirements,

4.11.2.9.3 The DO shall submit all quality measures in the formats and schedule in Exhibit O: Quality and Oversight Reporting Requirements or otherwise identified by the Department. This includes, as determined by the Department:

4.11.2.9.3.1. Gain access to and utilize the NH Medicaid Quality Information System, including participating in any the Department-required training necessary;

4.11.2.9.3.2. Attend all meetings with the relevant DO subject matter experts to discuss specifications for Confidential Data indicated in Exhibit O: Quality and Oversight Reporting Requirements; and

4.11.2.9.3.3. Communicate and distribute all specifications and templates provided by the Department for measures in Exhibit O: Quality and Oversight Reporting Requirements to all DO subject matter experts involved in the production of Confidential Data in Exhibit O: Quality and Oversight Reporting Requirements.

4.11.2.9.4 If additional measures are added to the DQA or CMS measure sets, the DO shall include any such new measures in its reports to the Department.

4.11.2.9.5 For measures that are no longer part of the measure sets, the Department may, at its option, continue to require those measures; any changes to DO quality measure reporting requirements shall be communicated to DOs and documented within a

format similar to Exhibit O: Quality and Oversight Reporting Requirements.

4.11.2.9.6 The Department shall provide the DO with ninety (90) calendar days of notice of any additions or modifications to the measures and quality measure specifications.

4.11.2.9.7 At such time as the Department provides access to Medicare Confidential Data sets to the DO, the DO shall integrate expanded Medicare Confidential Data sets into its QAPI Plan and Care Coordination and Quality Programs, and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual Members. The DO shall:

4.11.2.9.7.1. Collect Confidential data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes and psycho-social outcomes resulting from Care Coordination of the dual Members;

4.11.2.9.7.2. Include Medicare Confidential Data in the Department quality reporting; and

4.11.2.9.7.3. Sign Confidential Data use Agreements and submit Confidential Data management plans, as required by the Department and CMS.

4.11.2.9.8 For failure to submit required reports and quality Confidential Data to the Department, the EQRO, and/or other Department-identified entities, the DO shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

4.11.3 Evaluation

4.11.3.1 The Department shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O: Quality and Oversight Reporting Requirements, in order to improve the performance of the DMCM program [42 CFR 438.66(c)(6)-(8)]:

4.11.3.1.1 Performance on required quality measures; and

4.11.3.1.2 The DO's QAPI Plan.

4.11.3.2 Starting in the second year of the Term of this Agreement, the DO shall include in its QAPI Plan a detailed report of the DO's

performance against its QAPI Plan throughout the duration of the preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.11.3.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.11.3.2.2 Performance trends on QAPI measures to assess performance in quality of care and quality of service (QOS) for all activities identified in the QAPI Plan;

4.11.3.2.3 An analysis of whether there have been any demonstrated improvements in the quality of care or service for all activities identified in the QAPI Plan;

4.11.3.2.4 An analysis of actions taken by the DO based on DO specific recommendations identified and other Quality Studies; and

4.11.3.2.5 An evaluation of the overall effectiveness of the DO's quality management program, including an analysis of barriers and recommendations for improvement.

4.11.3.2.6 The annual evaluation report, developed in accordance with Exhibit O: Quality and Oversight Reporting Requirements, shall be reviewed and approved by the DO's governing body and submitted to the Department for review [42 CFR 438.330(e)(2)].

4.11.3.2.7 The DO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate DO staff, as well as for posting on the web.

4.11.3.2.8 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the DO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to the Department and reviewed by the appropriate individuals within the organization.

4.11.4 Accountability for Quality Improvement

4.11.4.1 External Quality Review

4.11.4.1.1 The DO shall collaborate and cooperate fully with the Department's EQRO in the conducting of CMS EQR activities to identify opportunities for DO improvement [42 CFR 438.358].

4.11.4.1.2 Annually, the DO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

4.11.4.1.3 To facilitate this process, the DO shall supply information, including but not limited to:

4.11.4.1.4 Claims data,

4.11.4.1.5 Medical records,

4.11.4.1.6 Operational process details, and

4.11.4.1.7 Source code used to calculate performance measures to the EQRO as specified by the Department.

4.11.4.2 Quality Performance Withhold

4.11.4.2.1 As described in Section 5.4 (DMCM Withhold and Incentive Program), the DMCM program incorporates a withhold and incentive arrangement; the DO's performance in the program may be assessed on the basis of the DO's quality performance, as determined by the Department and indicated to the DO in periodic guidance.

4.12 Network Management

4.12.1 Network Requirements

4.12.1.1 The DO shall maintain and monitor a network of appropriate Participating Providers that is:

4.12.1.1.1 Supported by written agreements; and

4.12.1.1.2 Sufficient to provide adequate access to all services covered under this Agreement for all Members, including those with LEP or disabilities. [42 CFR 438.206(b)(1)]

4.12.1.2 In developing its network, the DO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.12.1.3 The DO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1); 42 CFR 455.101; Section 1932(d)(5) of the Act].

4.12.1.4 The DO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.12.1.5 The DO shall ensure its Participating Providers and Subcontractors meet all State and federal eligibility criteria,

reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.12.1.6 All Participating Providers shall be licensed and or certified in accordance with the laws of NH and not be under sanction or exclusion from any Medicare or Medicaid program. Participating Providers shall have a NH Medicaid identification number and unique National Provider Identifier (NPI) for every Provider type in accordance with 45 CFR 162, Subpart D.

4.12.1.7 The DO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Dental Conditions. [42 CFR 438.3(q)(1)]

4.12.1.8 The DO shall make arrangements with or referrals to, a sufficient number of dentists and dental specialists to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(3)]

4.12.1.9 The DO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.12.1.10 The DO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.12.2 Provider Enrollment

4.12.2.1 The DO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.12.2.2 The DO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by the Department for determination of the DO's network adequacy.

4.12.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.12.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the DO.

4.12.2.2.3 The DO shall confirm its provider network with the Department and post to its website no later than thirty (30) calendar days prior to the Member enrollment period.

4.12.2.3 The DO shall not discriminate relative to the participation, reimbursement, or indemnification of any Provider who is acting

within the scope of their license or certification under applicable State law, solely on the basis of that license or certification.

4.12.2.4 If the DO declines to include individual Provider or Provider groups in its network, the DO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.12.2.5 The requirements in 42 CFR 438.12(a) shall not be construed to:

4.12.2.5.1 Require the DO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.12.2.5.2 Preclude the DO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.12.2.5.3 Preclude the DO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)-(3)]

4.12.2.6 The DO shall ensure that Participating Providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with Provider disclosure, screening and enrollment requirements. [42 CFR 438.608(b); 42 CFR 455.100-107; 42 CFR 455.400-470]

4.12.3 Provider Screening, Credentialing and Re-Credentialing

4.12.3.1 The Department shall screen and enroll, and periodically revalidate all DO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

4.12.3.2 The DO shall rely on the Department's NH Medicaid providers' affirmative screening in accordance with federal requirements and the current NCQA Standards and Guidelines for the credentialing and re-credentialing of licensed independent Providers and Provider groups with whom it contracts or employs and who fall within its scope of authority and action. [42 CFR 455.410; 42 CFR 438.206)(b)(6)]

4.12.3.3 The DO shall utilize a universal provider Confidential Data source, at no charge to the provider, to reduce administrative requirements and streamline Confidential Data collection during the credentialing and re-credentialing process.

4.12.3.4 The DO shall demonstrate that its Participating Providers are credentialed, and shall comply with any additional Provider selection requirements established by the Department. [42 CFR

438.12(a)(2); 42 CFR 438.214(b)(1); 42 CFR 438.214(c); 42 CFR 438.214(e); 42 CFR 438.206(b)(6)]

4.12.3.5 The DO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the DO. [42 CFR 438.214(b)]

4.12.3.6 The DO shall submit for the Department review during the Readiness Review period, policies and procedures for onboarding Participating Providers, which shall include its subcontracted entity's policies and procedures.

4.12.3.7 For Providers not currently enrolled with NH Medicaid, the DO shall:

4.12.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with the Department;

4.12.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the DO receives notice of the Providers' desire to enroll with the DO;

4.12.3.7.3 Concurrently work through DO and the Department contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.12.3.7.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.12.3.7.4.1. Authorization of out-of-network services;

4.12.3.7.4.2. Single case agreements for an individual Member; and

4.12.3.7.4.3. If agreed upon by the prospective Participating Provider, an opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for the prospective Participating Provider's compliance with network requirements and practices.

4.12.3.8 The DO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.12.3.8.1 For PDPs, within thirty (30) calendar days of receipt of clean and complete credentialing applications;

4.12.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications; and

4.12.3.8.3 For any Provider submitting new or missing information for its credentialing application, the DO shall act upon the new or updated information within ten (10) business days.

4.12.3.9 The start time for the approval process begins when the DO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.12.3.10 A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.12.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.12.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the DO.

4.12.3.11 In the event the DO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Section 4.12.3 of the Agreement, the DO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in Section 4.13.3.8 above.

4.12.3.12 For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the DO's Provider enrollment records by the Department or its designee, the DO shall be fined in accordance with Exhibit N: Liquidated Damages Matrix.

4.12.3.13 Nothing in this Agreement shall be construed to require the DO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent the DO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.12.4 Provider Engagement

4.12.4.1 Provider Support Services

4.12.4.1.1 The DO shall develop and make available Provider support services which include, at a minimum:

4.12.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.12.4.1.1.2. A dedicated contact number to DO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday, except Department-approved holidays.

4.12.4.1.1.3. Ability for Providers to contact the DO regarding contracting, billing, and service provisions;

4.12.4.1.1.4. Training specific to person-centered Care Management, social determinants of health, and quality, privacy and confidentiality of certain conditions;

4.12.4.1.1.5. Training on billing and required documentation;

4.12.4.1.1.6. Assistance and/or guidance on identified opportunities for quality improvement;

4.12.4.1.1.7. Training to Providers in supporting and assisting Members in grievances and appeals, as noted in Section 4.4.1 (General Requirements); and

4.12.4.1.1.8. Training to Providers in DO claims submittal through the DO Provider portal.

4.12.4.1.2 The DO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.12.4.1.3 As part of this function, the DO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of Department-approved holidays. The Provider call center shall meet the following minimum standards,

which may be modified by the Department as necessary:

4.12.4.1.3.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

4.12.4.1.3.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds; and

4.12.4.1.3.3. Average speed of voicemail response: ninety percent (90%) of voicemail messages shall be responded to no later than the next business day (defined as Monday through Friday, with the exception of the Department-approved holidays).

4.12.4.1.4 The DO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.12.4.1.5 The DO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent dental condition.

4.12.4.1.6 The DO shall track and trend Provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate pursuant to Exhibit O: Quality and Oversight Reporting Requirements.

4.12.5 Provider Advisory Board

4.12.5.1 The DO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback on the DMCM program, and shall include representation from at least one (1) FQHC and at least one (1) RHC Program.

4.12.5.2 The Provider Advisory Board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to the Department upon request.

4.12.6 Provider Contract Requirements

4.12.6.1 General Provisions

4.12.6.1.1 The DO's agreement with dental providers shall:

4.12.6.1.1.1. Be in writing;

4.12.6.1.1.2. Be in compliance with applicable State and federal laws and regulations; and

4.12.6.1.1.3. Include the requirements in this Agreement.

4.12.6.1.2 The DO shall submit all model Provider contracts to the Department for review before execution of the Provider contracts with NH Medicaid Providers.

4.12.6.1.3 The DO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.12.6.1.4 The Department retains the right to reject or require changes to any Provider contract.

4.12.6.1.5 In all contracts with Participating Providers, the DO shall comply with requirements in 42 CFR 438.214, RSA 420-F, and RSA 420-J:4 which includes selection and retention of Participating Providers, credentialing and re-credentialing requirements, and non-discrimination.

4.12.6.1.6 In all contracts with Participating Providers, the DO shall follow a documented process for credentialing and re-credentialing of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(b)(2)]

4.12.6.1.7 The DO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, the ADA of 1990, 42 U.S.C. Section 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

4.12.6.1.8 The DO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.12.6.1.9 Within 90 days upon availability or in accordance with applicable law, the DO shall include in Provider contracts or DO provider office reference manual a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other DO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.12.6.1.10 The DO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the DO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.12.6.1.11 The DO may execute Participating Provider agreements, pending the outcome of screening and enrollment in NH Medicaid, of up to one hundred and twenty (120) calendar days duration but shall terminate a Participating Provider immediately upon notification from that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.12.6.1.12 The DO shall maintain a Provider relations presence in NH, as approved by the Department.

4.12.6.1.13 The DO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and all Participating Providers.

4.12.6.1.13.1. The Provider Manual shall be available and easily accessible on the web and updated no less than annually.

4.12.6.1.14 The DO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.12.6.1.15 The DO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.12.6.1.16 The DO shall provide ongoing training to new and existing Providers as required by the DO, or as required by the Department.

4.12.6.1.17 Provider materials shall comply with State and federal laws and the Department and NHID requirements.

4.12.6.1.18 The DO shall submit any Provider Manual(s) and Provider training materials to the Department for review during the Readiness Review period and sixty (60) calendar days prior to any substantive revisions.

4.12.6.1.19 Any revisions required by the Department shall be provided to the DO within thirty (30) calendar days.

4.12.6.1.20 The DO Provider Manual shall consist of, at a minimum:

4.12.6.1.20.1. A description of the DO's enrollment and credentialing process;

4.12.6.1.20.2. How to access DO Provider relations assistance;

4.12.6.1.20.3. A description of the DO's Case Management programs;

4.12.6.1.20.4. Detail on the DO's Prior Authorization processes;

4.12.6.1.20.5. A description of the Covered Services and Benefits for Members;

4.12.6.1.20.6. A description of Emergency Services coverage;

4.12.6.1.20.7. The DO Payment policies and processes; and

4.12.6.1.20.8. The DO Member and Provider Grievance System.

4.12.6.1.21 The DO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1)-(2)]

4.12.6.1.22 The DO shall keep participating dental providers and other Participating Providers informed and engaged in the QAPI program and related activities, as

described in Section 4.11.2 (Quality Assessment and Performance Improvement Program).

4.12.6.1.23 The DO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other DO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.13 (Alternative Payment Models).

4.12.7 Compliance with DO Policies and Procedures

4.12.7.1 The DO shall require Participating Providers to comply with all DO policies and procedures, including without limitation:

4.12.7.1.1 The Provider Manual;

4.12.7.1.2 The DO's Compliance Program;

4.12.7.1.3 The DO's Grievance and Appeals and Provider Appeal Processes;

4.12.7.1.4 Clean Claims and Prompt Payment requirements;

4.12.7.1.5 ADA requirements;

4.12.7.1.6 Clinical Practice Guidelines; and

4.12.7.1.7 Prior Authorization requirements.

4.12.7.2 The DO shall inform Participating Providers, at the time they enter into a contract with the DO, about the following requirements, as described in Section 4.4 (Member Grievances and Appeals), of:

4.12.7.2.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.12.7.2.2 The Member's right to file grievances and appeals and the requirements and timeframe for filing;

4.12.7.2.3 The availability of assistance to the Member with filing grievances and appeals; [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A)-(C)]

4.12.7.2.4 The Member's right to request a State fair hearing after the DO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]

4.12.7.2.5 The Member's right to request continuation of benefits that the DO seeks to reduce or terminate during an appeal of State fair hearing filing, if filed within the permissible timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or State fair hearing is pending if the final decision is adverse to the

Member. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)]

4.12.8 Member Hold Harmless

4.12.8.1 The Provider shall agree to hold the Member harmless for the costs of Medically Necessary Covered Services except for applicable Cost Sharing and patient liability amounts indicated by the Department in this Agreement [RSA 420-J:8.I.(a)]

4.12.9 Requirement to Return Overpayment

4.12.9.1 The Provider shall comply with the Affordable Care Act and the DO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the DO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.12.9.2 Overpayments that are not returned within sixty (60) calendar days from the date the Overpayment was identified may be a violation of State or federal law.

4.12.10 Background Screening

4.12.10.1 The Provider shall screen its staff prior to contracting with the DO and monthly thereafter against the Exclusion Lists.

4.12.10.2 In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the DO within three (3) business days of learning that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the DO.

4.12.11 Books and Records Access

4.12.11.1 The selected Vendor(s) must maintain the following records during the resulting contract term where appropriate and as prescribed by the Department:

4.12.11.1.1 Books, records, documents and other electronic or physical Confidential Data evidencing and reflecting all costs and other expenses incurred by the selected Vendor(s) in the performance of the resulting contract(s), and all income received or collected by the selected Vendor(s).

4.12.11.1.2 All records must 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.

4.12.11.1.3 Statistical, enrollment, attendance or visit records for each recipient of services, which 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.

4.12.11.2 Medical records on each patient/recipient of services.

4.12.11.3 During the term of the resulting contract(s) 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 resulting contract(s) for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the resulting contract(s) and upon payment of the price limitation hereunder, the selected Vendor(s) and all the obligations of the parties hereunder (except such obligations as, by the terms of the resulting Contract(s) are to be performed after the end of the term of the contract(s) and/or survive the termination of the Contract(s)) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the selected Vendor(s) 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 selected Vendor(s).

4.12.11.4 The DO shall require that all Participating Providers comply with DO and State policies related to transition of care policies set forth in this Agreement and in the DO's Member Handbook.

4.12.12 Anti-Gag Clause

4.12.12.1 The DO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient:

4.12.12.2 For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.12.12.3 For any information the Member needs in order to decide among all relevant treatment options;

4.12.12.4 For the risks, benefits, and consequences of treatment or non-treatment; or

4.12.12.5 For the Member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions. [Section1932(b) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.12.12.6 The DO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.4.5 (Expedited Appeal). [42 CFR 438.410(b)]

4.12.13 Anti-Discrimination

4.12.13.1 The DO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification or against any Provider that serves high- risk populations or specializes in conditions that require costly treatment.

4.12.13.2 This paragraph shall not be construed to prohibit an organization from:

4.12.13.2.1 Including Providers only to the extent necessary to meet the needs of the organization's Members;

4.12.13.2.2 Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization; or

4.12.13.2.3 Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.12.13.3 If the DO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

4.12.13.4 In all contracts with Participating Providers, the DO's Provider selection policies and procedures shall not discriminate against particular Providers that service high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.12(a)(2); 42 CFR 438.214(c)]

4.12.14 Access and Availability

4.12.14.1 The DO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those

described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.3.4 (Additional Provider Standards).

4.12.15 Payment Models

4.12.15.1 The DO shall negotiate rates with Providers in accordance with Section 4.14 (Provider Payments) of this Agreement, unless otherwise specified by the Department.

4.12.15.2 The DO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the DO, including for Providers paid by an DO Subcontractor.

4.12.15.3 The DO Provider contract shall detail how the DO shall meet its reporting obligations to Providers as described within this Agreement.

4.12.16 Non-Exclusivity

4.12.16.1 The DO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the DO as a condition for network participation.

4.12.17 Proof of Membership

4.12.17.1 The DO Provider contract shall require Providers in the DO network to accept the Member's Medicaid identification card as proof of enrollment in the DO until the Member receives his/her DO identification card.

4.12.18 Other Provisions

4.12.18.1 The DO's Provider contract shall also contain:

4.12.18.1.1 All required activities and obligations of the Provider and related reporting responsibilities;

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

4.12.18.1.3 A requirement to notify the DO within one (1) business day of being cited by any State or federal regulatory authority.

4.12.19 Reporting

4.12.19.1 The DO shall comply with and complete all reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements, this Agreement, and as further specified by the Department.

4.12.19.2 The DO shall implement and maintain arrangements or procedures for notification to the Department when it receives

information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the DO. [42 CFR 438.608(a)(4)]

4.12.19.3 The DO shall notify the Department within seven (7) calendar days of any significant changes to the Participating Provider network.

4.12.19.4 As part of the notice, the DO shall submit a Transition Plan to the Department to address continued Member access to needed service and how the DO shall maintain compliance with its contractual obligations for Member access to needed services.

4.12.19.5 A significant change is defined as:

4.12.19.5.1 A decrease in the total number of PDPs by more than five percent (5%);

4.12.19.5.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and

4.12.19.5.3 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

4.12.19.6 The DO shall provide to the Department and/or the Department's Subcontractors Provider participation reports on an annual basis or as otherwise determined by the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements; these may include but are not limited to Provider participation by geographic location, categories of service, Provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to dental care.

4.12.20 Health Plan Accreditation

4.12.20.1 The DO and or its Subcontractor shall achieve applicable accreditation from URAC.

4.12.20.2 If the DO has previously achieved URAC Health Plan Accreditation prior to the Program Start Date, the DO shall maintain its health plan accreditation status throughout the period of the Agreement.

4.12.20.3 If the DO is newly participating in the DMCM program, the DO shall achieve applicable accreditation from URAC, within eighteen (18) months of the Program Start Date.

4.12.20.4 To demonstrate its progress toward meeting this requirement, the newly participating DO shall complete the following milestones:

4.12.20.4.1 Within sixty (60) calendar days of the Program Start Date, the DO shall notify DHHS of the initiation of the process to obtain URAC Health Plan Accreditation; and

4.12.20.4.2 Within thirty (30) calendar days of the date of the URAC Health Plan Accreditation survey on-site review, the DO shall notify DHHS of the date of the scheduled on-site review.

4.12.20.5 The DO shall inform DHHS of whether it has been accredited by any private independent accrediting entity, in addition to URAC Health Plan Accreditation.

4.12.20.6 The DO shall authorize URAC, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to DHHS, including [42 CFR 438.332(a)]:

4.12.20.6.1 Accreditation status, survey type, and level (as applicable);

4.12.20.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.12.20.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1)-(3)]

4.12.20.7 To avoid duplication of mandatory activities with accreditation reviews, DHHS may indicate in its quality strategy the accreditation review standards that are comparable to the standards established through federal EQR protocols and that DHHS shall consider met on the basis of the DO's achievement of URAC Health Plan Accreditation. [42 CFR 438.360]

4.12.20.8 A DO going through a URAC renewal survey shall complete the full Accreditation review of all URAC Health Plan Accreditation Standards.

4.12.20.9 During the renewal survey, the DO shall:

4.12.20.9.1 Request from URAC the full review of all URAC Health Plan Accreditation Standards and cannot participate in the URAC renewal survey option that allows attestation for certain requirements; and

4.12.20.9.2 Submit to DHHS a written confirmation from URAC stating that the renewal survey for the DO will be for all URAC Health Plan Accreditation Standards without attestation.

4.12.21 The DO shall maintain credentialing and re-credentialing accreditation with either NCQA throughout the period of the Agreement.

4.13 Alternative Payment Models

4.13.1 The Department has implemented strategies to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to the Department, Providers, and the stakeholder community.

4.13.2 In developing and refining its APM strategy, the Department relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to:

4.13.2.1 Clearly and effectively communicate the Department requirements through use of the defined categories established by HCP-LAN;

4.13.2.2 Encourage the DO to align DMCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.13.2.3 Provide an established framework for monitoring DO performance on APMs.

4.13.3 Prior to and/or over the course of the Term of this Agreement, the Department shall develop the DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the DO is subject under this Agreement.

4.13.4 Within the guidance parameters established and issued by the Department and subject to Department approval, the DO shall have flexibility to design Qualifying APMs) consistent with the Department Medicaid APM strategy and in conformance with CMS guidance.

4.13.5 The DO shall support the Department in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs, sharing Confidential Data and analysis, and other activities as specified by the Department.

4.13.6 For any APMs that direct the DO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the DO and the Department shall ensure that it:

4.13.6.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.13.6.2 Uses a common set of performance measures across all the Providers;

4.13.6.3 Does not set the amount or frequency of the expenditures; and

4.13.6.4 Does not permit the Department to recoup any unspent funds allocated for these arrangements from the DO. [42 CFR 438.6(c)]

4.13.7 DO Incentives and Penalties for APM Implementation

4.13.7.1 The DO shall include, through APMs and other means, Provider alignment incentives to leverage the combined the Department, DO, and providers to achieve the purpose of the incentives.

4.13.7.2 DOs shall be subject to incentives, at the Department's sole discretion, and/or penalties to achieve improved performance, use of the DMCM Withhold and Incentive Program, and other incentives.

4.13.8 Qualifying Alternative Payment Models

4.13.8.1 A Qualifying APM is a payment approach approved by the Department as consistent with the standards specified in this Section 4.13.8 (Qualifying Alternative Payment Models) and the Department's Medicaid APM Strategy.

4.13.8.2 At minimum, a Qualifying APM shall meet the requirements of the HCP-LAN APM framework Category 2B based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions.

4.13.8.3 As indicated in the HCP-LAN APM framework white paper, Category 2B.

4.13.8.4 HCP-LAN Categories 2C, 3A, and 3B shall all also be considered Qualifying APMs, and the DO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

4.13.8.5 The Department shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.13.14 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to the Department, the HCP-LAN Category to which the DO's APM(s) is/are aligned.

4.13.8.6 Under no circumstances shall the Department consider a payment methodology that takes cost of care into account without also considering quality as a Qualifying APM.

4.13.9 Accommodations for Other Providers

4.13.9.1 The DO may develop Qualifying APM models appropriate for small Providers, and/or Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy.

4.13.9.2 For example, the DO may propose to the Department models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.13.10 DO Alternative Payment Model Implementation Plan

4.13.10.1 The DO shall submit to the Department for review and approval an APM Implementation Plan in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.13.10.2 The APM Implementation Plan shall meet the requirements of this section and of any subsequent guidance issued as part of the Department Medicaid APM Strategy.

4.13.10.3 Additional details on the timing, format, and required contents of the DO APM Implementation Plan shall be specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements and/or through additional guidance.

4.13.11 Alternative Payment Model Transparency

4.13.11.1 The DO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the DO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.13.11 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the model among the DO, Providers, and Members.

4.13.12 Provider Engagement and Support

4.13.12.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the DO shall use to assess and advance such readiness over time.

4.13.12.2 The APM Implementation Plan shall outline in detail what strategies the DO plans to use, such as, meetings with Providers, as appropriate, and the frequency of such meetings, the provision of technical support, and a Confidential Data sharing strategy for Providers reflecting the transparency, reporting and Confidential Data sharing obligations herein and in the Department Medicaid APM Strategy.

4.13.12.3 The DO APM Implementation Plan shall ensure Providers, as appropriate, are supported by Confidential Data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance Confidential Data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.

4.13.12.4 DO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.13.12.5 Implementation Approach

4.13.12.6 The DO shall include in the APM Implementation Plan a detailed description of the steps the DO shall take to advance its APM Implementation Plan:

4.13.12.6.1 In advance of the Program Start Date;

4.13.12.6.2 During the first year of this Agreement; and

4.13.12.6.3 Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

4.13.12.7 The APM Implementation Plan shall include the DO's plan for providing the necessary Confidential Data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations included in the APM, including how the DO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.13.12.8 The DO shall provide Confidential Data to Providers, as appropriate, that describe the retrospective cost and utilization patterns for Members, which shall inform the strategy and design of APMs.

4.13.12.9 For each APM entered into, the DO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM.

4.13.12.10 In addition, the DO shall provide Member and Provider level Confidential Data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.13.12.11 The APM Implementation Plan shall describe in example form to the Department the level of information that shall be given to Providers that enter into APM Agreements with the DO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.13.12.12 The information provided shall be consistent with the requirements outlined under Section 4.13.13 (Alternative Payment Model Transparency and Reporting Requirements). The DOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.13.13 Alternative Payment Model Transparency and Reporting Requirements

4.13.14 Transparency

4.13.14.1 In the DO APM Implementation Plan, the DO shall provide to the Department for each APM, as applicable, the following information at a minimum:

4.13.14.1.1 The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.13.14.1.2 The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, and the attachment points for cost targets;

4.13.14.1.3 The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that shall be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

4.13.14.1.4 The frequency at which the DO shall regularly report cost and quality Confidential Data related to APM performance to Providers, and the information that shall be included in each report.

4.13.15 Additional information may be required by the Department in supplemental guidance. All information provided to the Department shall be made available to Providers eligible to participate in or already participating in the APM unless the DO requests and receives the Department approval for specified information not to be made available.

4.13.16 Standardized Assessment of Alternative Payment Model Usage

4.13.16.1 The DO shall complete, attest to the contents of, and submit to the Department the HCP-LAN APM assessment in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.13.16.2 Thereafter, the DO shall complete, attest to the contents of, and submit to the Department the HCP-LAN APM assessment in accordance with Exhibit O: Quality and Oversight Reporting Requirements and/or the Department Medicaid APM Strategy.

4.13.16.3 If the DO reaches an agreement with the Department that its implementation of the required APM model(s) may be delayed, the DO shall comply with all terms set forth by the Department for the additional and/or alternative timing of the DO's submission of the HCP-LAN APM assessment.

4.13.17 Additional Reporting on Alternative Payment Model Outcomes

4.13.17.1 The DO shall provide additional information required by the Department in Exhibit O: Quality and Oversight Reporting

Requirements or other Department guidance on the type, usage, effectiveness and outcomes of its APMs.

4.13.18 Development Period for DO Implementation

4.13.18.1 Consistent with the requirements for new DOs, outlined in Section 4.13.8 (Qualifying Alternative Payment Models) above, the Department acknowledges that DOs may require time to advance their DO Implementation Plan. The Department shall provide additional detail, in its Medicaid APM Strategy, that describes how DOs should expect to advance use of APMs over time.

4.13.19 Emerging State Medicaid and Public Health Priorities

4.13.19.1 The DO shall address priorities identified by the Department in the Medicaid APM Plan or related guidance.

4.13.19.2 If the Department adds or modifies priorities after the Program Start Date, the DO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of it APM Implementation Plan.

4.13.20 Dental Provider Incentive Plans

4.13.20.1 The DO shall submit all Dental Provider Incentive Plans to the Department for review as part of its APM Implementation Plan or upon development of Dental Provider Incentive Plans that are separate from the DO's APM Implementation Plan.

4.13.20.2 The DO shall not implement Dental Provider Incentive Plans until they have been reviewed and approved by the Department.

4.13.20.3 Any Dental Provider Incentive Plan, including those detailed within the DO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "DO," "the Department," and "Members," respectively. These include that:

4.13.20.3.1 The DO may only operate a Dental Provider Incentive Plan if no specific payment can be made directly or indirectly under a Dental Provider Incentive Plan to a dentist or Dental Provider Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.13.20.3.2 If the DO puts a dentist or Dental Provider Group at substantial financial risk for services not provided by the dentist or Dental Provider Group, the DO shall ensure that the dentist or Dental Provider Group has adequate stop-loss protection. [Section

1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.13.20.4 The DO shall submit to the Department annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously reviewed) Dental Provider Incentive Plans, as described in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.20.5 Annual Dental Provider Incentive Plan reports shall provide assurance satisfactory to the Department that the requirements of 42 CFR 438.208 are met. The DO shall, upon request, provide additional detail in response to any Department request to understand the terms of Provider payment arrangements.

4.13.20.6 The DO shall provide to Members upon request the following information:

4.13.20.6.1 Whether the DO uses a Dental Provider Incentive Plan that affects the use of referral services;

4.13.20.6.2 The type of incentive arrangement; and

4.13.20.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.14 Provider Payments

4.14.1 General Requirements

4.14.1.1 The DO shall not, directly or indirectly, make payment to a dentist or Dental Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.14.1.2 The DO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) [Section 1903 of the Social Security Act]:

4.14.1.2.1 Furnished under the DO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

4.14.1.2.2 Furnished at the medical direction or on the prescription of a dentist, during the period when such dentist is excluded from participation under Title V, XVIII, or XX of the Social Security Act or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act when the person knew or had

any reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

4.14.1.2.3 Furnished by an individual or entity to whom the State has suspended payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.

4.14.1.2.4 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A-C) of the Social Security Act; section 1903(i)(16-17) of the Social Security Act]

4.14.1.3 No payment shall be made to a Participating Provider other than by the DO for services covered under the Agreement between the Department and the DO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR Chapter IV, or when the Department makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan, or have been otherwise approved by CMS. [42 CFR 438.60]

4.14.1.4 The DO shall reimburse Providers based on the Current Dental Terminology (CDT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CDT code or other billing code has been provided by the Department, the DO shall contact the Department and obtain a CDT code and shall retroactively reimburse claims based on the CDT effective date as a result of the CDT annual updates.

4.14.1.4.1 For DO provider contracts based on NH Medicaid fee schedules, the DO shall reimburse providers for annual and periodic fee schedule adjustments in accordance with their effective dates.

4.14.1.5 The DO shall permit Providers up to three hundred sixty five (365) calendar days to submit a timely claim. The DO shall establish reasonable policies that allow for good cause exceptions to the three hundred sixty five (365) calendar day timeframe.

4.14.1.6 Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.14.1.6.1 A Member providing the wrong Medicaid identification number;

4.14.1.6.2 Natural disasters; or

4.14.1.6.3 Failed information technology systems.

4.14.1.7 The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.14.1.8 Within the first one hundred and eighty (180) calendar days of the Program Start Date, the Department has discretion to direct DOs to extend the three hundred sixty five (365) calendar days on case by case basis.

4.14.1.9 The DO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

4.14.1.10 The DO shall collect Confidential Data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and Care Coordination efforts. [42 CFR 438.242(b)(3)(iii)]

4.14.1.11 The DO shall implement and maintain arrangements or procedures for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to the Department. [42 CFR 438.608(a)(2)]

4.14.1.12 Hospital-Acquired and Provider Preventable Conditions

4.14.1.12.1 The DO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider-Preventable Conditions.

4.14.1.12.2 The DO shall not make payments to a Provider for a Provider-Preventable Condition that meets the following criteria:

4.14.1.12.2.1. Is identified in the Medicaid State Plan;

4.14.1.12.2.2. Has been found based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

4.14.1.12.2.3. Has a negative consequence for the Member;

4.14.1.12.2.4. Is auditable; and

4.14.1.12.2.5. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.3(g); 42 CFR 438.6(a)(12)(i); 42 CFR 447.26(b)]

4.14.1.12.3 The DO shall require all Providers to report Provider-Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made, in accordance with Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.14.2 Payment Standards

4.14.2.1 The DO shall reimburse all Dental Providers for covered dental services at least at NH Medicaid fee schedule rates.

4.14.2.2 Any directed payments shall be described in the program's actuarial certification for the rating period.

4.14.3 Payment Standards for Indian Health Care Providers

4.14.3.1 The DO shall pay IHCPs, whether Participating Providers or not, for Covered Services provided to American Indian Members who are eligible to receive services at a negotiated rate between the DO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the DO would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i-ii)]

4.14.3.2 For contracts involving IHCPs, the DO shall meet the requirements of FFS timely payment for all I/T/U Providers in its network, including the paying of ninety-five percent (95%) of all Clean Claims within thirty (30) calendar days of the date of receipt; and paying ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of the date of receipt. [42 CFR 438.14(b)(2)(iii); ARRA 5006(d); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001)]

4.14.3.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the DO shall be paid an amount equal to the amount the DO would pay an FQHC that is a Participating Provider but is not an IHCP, including any supplemental payment from the Department to make up the difference between the amount the DO pays and what the IIHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.14.3.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an DO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.14.3.5 When the amount the IHCP receives from the DO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the Department shall make a supplemental payment to the IHCP to make up the difference between the amount the DO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.15 Readiness Requirements Prior to Operations

4.15.1 General Requirements

4.15.1.1 Prior to the Program Start Date, the DO shall demonstrate to the Department's satisfaction its operational readiness and its ability to provide Covered Services to Members at the start of this Agreement in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 437.66(d)(1)(i).

4.15.1.2 The readiness review requirements shall apply to all DOs regardless of whether they have previously contracted with the Department. [42 CFR 438.66(d)(1)(ii)]

4.15.1.3 The DO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by the Department.

4.15.1.4 The readiness review requirements shall apply to all DOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.15.1.5 In order to demonstrate its readiness, the DO shall cooperate in the Readiness Review conducted by the Department.

4.15.1.6 If the DO is unable to demonstrate its ability to meet the requirements of this Agreement, as determined solely by the Department, within the timeframes determined solely by the Department, then the Department shall have the right to terminate this Agreement in accordance with Section 7.1 (Termination for Cause).

4.15.1.7 The DO shall participate in all the Department trainings in preparation for implementation of the Agreement.

4.15.2 Emergency Response Plan/Disaster Recovery Plan

4.15.2.1 The DO shall submit an Emergency Response Plan to the Department for review prior to the Program Start Date, in compliance with the Exhibit Q IT Requirements Workbook.

4.15.2.2 The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.15.2.2.1 Staff and Provider training;

4.15.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.15.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.15.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.15.2.2.5 Plans to ensure continuity of services to Providers and Members;

4.15.2.2.6 How the DO shall coordinate with and support the Department ; and

4.15.2.2.7 How the plan shall be tested, updated and maintained.

4.15.2.3 On an annual basis, or as otherwise specified in Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, the DO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.16 Managed Care Information System

4.16.1 System Functionality

4.16.1.1 The DO shall have a comprehensive, automated, and integrated MCIS that:

4.16.1.1.1 Complies with the Exhibit Q, IT Requirements Workbook;

4.16.1.1.2 Collects, analyzes, integrates, and reports Confidential Data; [42 CFR 438.242(a)];

4.16.1.1.3 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.16.1.1.4 Collects and maintains Confidential Data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an Encounter Confidential Data system [42 CFR 438.242(b)(2)];

4.16.1.1.5 Is capable of meeting the requirements listed throughout this Agreement; and

4.16.1.1.6 Is capable of providing all of the Confidential Data and information necessary for the Department to meet State and federal Medicaid reporting and information regulations.

4.16.1.2 The DO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The DO shall provide for:

4.16.1.2.1 Collection and maintenance of sufficient Member Encounter Confidential Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.16.1.2.2 Submission of Member Encounter Confidential Data to the Department at the frequency and level of detail specified by CMS and by the Department;

4.16.1.2.3 Submission of all Member Encounter Confidential Data that NH is required to report to CMS; and

4.16.1.2.4 Submission of Member Encounter Confidential Data to the Department in standardized ASC X12N 837 format, and other proprietary file layouts as defined by the Department. [42 CFR 438.242(c)(1-4); 42 CFR 438.818]

4.16.1.3 All Subcontractors shall meet the same standards, as described in this Section 4.16 (Managed Care Information System) of the Agreement, as the DO. The DO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.16.1.4 The DO MCIS shall include, but not be limited to:

4.16.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.16.1.4.2 Management of Provider Enrollment and Credentialing;

4.16.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.16.1.4.4 Eligibility Verification;

4.16.1.4.5 Encounter Data;

4.16.1.4.6 Reference File Updates;

4.16.1.4.7 Service Authorization Tracking, Support and Management;

4.16.1.4.8 Third Party Coverage and Cost Avoidance Management;

4.16.1.4.9 Financial Transactions Management and Reporting;

4.16.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);

4.16.1.4.11 Reporting (Ah hoc and Pre-Defined/Scheduled and On-Demand);

4.16.1.4.12 Call Center Management;

4.16.1.4.13 Claims Adjudication;

4.16.1.4.14 Claims Payments; and

4.16.1.4.15 QOS metrics.

4.16.1.5 Specific functionality related to the above shall include, but is not limited to, the following:

4.16.1.5.1 The MCIS Membership management system shall have the capability to receive, update, and maintain NH's Membership files consistent with information provided by the Department;

4.16.1.5.2 The MCIS shall have the capability to provide daily updates of Membership information to subcontractors or Providers with responsibility for processing claims or authorizing services based on Membership information;

4.16.1.5.3 The MCIS's Provider file shall be maintained with detailed information on each Provider sufficient to support Provider enrollment and payment and also meet the Department's reporting and Encounter Confidential Data requirements;

4.16.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;

4.16.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

4.16.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all Department reporting and encounter requirements;

4.16.1.5.7 The MCIS's credentialing system shall have the capability to store and report on Provider specific Confidential Data sufficient to meet the Provider credentialing requirements, Quality Management, and Utilization Management Program Requirements;

4.16.1.5.8 The MCIS shall be bi-directionally linked to the other operational systems maintained by the Department, in order to ensure that Confidential Data captured in encounter records accurately matches Confidential Data in Member, Provider, claims and authorization files, and in order to enable Encounter Confidential Data to be utilized for Member profiling, Provider profiling, claims validation, fraud, waste and abuse monitoring activities, quality improvement, and any other research and reporting purposes defined by the Department; and

4.16.1.5.9 The Encounter Confidential Data system shall have a mechanism in place to receive, process, and store the required data.

4.16.1.6 The DO system shall be compliant with the requirements NPI, and transaction processing, including being able to process electronic Confidential Data interchange (EDI) transactions in the ASC 5010 format.

4.16.1.7 The DO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect Confidential Data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act. [42 CFR 438.242(b)(1)]

4.16.1.8 MCIS capability shall include, but not be limited to the following:

4.16.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.16.1.8.2 Documented scheduled down time and maintenance windows, as agreed upon by DHHS, for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

4.16.1.8.3 The Department on-line web access to applications and Confidential Data required by the State to utilize agreed upon workflows, processes, and procedures (reviewed by the Department) to access, analyze, or utilize Confidential Data captured in the DO

system(s) and to perform appropriate reporting and operational activities;

4.16.1.8.4 The Department access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals; and

4.16.1.8.5 Documented instructions and user manuals for each component.

4.16.2 Managed Care Information System Up-Time

4.16.2.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by the Department. The maintenance period shall not exceed four (4) consecutive hours without prior the Department approval.

4.16.2.2 DO shall provide redundant telecommunication backups and ensure that interrupted transmissions shall result in immediate failover to redundant communications path as well as guarantee Confidential Data transmission is complete, accurate and fully synchronized with operational systems.

4.16.3 Information System Confidential Data Transfer

4.16.3.1 Effective communication between the DO and the Department requires secure, accurate, complete, and auditable transfer of Confidential Data to/from the DO and the Department Confidential Data management information systems. Elements of Confidential Data transfer requirements between the DO and the Department management information systems shall include, but not be limited to:

4.16.3.1.1 Department read access to all DMCM Confidential Data in reporting databases where Confidential Data is stored, which includes all tools required to access the Confidential Data at no additional cost to the Department;

4.16.3.1.2 Exchanges of Confidential Data between the DO and the Department in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the Confidential Data source and target;

4.16.3.1.3 Secure (encrypted) communication protocols to provide timely notification of any Confidential Data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to

identify and resolve issues according to the timelines set forth by the State;

4.16.3.1.4 Collaborative relationships with the Department, its MMIS fiscal agent, and other interfacing entities to effectively implement the requisite exchanges of Confidential Data necessary to support the requirements of this Agreement;

4.16.3.1.5 DO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.16.3.1.6 Utilization of Confidential Data extract, transformation, and load (ETL) or similar methods for Confidential Data conversion and Confidential Data interface handling that, to the maximum extent possible, automate the ETL processes, and provide for source to target or source to specification mappings;

4.16.3.1.7 Mechanisms to support the electronic reconciliation of all Confidential Data extracts to source tables to validate the integrity of Confidential Data extracts; and

4.16.3.1.8 A given day's Confidential Data transmissions, as specified in this Section 4.16.3 (Information System Confidential Data Transfer) of the Agreement, are to be downloaded to the Department according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions shall be included in the next batch transmission.

4.16.3.2 The DO shall designate a single point of contact to coordinate Confidential Data transfer issues with the Department.

4.16.3.3 The Department shall provide for a Centralized Electronic Repository, providing for secure access to authorized DO and the Department staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.16.3.4 Confidential Data transmissions from the Department to the DO shall include, but not be limited to the following:

4.16.3.4.1 Provider Extract (Daily);

4.16.3.4.2 Recipient Eligibility Extract (Daily);

4.16.3.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.16.3.4.4 Dental Authorizations (Daily);

4.16.3.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.16.3.4.6 Claims History (Bi-Weekly); and

4.16.3.4.7 Capitation Payment Confidential Data (Monthly).

4.16.3.5 Confidential Data transmissions from the DO to the Department shall include, but not be limited to the following:

4.16.3.5.1 Member Demographic changes (Daily);

4.16.3.5.2 Member Dental Provider Selection (Daily);

4.16.3.5.3 DO Provider Network Confidential Data (Daily);

4.16.3.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.16.3.5.5 Member Encounter Confidential Data including paid, denied, adjustment transactions by pay period (Weekly);

4.16.3.5.6 Financial Transaction Confidential Data (Weekly); and

4.16.3.5.7 Updates to Third Party Coverage Confidential Data (Weekly).

4.16.3.6 The DO shall provide Department staff with access to timely and complete Confidential Data and shall meet the following requirements:

4.16.3.6.1 All exchanges of Confidential Data between the DO and the Department shall be in a format, file record layout, and scheduled as prescribed by the Department;

4.16.3.6.2 The DO shall work collaboratively with the Department, the Department's MMIS fiscal agent, the NH Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of Confidential Data necessary to support the requirements of this Agreement;

4.16.3.6.3 The DO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide the Department with a network diagram depicting the DO's communications infrastructure, including but not limited to connectivity between the Department and the DO, including any DO/Subcontractor locations supporting the NH program;

4.16.3.6.4 The DO shall provide support to the Department and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data; and

4.16.3.6.5 The DO shall be responsible for correcting Confidential Data extract errors in a timeline set forth by the Department as outlined within this Agreement.

4.16.4 Systems Operation and Support

4.16.4.1 Systems operations and support shall include, but not be limited to:

4.16.4.1.1 On-call procedures and contacts;

4.16.4.1.2 Job scheduling and failure notification documentation;

4.16.4.1.3 Secure (encrypted) Confidential Data transmission and storage methodology;

4.16.4.1.4 Interface acknowledgements and error reporting;

4.16.4.1.5 Technical issue escalation procedures;

4.16.4.1.6 Business and Member notification;

4.16.4.1.7 Change control management;

4.16.4.1.8 Assistance with UAT and implementation coordination;

4.16.4.1.9 Documented Confidential Data interface specifications – Confidential Data imported and extracts exported including database mapping specifications;

4.16.4.1.10 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.16.4.1.11 Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

4.16.4.2 The DO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.16.4.2.1 Network diagram that fully defines the topology of the DO's network;

4.16.4.2.2 DHHS/DO connectivity;

4.16.4.2.3 Any DO/Subcontractor locations requiring MCIS access/support; and

4.16.4.2.4 Web access for the Department staff, Providers and recipients.

4.16.5 Ownership and Access to Systems and Data

4.16.5.1 The DO shall make available to the Department and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.16.5.2 Confidential Data accumulated, as part of the DMCM program shall remain the property of the State.

4.16.5.3 The DO shall provide the Department with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports, as well as the ability to respond promptly to ad-hoc requests to support the Department Confidential Data and information needs.

4.16.5.4 The Department acknowledges the DO's obligations to appropriately protect Confidential Data and system performance, and the parties agree to work together to ensure the Department information needs can be met while minimizing risk and impact to the DO's systems.

4.16.6 Records Retention

4.16.6.1 The DO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.16.6.2 Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation.

4.16.6.3 Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

4.16.6.4 Upon expiration of the ten (10) year retention period and upon request, the subject records shall be transferred to the Department's possession, refer to the End of Contract Transition Services section for additional requirements.

4.16.6.5 No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

4.16.7 Web Access and Use by Providers and Members

4.16.7.1 The MCIS shall include web access for use by and support to Participating Providers and Members.

4.16.7.2 The services shall be provided at no cost to the Participating Provider or Members.

4.16.7.3 All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the DO.

4.16.7.4 The DO shall create secure web access for Medicaid Providers and Members and authorized the Department staff to access case-specific information; this web access shall fulfill the following requirements, and shall be available no later than the Program Start Date:

4.16.7.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.16.7.4.2 Providers and Members shall have the ability to download and print any needed Medicaid DO program forms and other information;

4.16.7.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

4.16.7.4.4 The DO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.16.7.4.5 The website shall provide an encrypted e-mail link to the DO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.16.7.4.6 The website shall provide a link to the State's Medicaid website;

4.16.7.4.7 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.16.7.4.8 Access shall be limited to verified users.

4.16.7.5 The DO shall manage Provider and Member access to the system, and operational services necessary to assist Providers and Members with gaining access and utilizing the web portal.

4.16.7.6 System Support Performance Standards shall include:

4.16.7.6.1 Email inquiries – one (1) business day response;

4.16.7.6.2 New information posted within one (1) business day of receipt, and up to two (2) business days of receipt

for materials that shall be made ADA compliant with Section 508 of the Rehabilitation Act;

4.16.7.6.3 Routine maintenance;

4.16.7.6.4 Standard reports regarding portal usage such as hits per month by Providers/Members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports; and

4.16.7.6.5 Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, MS Edge, Firefox, Safari, etc.). If user does not have compliant browser, DO shall redirect user to site to install appropriate browser.

4.16.8 Contingency Plans and Quality Assurance

4.16.8.1 Critical systems within the MCIS support the delivery of critical dental services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

4.16.8.2 The DO shall host the MCIS at the DO's Confidential Data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.16.8.3 Archiving processes shall not modify the Confidential Data composition of the Department's records, and archived Confidential Data shall be retrievable at the request of the Department. Archiving shall be conducted at intervals agreed upon between the DO and the Department.

4.16.8.4 The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, Provider billing agents/clearing houses, or the Department and the DO.

4.16.8.5 Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with Exhibit G: IT Requirements Workbook and security and access rights granted to users.

4.16.8.6 In accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, the DO shall submit the following documents and corresponding checklists for the Departments Information Security review:

4.16.8.6.1 Disaster Recovery Plan;

4.16.8.6.2 Business Continuity Plan;

4.16.8.6.3 Security Plan;

4.16.8.6.4 The following documents which, if after the original documents are submitted the DO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for Department review:

4.16.8.6.4.1. Risk Management Plan;

4.16.8.6.4.2. Systems Quality Assurance Plan; and

4.16.8.6.4.3. Confirmation of 5010 compliance and Companion Guides.

4.16.8.7 Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements, at a minimum, shall be part of the DO's change management process:

4.16.8.7.1 The complete system shall have proper configuration management/change management in place (to be reviewed by the Department).

4.16.8.7.2 The DO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

4.16.8.7.3 The DO shall provide the Department with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to Subcontractors, and specifically identifying any change impact to the Confidential Data interfaces or transaction exchanges between the DO and the Department and/or the fiscal agent.

4.16.8.7.4 The Department retains the right to modify or waive the notification requirement contingent upon the nature of the request from the DO.

4.16.8.7.5 The DO shall provide the Department with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day.

4.16.8.7.6 The DO shall provide the Department with official points of contact for MCIS issues on an ongoing basis.

4.16.8.7.7 The DO shall ensure appropriate testing is done for all system changes. DO shall also provide a test system for the Department to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI Confidential Data of any Member.

4.16.8.7.8 The DO shall make timely changes or defect fixes to Confidential Data interfaces and execute testing with the Department and other applicable entities to validate the integrity of the interface changes.

4.16.8.8 The Department, or its agent, may conduct a Systems readiness review to validate the DO's ability to meet the MCIS requirements.

4.16.8.9 The System readiness review may include a desk review and/or an onsite review. If the Department determines that it is necessary to conduct an onsite review, the DO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from the Department.

4.16.8.10 For purposes of this Section of the Agreement, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by the Department or its authorized agent in connection with the onsite reviews.

4.16.8.11 If for any reason the DO does not fully meet the MCIS requirements, the DO shall, upon request by the Department, either correct such deficiency or submit to the Department a CAP and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, the Department may impose contractual remedies according to the severity of the deficiency as described in Section 5.5 (Remedies) of this Agreement.

4.16.8.12 QOS metrics shall include:

4.16.8.12.1 The security of the Care Management processing system shall minimally provide the following three types of controls to maintain Confidential Data integrity that directly impacts QOS. These controls shall be in place at all appropriate points of processing:

4.16.8.12.1.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring;

4.16.8.12.1.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system; and

4.16.8.12.1.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.16.8.12.2 System Administration: Ability to comply with HIPAA, ADA, and other State and federal regulations, and perform in accordance with Agreement terms and conditions, ability to provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development.

4.16.8.12.3 The system shall accommodate changes with global impacts (e.g., implementation of electronic health record, e-Prescribe) as well as new transactions at no additional cost.

4.16.9 Interoperability and Patient Access

4.16.9.1 The DO shall comply with the Centers for Medicare & Medicaid Services published final rule, "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," (referred to as the "CMS Interoperability and Patient Access final rule") to further advance interoperability for Medicaid and Children's Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data.

4.16.9.2 The DO shall implement this final rule in a manner consistent with existing guidance and the published "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" final rule (referred to as the ONC 21st Century Cures Act final rule), including:

4.16.9.2.1 Patient Access Application Program Interfaces (API). [42 CFR 438.242(b)(5); 42 CFR 457.1233(d); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)];

4.16.9.2.2 Provider Directory Application Program Interfaces (API). [42 CFR 438.242(b)(6); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)]; and

4.16.9.2.3 Implement and maintain a Payer-to-Payer Confidential Data Exchange. [42 CFR 438.62(b)(1)(vi)-(vii); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)].

4.16.9.3 The DO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60, and include(s):

4.16.9.3.1 Confidential Data concerning adjudicated claims, including claims Confidential Data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

4.16.9.3.2 Encounter data, including encounter Confidential Data from any network providers the DO is compensating on the basis of capitation payments and adjudicated claims and encounter Confidential Data from any Subcontractors no later than one (1) business day after receiving the Confidential Data from providers; and

4.16.9.3.3 Clinical data, including laboratory results, if the DO maintains any such data, no later than one (1) business day after the Confidential Data is received by the State.

4.16.9.4 The DO shall implement and maintain a publicly accessible standards-based API no later than July 1, 2023 as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2). [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)]

4.17 Claims Quality Assurance Standards

4.17.1 Claims Payment Standards

4.17.1.1 For purposes of this Section 4.17 (Claims Quality Assurance Standards), the Department has adopted the claims definitions established by CMS. [42 CFR 447.25(b)]

4.17.1.1.1 "Clean Claim" as defined in Section 2.1 (Definitions); and

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

4.17.1.2 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the DO's mailroom by its date stamp or the date an electronic claim is submitted.

4.17.1.3 The paid date is the date a payment check or EFT is issued to the service Provider. [42 CFR 447.45(d)(5-6); 42 CFR 447.46; sections 1932(f) and 1902(a)(37)(A) of the Act]

4.17.1.4 The denied date is the date at which the DO determines that the submitted claim is not eligible for payment.

4.17.1.5 The DO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt, or receipt of additional information.

4.17.1.6 The DO shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) calendar days of receipt. [42 CFR 447.46; 42 CFR 447.45(d)(2)-(3) and (d)(5)-(6); Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act].

4.17.1.7 The DO shall request all additional information necessary to process Incomplete Claims from the Provider within thirty (30) calendar days from the date of original claim receipt.

4.17.2 Claims Quality Assurance Program

4.17.2.1 The DO shall verify the accuracy and timeliness of Confidential Data reported by Providers, including Confidential Data from Participating Providers the DO is compensating through a capitated payment arrangement.

4.17.2.2 The DO shall screen the Confidential Data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

4.17.2.3 The DO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to the Department, in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

4.17.2.4 As indicated in Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, reporting to the Department shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

4.17.2.5 The DO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to the Department.

4.17.3 Claims Financial Accuracy

4.17.3.1 Claims financial accuracy measures the accuracy of dollars paid to Providers. It is measured by evaluating dollars overpaid and

underpaid in relation to total paid amounts taking into account the dollar stratification of claims.

4.17.3.2 The DO shall pay ninety-nine percent (99%) of dollars accurately.

4.17.4 Claims Payment Accuracy

4.17.4.1 Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed.

4.17.4.2 The DO shall pay ninety-seven percent (97%) of claims accurately.

4.17.5 Claims Processing Accuracy

4.17.5.1 Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed.

4.17.5.2 The DO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

5.1.1.1 As indicated throughout this Agreement, the Department shall document ongoing DO reporting requirements through Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements and additional specifications provided by the Department.

5.1.1.2 The DO shall provide data, reports, and plans in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, this Agreement, and any additional specifications provided by the Department.

5.1.1.3 The DO shall comply with all NHID rules for Confidential Data reporting, including those related to the NH CHIS.

5.1.1.4 The DO shall make all collected Confidential Data available to the Department upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.5 The DO shall collect Confidential Data on Member and Provider characteristics as specified by the Department and on services furnished to Members through a MCIS system or other methods as may be specified by the Department. [42 CFR 438.242(b)(2)]

5.1.1.6 The DO shall ensure that Confidential Data received from Providers are accurate and complete by:

5.1.1.6.1 Verifying the accuracy and timeliness of reported data;

5.1.1.6.2 Screening the Confidential Data for completeness, logic, and consistency; and

5.1.1.6.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.7 The Department shall at a minimum collect, and the DO shall provide, the following information, and the information specified throughout the Agreement and within Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, in order to improve the performance of the DMCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.7.1 Enrollment and disenrollment data;

5.1.1.7.2 Member grievance and appeal logs;

5.1.1.7.3 Medical management committee reports and minutes;

5.1.1.7.4 Audited financial and encounter data;

5.1.1.7.5 The MLR summary reports;

5.1.1.7.6 Customer service performance data;

5.1.1.7.7 Performance on required quality measures; and

5.1.1.7.8 The DO's QAPI Plan.

5.1.1.8 The DO shall be responsible for preparing, submitting, and presenting to the Governor, Legislature, and the Department a report that includes the following information, or information otherwise indicated by the State:

5.1.1.8.1 A description of how the DO has addressed State priorities for the DMCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.8.2 A description of the innovative programs the DO has developed and the outcomes associated with those programs;

5.1.1.8.3 A description of how the DO is addressing social determinants of health and the outcomes associated with DO-implemented interventions;

5.1.1.8.4 A description of how the DO is improving oral health outcomes in the State; and

5.1.1.8.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.9 Prior to Program Start Date and at any other time upon the Department request or as indicated in this Agreement, the Department shall conduct a review of DO policies and procedures and/or other administrative documentation.

5.1.1.9.1 The Department shall deem materials as pass or fail following the Department review.

5.1.1.9.2 The DO shall complete and submit a DHHS-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.9.3 The Department may require modifications to DO policies and procedures or other documentation at any time as determined by the Department.

5.1.2 Requirements for Waiver Programs

5.1.2.1 The DO shall provide to the Department the Confidential Data and information required for its current CMS waiver programs and any waiver programs it enters during the Term of this Agreement that require Confidential Data for Members covered by the DO. These include but are not limited to:

5.1.2.1.1 Mandatory managed care 1915b waiver; and

5.1.2.1.2 Granite Advantage 1115 waiver.

5.1.3 Encounter Data

5.1.3.1 The DO shall submit Encounter Confidential Data in the format and content, timeliness, completeness, and accuracy as specified by the Department and in accordance with timeliness, completeness, and accuracy standards as established by the Department. [42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818]

5.1.3.2 All DO encounter requirements apply to all Subcontractors. The DO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the DO meets all Department reporting requirements.

5.1.3.3 The DO shall submit to the Department for review, during the Readiness Review process, its policies and procedures that detail the DO's encounter process. The DO-submitted policies and procedures shall at minimum include to the Department's satisfaction:

5.1.3.3.1 An end-to-end description of the DO's encounter process;

5.1.3.3.2 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.3 A detailed description of the internal reconciliation process followed by the DO, and all Subcontractors that process claims on the DO's behalf.

5.1.3.4 The DO shall, as requested by the Department, submit updates to and revise upon request its policies and procedures that detail the DO's encounter process.

5.1.3.5 All Encounter Confidential Data shall remain the property of the Department and the Department retains the right to use it for any purpose it deems necessary.

5.1.3.6 The DO shall submit Encounter Confidential Data to the EQRO and the Department in accordance with this Section 5.1.3 (Encounter Data) of the Agreement and to the Department's actuaries, as requested, according to the format and specification of the actuaries.

5.1.3.7 Submission of Encounter Confidential Data to the Department does not eliminate the DO's responsibility to comply with N.H. Code of Administrative Rules, Chapter Ins 4000 Uniform Reporting System for Health Care Claims Confidential Data Sets.

5.1.3.8 The DO shall ensure that encounter records are consistent with the Department requirements and all applicable State and federal laws.

5.1.3.9 DO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.10 The level of detail associated with encounters from Providers with whom the DO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the DO received and settled a FFS claim.

5.1.3.11 The DO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the DO's encounter records.

5.1.3.12 The DO shall have a computer and Confidential Data processing system, and staff, sufficient to accurately produce the data, reports, and encounter record set in formats and timelines as defined in this Agreement.

5.1.3.13 The System shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

5.1.3.14 The DO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these Confidential Data in a standardized format approved by the Department.

5.1.3.15 The DO shall make all collected Confidential Data available to the Department after it is tested for compliance, accuracy, completeness, logic, and consistency.

5.1.3.16 The DO's systems that are required to use or otherwise contain the applicable Confidential Data type shall conform to current and future HIPAA-based standard code sets; the processes through which the Confidential Data are generated shall conform to the same standards, including application of:

5.1.3.16.1 Code on Dental Procedures and Nomenclature (CDT) which is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA);

5.1.3.16.2 POS Codes which are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry;

5.1.3.16.3 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the Provider or the patient when other insurance is involved; and

5.1.3.16.4 Reason and Remark Codes (RARC) which are used when other insurance denial information is submitted to the MMIS using standard codes defined and maintained by CMS and the NCPDP.

5.1.3.17 All DO encounters shall be submitted electronically to the Department or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats or at the discretion of the Department the ANSI X12N 837 post adjudicated transaction formats, and other proprietary file layouts as defined by the Department.

5.1.3.18 All DO encounters shall be submitted with DO paid amount, the FFS equivalent, and, as applicable, the Medicare paid amount, other insurance paid amount and/or expected Member Copayment amount.

5.1.3.19 The paid amount (or FFS equivalent) submitted with Encounter Confidential Data shall be the amount paid to Providers, not the amount paid to DO Subcontractors or Providers of shared services within the DO's organization, third party administrators, or capitated entities.

5.1.3.20 The DO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.21 The DO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.22 The DO shall collect, and submit to the State's fiscal agent, Member service level Encounter Confidential Data for all Covered Services.

5.1.3.23 The DO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.24 The DO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.24.1 Batch and Online Transaction Types are as follows:

5.1.3.24.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.24.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.24.1.3. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.24.2 Online transaction types are as follows:

5.1.3.24.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

5.1.3.24.2.2. ASC X12N 276 Claims Status Inquiry;

5.1.3.24.2.3. ASC X12N 277 Claims Status Response;

5.1.3.24.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and

5.1.3.25 Submitted Encounter Confidential Data shall include all elements specified by the Department, including but not limited to those specified in the Department Medicaid Encounter Submission Requirements Policy.

5.1.3.26 The DO shall submit summary reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, to be used to validate Encounter submissions.

5.1.3.27 The DO shall use the procedure codes, diagnosis codes, and other codes as directed by the Department for reporting Encounters and fee- for-service claims.

5.1.3.28 Any exceptions shall be considered on a code-by-code basis after the Department receives written notice from the DO requesting an exception.

5.1.3.29 The DO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.30 The DO shall provide, as a supplement to the Encounter Confidential Data submission, a Member file on a monthly basis, which shall contain appropriate Member Medicaid identification numbers, the PCP assignment of each Member, and the group affiliation and service location address of the PCP.

5.1.3.31 The DO shall submit complete Encounter Confidential Data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

5.1.3.32 The DO shall assign staff to participate in encounter technical work group meetings as directed by the Department.

5.1.3.33 The DO shall provide complete and accurate encounters to the Department.

5.1.3.34 The DO shall implement review procedures to validate Encounter Confidential Data submitted by Providers. The DO shall meet the following standards:

5.1.3.34.1 Completeness

5.1.3.34.1.1. The DO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.34.2 Accuracy

5.1.3.34.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in a DO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions

of each individual batch and online transaction type.

5.1.3.34.2.2. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.34.2.3. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.34.2.4. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.34.2.5. The DO shall submit a monthly supplemental Provider file, to include Confidential Data elements as defined by the Department, for all Providers that were submitted on encounters in the prior month.

5.1.3.34.2.6. For the first six (6) months of encounter production submissions, the DO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Confidential Data quality.

5.1.3.34.2.7. The end to end test shall include a review of the Provider claim to what Confidential Data is in the DO claims processing system, and the encounter file record produced for that claim.

5.1.3.34.2.8. The DO shall report a pass or fail to the Department. If the result is a fail, the DO shall also submit a root cause analysis that includes plans for remediation.

5.1.3.34.2.9. If the Department or the DO identifies a Confidential Data defect, the DO shall, for six (6) months post Confidential Data defect identification, conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Confidential Data quality.

5.1.3.34.2.10. If two (2) or more Encounter Confidential Data defects are identified within a rolling twelve (12) month period, the Department may require the DO to contract with an external vendor to independently assess the DO Encounter Confidential Data process. The external vendor shall produce a report that shall be shared with the Department.

5.1.3.34.3 Timeliness

5.1.3.34.3.1. Encounter Confidential Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.34.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.34.3.3. The DO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.34.4 Error Resolution

5.1.3.34.4.1. For all historical encounters submitted after the submission start date, if the Department or its fiscal agent notifies the DO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the DO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.34.4.2. For all ongoing claim encounters, if the Department or its fiscal agent notifies the DO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the DO shall remediate all such encounters within fourteen (14) calendar days after such notice.

5.1.3.34.4.3. If the DO fails to comply with either error resolution timeline, the Department shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.3.34.4.4. The DO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by the Department.

5.1.3.34.5 Survival

5.1.3.34.5.1. All Encounter Confidential Data accumulated as part of the DMCM program shall remain the property of the Department and, upon termination of the Agreement, the Confidential Data shall be electronically transmitted to the Department in a format and schedule prescribed by the Department and as is further described in Section 7.7.2 (Data).

5.1.3.34.6 Reporting

5.1.3.34.6.1. The DO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to the DO, including base Confidential Data that is generated by the DO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

5.1.3.34.6.2. When requested by the Department, the DO shall submit Encounter Data, financial data, and other Confidential Data to the Department to ensure actuarial soundness in development of the capitated rates, or any other actuarial analysis required by the Department or State or federal law.

5.1.3.34.6.3. The DO's CFO shall submit and concurrently certify to the best of their information, knowledge, and belief that all Confidential Data and information described in 42 CFR

438.604(a), which the Department uses to determine the capitated rates, is accurate. [42 CFR 438.606]

5.1.4 Confidential Data Certification

5.1.4.1 All Confidential Data submitted to the Department by the DO shall be certified by one (1) of the following:

5.1.4.1.1 The DO's Contract Manager; or

5.1.4.1.2 An individual who has delegated authority to sign for, and who reports directly to, the DO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

5.1.4.2 The Confidential Data that shall be certified include, but are not limited to, all documents specified by the Department, enrollment information, Encounter Data, and other information contained in this Agreement or proposals.

5.1.4.3 The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data.

5.1.4.4 The DO shall submit the certification concurrently with the certified Confidential Data and documents. [42 CFR 438.604; 42 CFR 438.606]

5.1.4.5 The DO shall submit the DO Confidential Data Certification process policies and procedures for the Department review during the Readiness Review process.

5.1.5 Confidential Data System Support for Quality Assurance & Performance Improvement

5.1.5.1 The DO shall have a Confidential Data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.11.2 (Quality Assessment and Performance Improvement Program).

5.1.5.2 The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of Participating Providers, Member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

5.2 Contract Oversight Program

5.2.1 The DO shall have a formalized Contract Oversight Program to ensure that it complies with this Agreement, which at a minimum, should outline:

5.2.1.1 The specific monitoring and auditing activities that the DO shall undertake to ensure its and its Subcontractors' compliance with certain provisions and requirements of the Agreement;

5.2.1.2 The frequency of those contract oversight activities; and

5.2.1.3 The person(s) responsible for those contract oversight activities.

5.2.2 The Contract Oversight Program shall specifically address how the DO shall oversee the DO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1 Section 3.1.15 (Subcontractors);

5.2.2.2 Section 4 (Program Requirements); and

5.2.2.3 All Confidential Data and reporting requirements.

5.2.3 The Contract Oversight Program shall set forth how the DO's Contract Manager, Compliance Officer and Board of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The DO shall present to the Department for review as part of the Readiness Review a copy of the Contract Oversight Program and any implementing policies.

5.2.5 The DO shall present to the Department for review redlined copies of proposed changes to the Contract Oversight Program and its implementing policies prior to adoption.

5.2.6 This Contract Oversight Program is distinct from the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan discussed in Section 5.3 (Program Integrity).

5.2.7 The DO shall promptly, but no later than thirty (30) calendar days after the date of discovery, report any material non-compliance identified through the Contract Oversight Program and submit a Corrective Action Plan to the Department to remediate such non-compliance.

5.2.8 The DO shall implement any changes to the Corrective Action Plan requested by the Department.

5.3 Program Integrity

5.3.1 General Requirements

5.3.1.1 The DO shall present to the Department for review, as part of the Readiness Review process, a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan and shall comply with policies and procedures that guide and require the DO and the DO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2 The DO shall present to the Department for review redlined copies of proposed changes to the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan prior to adoption.

5.3.1.3 The DO shall include program integrity requirements in its Subcontracts and provider application, credentialing and re-credentialing processes.

5.3.1.4 The DO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 Section 1902(a)(68) of the Social Security Act;

5.3.1.4.2 42 CFR Section 438;

5.3.1.4.3 42 CFR Section 455;

5.3.1.4.4 42 CFR Section 1000 through 1008; and

5.3.1.4.5 CMS Toolkits.

5.3.1.5 The DO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of fraud, waste and abuse and the DO's and its Subcontractors' compliance with all program integrity reporting requirements to the Department.

5.3.1.6 The DO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against fraud, waste and abuse.

5.3.1.7 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent and deter fraud, waste and abuse.

5.3.1.8 The DO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9 The DO shall work with the Department on program integrity issues, and with MFCU as directed by the Department, on fraud, waste or abuse investigations. This shall include, at a minimum, the following:

5.3.1.9.1 Participation in DO program integrity meetings with the Department following the submission of the monthly allegation log submitted by the DO in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

5.3.1.9.2 The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.3 Discussion at these meetings shall include, but not be limited to, case development and monitoring.

5.3.1.9.4 The DO shall ensure Subcontractors attend monthly meetings when requested by the Department;

5.3.1.9.5 Participation in bi-annual DO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned;

5.3.1.9.6 Quality control and review of encounter Confidential Data submitted to the Department; and

5.3.1.9.7 Participation in meetings with MFCU, as determined by MFCU and the Department.

5.3.2 Fraud, Waste and Abuse

5.3.2.1 The DO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse. [42 CFR 438.608(a)]

5.3.2.2 The arrangements or procedures shall include the following:

5.3.2.2.1 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan that includes, at a minimum, all of the following elements:

5.3.2.2.2 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.3 Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.4 Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the DO's compliance program and its compliance with this Agreement;

5.3.2.2.5 System for training and education for the Compliance Officer, the DO's senior management, employees, and Subcontractor on the federal and

State standards and requirements under this Agreement;

5.3.2.2.6 Effective lines of communication between the Compliance Officer and DO's staff and Subcontractors;

5.3.2.2.7 Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.8 Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i-vii)]

5.3.2.2.9 The process by which the DO shall monitor their marketing representative activities to ensure that the DO does not engage in inappropriate activities, such as inducements;

5.3.2.2.10 A requirement that the DO shall report on staff termination for engaging in prohibited marketing conduct or fraud, waste and abuse to the Department within thirty (30) business days;

5.3.2.2.11 A description of the DO's specific controls to detect and prevent potential fraud, waste and abuse including, without limitation:

5.3.2.2.11.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.11.2. A list of automated post-payment claims edits;

5.3.2.2.11.3. In accordance with 42 CFR 438.602(b), the DO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The DO shall amend edits on its claims

systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.11.4. At least three (3) Confidential Data analytic algorithms for fraud detection specified by the Department Program Integrity and three (3) additional Confidential Data analytic algorithms as determined by the DO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change at least annually;

5.3.2.2.11.5. A list of audits of post-processing review of claims planned;

5.3.2.2.11.6. A list of reports on Participating Provider and Non-Participating Provider profiling used to aid program integrity reviews;

5.3.2.2.11.7. The methods the DO shall use to identify high-risk claims and the DO's definition of "high-risk claims";

5.3.2.2.11.8. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.11.9. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

5.3.2.2.11.10. A method to verify, by sampling or other method, whether services that have been represented to have been delivered by Participating Providers and were received by Members and the application of such verification processes on a regular basis. The DO may use an explanation of benefits (EOB) for such verification only if the DO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family

planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.11.11. Provider and Member materials identifying the DO's fraud and abuse reporting hotline number;

5.3.2.2.11.12. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.11.13. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.11.14. The ability to suspend a Participating Provider's or Non-Participating Provider's payment due to credible allegation of fraud if directed by the Department Program Integrity; and

5.3.2.2.11.15. The process by which the DO shall recover inappropriately paid funds if the DO discovers wasteful and/or abusive, incorrect billing trends with a particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.12 A provision for the prompt reporting of all Overpayments identified and recovered, specifying the Overpayments due to potential fraud;

5.3.2.2.13 A provision for referral of any potential Participating Provider or Non-Participating Provider fraud, waste and abuse that the DO or Subcontractor identifies to the Department Program Integrity and any potential fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.14 A provision for the DO's suspension of payments to a Participating Provider for which the Department determines there is credible allegation of fraud in

accordance with this Agreement and 42 CFR 455.23; and

5.3.2.2.15 A provision for notification to the Department when the DO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the DMCM program, including the termination of the provider agreement with the DO as detailed in Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

5.3.2.3 The DO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4 The DO, and if required by the DO's Subcontractors, shall post and maintain the Department-approved information related to fraud, waste and abuse on its website, including but not limited to, provider notices, current listing of Participating Providers, providers that have been excluded or sanctioned from the Medicaid Care Management Program, any updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

5.3.3 Identification and Recoveries of Overpayments

5.3.3.1 The DO shall maintain an effective fraud, waste and abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2 The DO shall perform ongoing analysis of its authorization, utilization, claims, Provider's billing patterns, and encounter Confidential Data to detect improper payments, and shall perform audits and investigations of Subcontractors, Providers and Provider entities.

5.3.3.3 This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with Providers, and a system for managing and tracking of investigation findings, Recoveries, and underpayments related to fraud, waste and abuse investigations/audit/any other overpayment recovery process as described in the fraud, waste and abuse reports provided to the Department in accordance with Exhibit O: Quality and Oversight

Reporting Requirements: Quality and Oversight Reporting Requirements.

5.3.3.4 The DO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste and abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5 The DO and its subcontractors shall report to the Department within sixty (60) calendar days when it has identified Capitation Payments or other payment amounts received are in excess to the amounts specified in this Agreement. [42 CFR 438.608(c)(3)].

5.3.3.6 The Department may recover Overpayments that are not recovered by or returned to the DO within sixty (60) calendar days of notification by the Department to pursue.

5.3.3.7 This Section of the Agreement does not apply to any amount of a recovery to be retained under False Claim Act cases or through other investigations.

5.3.3.8 Any settlement reached by the DO or its Subcontractors and a Provider shall not bind or preclude the State from further action.

5.3.3.9 The Department shall utilize the information and documentation collected under this Agreement, as well as nationally recognized information on average recovery amounts as reported by State MFCUs and commercial insurance plans for setting actuarially sound Capitation Payments for each DO consistent with the requirements in 42 CFR 438.4.

5.3.3.10 If the DO does not meet the required metrics related to expected fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, the Department shall impose liquidated damages, unless the DO can demonstrate good cause for failure to meet such metrics.

5.3.4 Referrals of Credible Allegations of Fraud and Provider and Payment Suspensions

5.3.4.1 General

5.3.4.1.1 The DO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to the Department Program Integrity Unit and the MFCU on credible allegations of fraud and for payment suspension when there is a credible allegation of fraud. [42 CFR 438.608(a)(8); 42 CFR 455.23].

5.3.4.1.2 The DO shall complete a Department "Request to Open" form for any potential fraud, waste, or abuse case, including those that lead to a credible allegation of fraud. DHHS Program Integrity Unit shall have fifteen (15) business days to respond to the DO's "Request to Open" form.

5.3.4.1.3 When the DO or its Subcontractor has concluded that a credible allegation of fraud or abuse exists, the DO shall make a referral to DHHS Program Integrity Unit and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by the Department. [42 CFR 438.608(a)(7)]

5.3.4.1.4 Unless and until prior written approval is obtained from the Department, neither the DO nor a Subcontractor shall take any administrative action or any of the following regarding the allegations of suspected fraud:

5.3.4.1.4.1. Suspend Provider payments;

5.3.4.1.4.2. Contact the subject of the investigation about any matters related to the investigation;

5.3.4.1.4.3. Continue the investigation into the matter;

5.3.4.1.4.4. Enter into or attempt to negotiate any settlement or agreement regarding the matter; or

5.3.4.1.4.5. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

5.3.4.1.5 The DO shall employ pre-payment review when directed by the Department.

5.3.4.1.6 In addition, the DO may employ pre-payment review in the following circumstances without approval:

5.3.4.1.6.1. Upon new Participating Provider enrollment;

5.3.4.1.6.2. For delayed payment during Provider education;

5.3.4.1.6.3. For existing Providers with billing inaccuracies;

5.3.4.1.6.4. Upon receipt of a credible allegation of fraud or abuse; or

5.3.4.1.6.5. Upon identification from Confidential Data analysis or other grounds.

5.3.4.1.7 If the Department, MFCU or another law enforcement agency accepts the allegation for investigation, the Department shall notify the DO's Compliance Officer within two (2) business days of the acceptance notification, along with a directive to suspend payment to the affected Provider(s) if it is determined that suspension shall not impair MFCU's or law enforcement's investigation or shall not fulfill any other good cause not to suspend payments under 42 CFR 455.23(e) as determined by DHHS.

5.3.4.1.8 The Department shall notify the DO if the referral is declined for investigation.

5.3.4.1.9 If the Department, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the DO may proceed with its own investigation and comply with the reporting requirements contained in this Section of the Agreement.

5.3.4.1.10 Upon receipt of notification from the Department, the DO shall send notice of the decision to suspend program payments to the Provider within the following timeframe:

5.3.4.1.10.1. Within five (5) calendar days of taking such action unless requested in writing by the Department, the MFCU, or law enforcement to temporarily withhold such notice; or

5.3.4.1.10.2. Within thirty (30) calendar days if requested by the Department, MFCU, or law enforcement in writing to delay sending such notice.

5.3.4.1.10.3. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.

5.3.4.1.11 The notice shall include or address all of the following (42 CFR 455.23(b)(2)):

5.3.4.1.11.1. That payments are being suspended in accordance with this provision;

5.3.4.1.11.2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

5.3.4.1.11.3. That the suspension is for a temporary period and cite the circumstances under which the suspension shall be lifted;

5.3.4.1.11.4. Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

5.3.4.1.11.5. Where applicable and appropriate, inform the Provider of any appeal rights available to the Provider, along with the Provider's right to submit written evidence for consideration by the DO.

5.3.4.1.12 All suspension of payment actions under this Section of the Agreement shall be temporary and shall not continue after either of the following:

5.3.4.1.12.1. The DO is notified by the Department that there is insufficient evidence of fraud by the Provider; or

5.3.4.1.12.2. The DO is notified by the Department that the legal proceedings related to the Provider's alleged fraud are completed.

5.3.4.1.13 The DO shall document in writing the termination of a payment suspension and issue a notice of the termination to the Provider and to the Department.

5.3.4.1.14 The DHHS Program Integrity Unit may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

5.3.4.1.14.1. MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment

suspension may compromise or jeopardize an investigation;

5.3.4.1.14.2. Other available remedies are available to the DO, after the Department approves the remedies that more effectively or quickly protect Medicaid funds; and

5.3.4.1.14.3. The DO determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed.

5.3.4.1.15 The DO shall review evidence submitted by the Provider and submit it with a recommendation to the Department.

5.3.4.1.16 The Department shall direct the DO to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence;

5.3.4.1.17 Member access to items or services would be jeopardized by a payment suspension because of either of the following:

5.3.4.1.17.1. An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or

5.3.4.1.17.2. The individual or entity serves a large number of Members within a federal HRSA designated a medically underserved area;

5.3.4.1.17.3. MFCU or law enforcement declines to certify that a matter continues to be under investigation; or

5.3.4.1.17.4. The Department determines that payment suspension is not in the best interests of the Medicaid program.

5.3.4.1.18 The DO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.1.18.1. Details of payment suspensions that were imposed in whole or in part; and

5.3.4.1.18.2. Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.1.19 If the DO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and the Department directed the DO to suspend payments, the Department may impose liquidated damages.

5.3.4.1.20 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the State, and the DO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.1.21 Furthermore, the DO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the State for all criminal, civil and administrative action recoveries undertaken by any government entity, including but not limited to all claims the DO or its Subcontractor(s) has or may have against any entity or individual that directly or indirectly receives funds under this Agreement, including but not limited to any health care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other Provider in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DME, or other health care related products or services.

5.3.4.1.22 For the purposes of this Section of the Agreement, "subrogation" means the right of any State government entity or local law enforcement to stand in the place of the DO or client in the collection against a third party.

5.3.4.1.23 Any funds recovered and retained by a government entity shall be reported to the actuary to consider in the rate-setting process.

5.3.5 Investigations

5.3.5.1 The DO and its Subcontractors shall cooperate with all State and federal agencies that investigate fraud, waste and abuse.

5.3.5.2 The DO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3 The DO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, the Department, OIG, and CMS).

5.3.5.4 The DO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5 The DO and its Subcontractors shall maintain all records, documents and claim or encounter Confidential Data for Members, Providers and Subcontractors who are under investigation by any State or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating State or federal agency.

5.3.5.6 The DO shall provide any Confidential Data access or detail records upon written request from the Department for any potential fraud, waste and abuse investigation, Provider or claim audit, or for DO oversight review.

5.3.5.7 The additional access shall be provided within three (3) business days of the request.

5.3.5.8 The DO and its Subcontractors shall request a refund from a third-party payer, Provider or Subcontractor when an investigation indicates that such a refund is due.

5.3.5.8.1 These refunds shall be reported to the Department as Overpayments.

5.3.5.9 The Department shall conduct investigations related to suspected Provider fraud, waste and abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the DO has not submitted a request to open and for which the DO continued to pursue the case. The State shall notify the DO of any investigation it intends to open prior to contacting the Provider.

5.3.6 Reporting

5.3.6.1 Annual Fraud Prevention Report

5.3.6.1.1 The DO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

5.3.6.1.2 The annual Fraud Prevention summary shall include, at a minimum, the following elements, in

accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements:

5.3.6.1.2.1. The name of the person and department responsible for submitting the Fraud Prevention Report;

5.3.6.1.2.2. The date the report was prepared;

5.3.6.1.2.3. The date the report is submitted;

5.3.6.1.2.4. A description of the SIU;

5.3.6.1.2.5. Cumulative Overpayments identified and recovered;

5.3.6.1.2.6. Investigations initiated, completed, and referred;

5.3.6.1.2.7. Analysis of the effectiveness of the activities performed; and

5.3.6.1.2.8. Other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

5.3.6.1.3 As part of this report, the DO shall submit to the Department the Overpayments it recovered, certified by its CFO that this information is accurate to the best of their information, knowledge, and belief, as required by Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements. [42 CFR 438.606]

5.3.6.2 Reporting Member Fraud

5.3.6.2.1 The DO shall notify the Department of any cases in which the DO believes there is a serious likelihood of Member fraud by sending a secure email to the Department Special Investigation Unit.

5.3.6.2.2 The DO is responsible for investigating Member fraud, waste and abuse and referring Member fraud to the Department. The DO shall provide initial allegations, investigations and resolutions of Member fraud to the Department.

5.3.6.3 Termination Report

5.3.6.3.1 The DO shall submit to the Department a monthly Termination Report including Providers terminated due to sanction, invalid licenses, services, billing,

Confidential Data mining, investigation and any related program integrity involuntary termination; Provider terminations for convenience; and Providers who self-terminated.

5.3.6.3.2 The report shall be completed using the Department template.

5.3.6.4 Other Reports

5.3.6.4.1 The DO shall submit to the Department demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 The DO shall report at least annually to the Department, and as otherwise required by this Agreement, on their recoveries of Overpayments. [42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

5.3.7 Access to Records, On-Site Inspections and Periodic Audits

5.3.7.1 As an integral part of the DO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the DO shall provide the Department program integrity staff (or its designee), real time access to all of the DO electronic encounter and claims Confidential Data (including the Department third-party liability) from the DO's current claims reporting system.

5.3.7.2 The DO shall provide the Department with the capability to access accurate, timely, and complete Confidential Data as specified in Section 4.17.2 Claims Quality Assurance Program).

5.3.7.3 Upon request, the DO and the DO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the DO's and the DO's Providers and Subcontractors premises during normal business hours to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the DO and its Providers and Subcontractors.

5.3.7.4 The DO and its Providers and Subcontractors shall forthwith produce all records, documents, or other Confidential Data requested as part of such inspection, review, audit, investigation, monitoring or evaluation.

5.3.7.5 Copies of records and documents shall be made at no cost to the requesting agency. [42 CFR 438.3(h)]; 42 CFR 455.21(a)(2); 42 CFR 431.107(b)(2)]. A record includes, but is not limited to:

5.3.7.5.1 Dental records;

5.3.7.5.2 Billing records;

5.3.7.5.3 Financial records;

5.3.7.5.4 Any record related to services rendered, and quality, appropriateness, and timeliness of such service;

5.3.7.5.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

5.3.7.5.6 Any record of a DO-paid claim or encounter, or a DO-denied claim or encounter.

5.3.7.6 Upon request, the DO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate the Department, MFCU or other State or federal agencies.

5.3.7.7 The Department, CMS, MFCU, the OIG, the Comptroller General, or any other authorized State or federal agency or duly authorized representative shall be permitted to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time. [42 CFR 438.3(h)]

5.3.7.8 The DO and its Subcontractors shall be subject to on-site or offsite reviews by the Department and shall comply within fifteen (15) business days with any and all Department documentation and records requests.

5.3.7.9 Documents shall be furnished by the DO or its Subcontractors at the DO's expense.

5.3.7.10 The right to inspect and audit any records or documents of the DO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.11 The Department shall conduct, or contract for the conducting of, periodic audits of the DO no less frequently than once every three (3) years, for the accuracy, truthfulness, and completeness of the encounter and financial Confidential Data submitted by, or on behalf of, each DO. [42 CFR 438.602(e)]

5.3.7.12 This shall include, but not be limited to, any records relevant to the DO's obligation to bear the risk of financial losses or services performed or payable amounts under the Agreement.

5.3.8 Transparency

5.3.8.1 The Department shall post on its website, as required by 42 CFR 438.10(c)(3), the following documents and reports:

5.3.8.1.1 The Agreement;

5.3.8.1.2 42 CFR 438.604(a)(5) where the Department certifies that the DO has complied with the

Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 Under 42 CFR 438.602(e), a quality report on the accuracy, truthfulness, and completeness of the encounter and financial Data submitted and certified by the DO resulting from the State's periodic audit; and

5.3.8.1.4 Performance metrics and outcomes.

5.4 Withhold and Incentive Program

5.4.1 [Amendment #4] The Department shall institute a withhold arrangement through which an actuarially sound percentage of the DO's risk adjusted Capitation Payment will be recouped from the DO and be available for distribution ~~in future years~~ upon meeting specific criteria.

5.4.2 The Department shall issue DMCM Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by the Department.

5.4.3 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall:

5.4.3.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

5.4.3.2 Not be renewed automatically;

5.4.3.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.4 Not condition DO participation in the withhold arrangement on the DO entering into or adhering to intergovernmental transfer agreements; and

5.4.3.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the New Hampshire DMCM Quality Strategy.

5.4.4 The DO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.5 Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

5.4.6 The Department shall institute a Withhold and Incentive Program which directs an annual actuarially sound two percent (2%) retention of the DO's risk adjusted total Capitation for the rating period. The Withhold shall be

available for distribution in future contract years upon meeting specific performance criteria as described in separate guidance.

5.5 Remedies

5.5.1 Reservation of Rights and Remedies

5.5.1.1 The DO acknowledges that failure to comply with provisions of this Agreement may, at the Department's sole discretion, result in the assessment of liquidated damages, termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement and as otherwise available under State and federal law.

5.5.1.2 In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State to any existing or future right or remedy available by law.

5.5.1.3 Failure of the State to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release the DO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State to insist upon the strict performance of this Agreement.

5.5.1.4 In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, the State may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages.

5.5.1.5 The State reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

5.5.1.6 The remedies specified in this Section of the Agreement shall apply until the failure is cured or a resulting dispute is resolved in the DO's favor.

5.5.2 Liquidated Damages

5.5.2.1 The Department may perform an annual review to assess if the liquidated damages set forth in Exhibit N: Liquidated Damages Matrix align with actual damages and/or with the Department's strategic aims and areas of identified non-compliance, and update Exhibit N: Liquidated Damages Matrix as needed via contract amendment.

5.5.2.2 The Department and the DO agree that it shall be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event the DO fails to maintain the

required performance standards within this Section during this Agreement.

5.5.2.3 The parties agree that the liquidated damages as specified in this Agreement and set forth in Exhibit N, and as updated by the Department, are reasonable.

5.5.2.4 Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies that may be available to the Department.

5.5.2.5 To the extent provided herein, the Department shall be entitled to recover liquidated damages for each day, incidence or occurrence, as applicable, of a violation or failure.

5.5.2.6 The liquidated damages shall be assessed based on the categorization of the violation or non-compliance and are set forth in Exhibit N: Liquidated Damages Matrix.

5.5.2.7 The DO shall be subject to liquidated damages for failure to comply in a timely manner with all reporting requirements in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

5.5.2.8 At its sole discretion, the Department may temporarily provide the DO partial relief or exemption from one or more Liquidated Damages.

5.5.3 Suspension of Payment

5.5.3.1 Payment of Capitation Payments may be suspended at the Department's sole discretion when the DO fails:

5.5.3.1.1 To cure a default under this Agreement to the Department's satisfaction within thirty (30) calendar days of notification;

5.5.3.1.2 To implement a CAP addressing violations or non-compliance; and

5.5.3.1.3 To implement an approved Program Management Plan.

5.5.3.2 Upon correction of the deficiency or omission, Capitation Payments shall be reinstated.

5.5.4 Intermediate Sanctions

5.5.4.1 The Department shall have the right to impose intermediate sanctions as set forth in 42 CFR Section 438.702(a), which include:

5.5.4.1.1 Civil monetary penalties (the Department shall not impose any civil monetary penalty against the DO in excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the DO;

5.5.4.1.3 Permitting Members to terminate enrollment without cause;

5.5.4.1.4 Suspending all new enrollment;

5.5.4.1.5 Suspending payments for new enrollment; and

5.5.4.1.6 Agreement termination.

5.5.4.2 The Department shall impose intermediate sanctions if the Department finds that the DO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the DO is required to provide services to by law and/or under its Agreement with the Department.

5.5.4.2.2 The Department may impose a civil monetary penalty of up to five thousand dollars ($5,000) for each failure to provide medically necessary services, and may also:

5.5.4.2.2.1. Appoint temporary management for the DO;

5.5.4.2.2.2. In the event of multiple Dos, the Department may:

5.5.4.2.2.3. Grant Members the right to disenroll without cause;

5.5.4.2.2.4. Suspend all new enrollments to the DO after the date the HHS Secretary or the Department notifies the DO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.2.5. Suspend payments for new enrollments to the DO until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.3 Imposes premiums or charges on Members that are in excess of those permitted in the Medicaid program, in which case, the State may impose a civil monetary of up to twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater). The State may also:

5.5.4.2.3.1. Appoint temporary management to the DO;

5.5.4.2.3.2. Grant Members the right to disenroll without cause;

5.5.4.2.3.3. Suspend all new enrollments to the DO after the date the HHS Secretary or the Department notifies the DO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the DO until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(2); 42 CFR 438.702(a); 42 CFR 438.704(c); sections 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Social Security Act]

5.5.4.2.4 Discriminates among Members on the basis of their health status or need for health services, in which case, the Department may impose a civil monetary penalty of up to twenty thousand dollars ($20,000) for each determination by the Department of discrimination. The Department may impose a civil monetary penalty of up to three thousand dollars ($3,000) for each individual the DO did not enroll because of a discriminatory practice, up to twenty thousand dollar ($20,000) maximum. The Department may also:

5.5.4.2.4.1. Appoint temporary management to the DO;

5.5.4.2.4.2. Grant Members the right to disenroll without cause;

5.5.4.2.4.3. Suspend all new enrollments to the DO after the date the HHS Secretary or the Department notifies the DO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.4.4. Suspend payments for new enrollments to the DO until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Social Security Act]

5.5.4.2.5 Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider, in which case, the Department may impose a civil monetary penalty of up to five thousand dollars ($5,000) for each instance of misrepresentation. The Department may also:

5.5.4.2.5.1. Appoint temporary management to the DO;

5.5.4.2.5.2. Grant Members the right to disenroll without case;

5.5.4.2.5.3. Suspend all new enrollments to the DO after the date the HHS Secretary or the Department notifies the DO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.5.4. Suspend payments for new enrollments to the DO until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B);

1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.6 Misrepresents or falsifies information that it furnishes to CMS or to the Department, in which case, the Department may impose a civil monetary penalty of up to twenty-five thousand dollars ($25,000) for each instance of misrepresentation. the Department may also:

5.5.4.2.6.1. Appoint temporary management to the DO;

5.5.4.2.6.2. Grant Members the right to disenroll without case;

5.5.4.2.6.3. Suspend all new enrollments to the DO after the date the HHS Secretary or the Department notifies the DO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the DO until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3 The Department shall have the right to impose civil monetary penalty of up to five thousand dollars ($5,000) for each distribution if the Department determines that the DO has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by the Department or that contain false or materially misleading information. [42 CFR 438.700(c); 42 CFR 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.4 The Department shall have the right to terminate this Agreement and enroll the DO's Members in other DOs if the Department determines that the DO has failed to either carry out the terms of this Agreement or meet applicable requirements in Sections 1905(t), 1903(m), and 1932 of the Social Security Act. [42 CFR

438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

5.5.4.5 The Department shall grant Members the right to terminate DO enrollment without cause when an DO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b-d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6 The Department shall only have the right to impose the following intermediate sanctions when the Department determines that the DO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of the Department's intent to terminate the Agreement;

5.5.4.6.3 Suspend all new enrollment, including default enrollment, after the date the HHS Secretary or the Department notifies the DO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700; 42 CFR 438.702(a); 42 CFR 438.704; 42 CFR 438.706(b); 42 CFR 438.722(a)-(b); Sections 1903(m)(5); 1932(e) of the Social Security Act]

5.5.5 Administrative and Other Remedies

5.5.5.1 At its sole discretion, the Department may, in addition to the other Remedies described within this Section 5.5 (Remedies), also impose the following remedies:

5.5.5.1.1 Requiring immediate remediation of any deficiency as determined by the Department;

5.5.5.1.2 Requiring the submission of a CAP;

5.5.5.1.3 Suspending part of or all new enrollments;

5.5.5.1.4 Suspending part of the Agreement;

5.5.5.1.5 Requiring mandated trainings; and/or

5.5.5.1.6 Suspending all or part of Marketing activities for varying lengths of time.

5.5.5.2 Temporary Management

5.5.5.2.1 The Department, at its sole discretion, shall impose temporary management when the Department finds, through onsite surveys, Member or other complaints, financial status, or any other source:

5.5.5.2.1.1. There is continued egregious behavior by the DO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the DO's Members in one (1) of two (2) circumstances while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the DO; [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.1.4. The Department shall impose mandatory temporary management when the DO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438; and

5.5.5.2.1.5. The Department shall not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines, in its sole discretion that the DO can ensure the sanctioned behavior shall not reoccur. [42 CFR 438.706(b)-(d); Section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.6 Corrective Action Plan

5.5.6.1 If requested by the Department, the DO shall submit a CAP within five (5) business days of the Department's request, unless the Department grants an extension to such timeframe.

5.5.6.2 The Department shall review and approve the CAP within five (5) days of receipt.

5.5.6.3 The DO shall implement the CAP in accordance with the timeframes specified in the CAP.

5.5.6.4 The Department shall validate the implementation of the CAP and impose liquidated damages if it determines that the DO failed to implement the CAP or a provision thereof as required.

5.5.7 Publication

5.5.7.1 The Department may publish on its website, on a quarterly basis, a list of DOs that had remedies imposed on them by the Department during the prior quarter, the reasons for the imposition, and the type of remedy(ies) imposed.

5.5.7.2 DOs that had their remedies reversed pursuant to the dispute resolution process prior to the posting shall not be listed.

5.5.8 Notice of Remedies

5.5.8.1 Prior to the imposition of remedies under this Agreement, except in the instance of required temporary management, the Department shall issue written notice of remedies that shall include, as applicable, the following:

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

5.5.8.1.2 The remedies to be applied and the date the remedies shall be imposed;

5.5.8.1.3 The basis for the Department's determination that the remedies shall be imposed;

5.5.8.1.4 The appeal rights of the DO;

5.5.8.1.5 Whether a CAP is being requested; and

5.5.8.1.6 The timeframe and procedure for the DO to dispute the Department's determination.

5.5.8.2 The DO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.3 Liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the DO's favor. [42 CFR 438.710(a)(1)-(2)]

5.5.8.4 The Department shall monitor accrual of performance standards-based liquidated damages for a period of three (3) to nine (9) months as a means to monitor performance and as mutually agreed in subregulatory guidance to allow for adjustments to start-up operations; thereafter, liquidated damages shall be levied and collected at the Department's discretion, as described in this Agreement and any subregulatory guidance.

5.6 State Audit Rights

5.6.1.1 [Amendment #1] The Department, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right, at any time, to inspect and audit ~~the~~ any records and/or documents of the DO or the DO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.1.2 HHS, the HHS Secretary, (or any person or organization designated by either), and the Department, have the right to audit and inspect any books or records of the DO or its Subcontractors pertaining to:

5.6.1.2.1 The ability of the DO to bear the risk of financial losses; and

5.6.1.2.2 Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.1.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements, no later than forty (40) business days after the end of the State Fiscal Year, the DO shall provide the Department a "SOC1" or a "SOC2" Type 2 report of the DO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.1.4 The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period.

5.6.1.5 The Department shall share the report with internal and external auditors of the State and federal oversight agencies. The SSAE 16 Type 2 report shall include:

5.6.1.5.1 Description by the DO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

5.6.1.5.2 Written assertion by the DO's management about whether:

5.6.1.5.2.1. The aforementioned description fairly presents the system in all material respects;

5.6.1.5.2.2. The controls were suitably designed to achieve the control objectives Stated in that description; and

5.6.1.5.2.3. The controls operated effectively throughout the specified period to achieve those control objectives.

5.6.1.5.3 Report of the DO's auditor, which:

5.6.1.5.3.1. Expresses an opinion on the matters covered in management's written assertion; and

5.6.1.5.3.2. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

5.6.1.6 The DO shall notify the Department if there are significant or material changes to the internal controls of the DO.

5.6.1.7 If the period covered by the most recent SSAE16 report is prior to June 30, the DO shall additionally provide a bridge letter certifying to that fact.

5.6.1.8 The DO shall respond to and provide resolution of audit inquiries and findings relative to the DO Managed Care activities.

5.6.1.9 The Department may require monthly plan oversight meetings to review progress on the DO's Program Management Plan, review any ongoing CAPs and review DO compliance with requirements and standards as specified in this Agreement.

5.6.1.10 The DO shall use reasonable efforts to respond to the Department oral and written correspondence within one (1) business day of receipt.

5.6.1.11 The DO shall file annual and interim financial Statements in accordance with the standards set forth below.

5.6.1.12 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the DO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial Statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]

5.6.1.13 Financial Statements shall be submitted in either paper format or electronic format, provided that all electronic submissions must

be sent encrypted, if PHI or PII is included, and in PDF format or another read-only format that maintains the documents' security and integrity.

5.6.1.14 The DO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual Statement and reports as prescribed and adopted by NHID.

5.6.1.15 The DO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

5.7.1.1 In connection with any action taken or decision made by the Department with respect to this Agreement, within thirty (30) calendar days following the action or decision, the DO may protest such action or decision by the delivery of a written notice of protest to the Department and by which the DO may protest said action or decision and/or request an informal hearing with the NH Medicaid Dental Director ("Medicaid Dental Director").

5.7.1.2 The DO shall provide the Department with a written Statement of the action being protested, an explanation of its legal basis for the protest, and its position on the action or decision.

5.7.1.3 The Director shall determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s).

5.7.1.4 The presentation and discussion of the disputed issue(s) shall be informal in nature.

5.7.1.5 The Director shall provide written notice of the time, format and location of the presentations.

5.7.1.6 At the conclusion of the presentations, the Director shall consider all evidence and shall render a written recommendation, subject to approval by the Department Commissioner, as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation.

5.7.1.7 The Director may appoint a designee to hear the matter and make a recommendation.

5.7.2 Hearing

5.7.2.1 In the event of a termination by the Department, pursuant to 42 CFR Section 438.708, the Department shall provide the DO with

notice and a pre-termination hearing in accordance with 42 CFR Section 438.710.

5.7.2.2 The Department shall provide written notice of the decision from the hearing.

5.7.2.3 In the event of an affirming decision at the hearing, the Department shall provide the effective date of the Agreement termination.

5.7.2.4 In the event of an affirming decision at the hearing, the Department shall give the Members of the DO notice of the termination, and shall inform Members of their options for receiving Medicaid services following the effective date of termination. [42 CFR 438.710(b); 42 CFR 438.710(b)(2)(i-iii); 42 CFR 438.10]

5.7.3 No Waiver

5.7.3.1 The DO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the DO's right to appeal a decision of the Department under RSA chapter 541-A, if applicable, or any applicable provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the DO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The DO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the DO may not pay money or transfer any assets for any reason to an affiliate without prior approval from the Department, if any of the following criteria apply:

6.1.3.1 Risk-based capital ratio was less than two (2) for the most recent year filing, per RSA 404-F:14 (III); and

6.1.3.2 The DO was not in compliance with the NHID solvency requirement.

6.1.4 The DO shall notify the Department within ten (10) calendar days when its agreement with an independent auditor or actuary has ended and seek

approval of, and the name of the replacement auditor or actuary, if any from the Department.

6.1.5 The DO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

6.1.6 The DO shall submit Confidential Data on the basis of which the Department has the ability to determine that the DO has made adequate provisions against the risk of insolvency.

6.1.7 The DO shall inform the Department and NHID staff by phone and by email within five (5) business days of when any key personnel learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the DO to perform under this Agreement.

6.2 Capitation Payments

6.2.1 Capitation payments made by the Department and retained by the DO shall be for Medicaid-eligible Members. [42 CFR 438.3(c)(2)]

6.2.1.1 The per member per month (PMPM) capitation rates for the current contract period are shown in Exhibit C: Payment Terms.

6.2.1.2 For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by the Department's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.1.3 Any rate adjustments shall be subject to the availability of State appropriations.

6.2.1.4 Capitation rates shall be based on generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board. [42 CFR 457.10]

6.2.2 In the event the DO incurs costs in the performance of this Agreement that exceed the capitation payments, the State and its agencies are not responsible for those costs and shall not provide additional payments to cover such costs.

6.2.3 The DO shall report to the Department within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement. [42 CFR 438.608(c)(3)]

6.2.4 The DO and the Department agree that the capitation rates in Appendix H - Cost Development may be adjusted periodically (at least annually) to

maintain actuarial soundness as determined by the Department's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.5 The DO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to an DO, including base Confidential Data that is generated by the DO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.6 When requested by the Department, the DO shall submit Encounter Data, financial data, and other Confidential Data to the Department to ensure actuarial soundness in development of the capitated rates, or any other actuarial analysis required by the Department or State or federal law.

6.2.7 The DO's CFO shall submit and concurrently certify to the best of their information, knowledge, and belief that all Confidential Data and information described in 42 CFR 438.604(a), which the Department uses to determine the capitated rates, is accurate. [42 CFR 438.606]

6.2.8 The DO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The capitation rates are calculated net of expected DO recoveries.

6.2.9 The Department shall make a monthly payment to the DO for each Member enrolled in the DO's plan as the Department currently structures its capitation payments.

6.2.9.1 Capitation payments for all standard Medicaid Members shall be made retrospectively with a one month plus five (5) business day lag as soon as the Department system modifications can be completed.

6.2.9.2 Capitation payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.10 Capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.11 Capitation rate does not change during the month, regardless of Member changes (e.g., age), unless the Member's plan enrollment is terminated and the Member is re-enrolled resulting in multiple spans within the month.

6.2.12 Capitation adjustments are processed systematically each month by the Department's MMIS.

6.2.13 The Department shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.14 If a Member is deceased, the Department shall recoup any and all capitation payments after the Member's date of death including any prorated share of a capitation payment intended to cover dates of services after the Member's date of death.

6.2.15 The Department has sole discretion over the capitation rate payment settlement process.

6.2.16 The DO shall follow policies and procedures for the settlement process as developed by the Department.

6.2.17 Based on the provisions herein, the Department shall not make any further retroactive adjustments other than those described herein or elsewhere in this Agreement.

6.2.18 The Department shall have the discretion to recoup payments retroactively up to twenty-four (24) months for Members whom the Department later determines were not eligible for Medicaid during the enrollment month for which capitation payment was made.

6.2.19 After the completion of each Agreement year, an actuarially sound withhold percentage of each DO's capitation payment net of directed payments to the DO shall be calculated as having been withheld by the Department. On the basis of the DO's performance, as determined under the Department's DMCM Withhold and Incentive Guidance.

6.2.20 Details of the DMCM Withhold and Incentive Program are described in DMCM Withhold and Incentive Program guidance provided by the Department as indicated in Section 5.4 (Withhold and Incentive Payment Program).

6.2.21 The Department shall inform the DO of any required program revisions or additions in a timely manner.

6.2.22 The Department may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.23 Unless DOs are exempted, through legislation or otherwise, from having to make payments to the NH Insurance Administrative Fund (Fund) pursuant to RSA 400-A:39, the Department shall reimburse DO for DO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the DO and verification of payment by the NHID.

6.2.24 Should any part of the scope of work under this Agreement relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the DO must do no work on that part after the effective date of the loss of program authority.

6.2.24.1 The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.24.2 If the DO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the DO will not be paid for that work.

6.2.24.3 If the State paid the DO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State.

6.2.24.4 However, if the DO worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the DO, the DO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6.3 Medical Loss Ratio Reporting and Settlement

6.3.1 Minimum Medical Loss Ratio Performance and Rebate Requirements

6.3.1.1 The DO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2 In the event the DO's MLR for any single reporting year is below the minimum of the eighty-five percent (85%) requirement, the DO shall provide to the Department a rebate, no later than sixty (60) calendar days following the Department notification, that amounts to the difference between the total amount of Capitation Payments received by the DO from the Department multiplied by the required MLR of eighty-five percent (85%) and the DO's actual MLR.

6.3.1.3 If the DO fails to pay any rebate owed to the Department in accordance with the time periods set forth by the Department, in addition to providing the required rebate to the Department, the DO shall pay the Department interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate.

6.3.2 Calculation of the Medical Loss Ratio

6.3.2.1 The DO shall calculate and report to the Department the MLR for each MLR reporting year, in accordance with 42 CFR 438.8 and the standards described within this Agreement. [42 CFR 438.8(a)]

6.3.2.2 The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). [42 CFR 438.8 (d)-(f)]

6.3.2.3 Each DO expense shall be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense shall be pro-rated between the two types of expenses.

6.3.2.3.1 Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on a pro rata basis. [42 CFR 438.8(g)(1)(i)-(ii)]

6.3.2.4 Expense allocation shall be based on a generally accepted accounting method that is extended to yield the most accurate results.

6.3.2.4.1 Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

6.3.2.4.2 Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to other entities. [42 CFR 438.8(g)(2)(i)-(iii)]

6.3.2.5 The DO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

6.3.2.5.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.5.2 The DO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

6.3.2.5.3 If the DO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 Medical Loss Ratio Reporting

6.3.3.1 The DO shall submit MLR summary reports quarterly to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements. [42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)].

6.3.3.2 The MLR summary reports shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year, including:

6.3.3.2.1 Total incurred claims;

6.3.3.2.2 Expenditures on quality improvement activities;

6.3.3.2.3 Expenditures related to activities compliant with the program integrity requirements;

6.3.3.2.4 Non-claims costs;

6.3.3.2.5 Premium revenue;

6.3.3.2.6 Taxes;

6.3.3.2.7 Licensing fees;

6.3.3.2.8 Regulatory fees;

6.3.3.2.9 Methodology(ies) for allocation of expenditures;

6.3.3.2.10 Any credibility adjustment applied;

6.3.3.2.11 The calculated MLR;

6.3.3.2.12 Any remittance owed to the State, if applicable;

6.3.3.2.13 A comparison of the information reported with the audited financial report;

6.3.3.2.14 A description of the aggregate method used to calculate total incurred claims; and

6.3.3.2.15 The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)]

6.3.3.3 The DO shall attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to the Department. [42 CFR 438.8(n); 42 CFR 438.8(k)]

6.3.3.4 Such summary reports shall be based on a template provided by the Department within sixty (60) calendar days of the Program Start Date. [42 CFR 438.8(a)]

6.3.3.5 The DO shall in its MLR summary reports aggregate Confidential Data for all Medicaid eligibility groups covered under this Agreement unless otherwise required by the Department.

6.3.3.6 The DO shall require any Subcontractor providing claims adjudication activities to provide all underlying Confidential Data associated with MLR reporting to the DO within one hundred and eighty (180) calendar days or the end of the MLR reporting year or within thirty (30) calendar days of a request by the DO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.7 In any instance in which the Department makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to the Department, the DO shall:

6.3.3.7.1 Re-calculate the MLR for all MLR reporting years affected by the change; and

6.3.3.7.2 Submit a new MLR report meeting the applicable requirements. [42 CFR 438.8(m); 42 CFR 438.8(k)]

6.3.4 The DO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.5 Risk Mitigation

6.3.5.1 [Amendment #3] ~~For the period April 2023 through June 2024, a~~ A minimum dental medical loss ratio (MLR) provision shall be implemented.

6.3.5.1.1 The DMCM capitation rates reflect a target MLR which measures the projected dental service costs as a percentage of the total at-risk DO capitation rates.

6.3.5.1.2 The minimum MLR will limit DO gains if the actual MLR is lower than the minimum MLR.

6.3.5.1.3 The minimum MLR is set on a program-wide basis for all populations combined, such that maximum profit achievable is 3.5%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.0%). Based on the target MLR, the minimum MLR shall be 85.0%.

6.3.5.2 Minimum MLR settlement operational requirements include:

6.3.5.2.1 The numerator for the actual MLR shall include all payments made to providers, such as fee-for-service payments, sub-capitation payments, incentive payments, and settlement payments. The numerator for the actual MLR shall include costs related to quality improvement activities or fraud, waste and abuse prevention.

6.3.5.2.2 Payments and revenue related to premium taxes shall be excluded from the numerator and denominator for the actual MLR.

6.3.5.2.3 Payments or recoupments related to the Withhold and Incentive Program shall be excluded from the minimum MLR settlement. The Withhold and Incentive Program settlement shall occur after the minimum MLR settlement is complete.

6.3.5.2.4 The minimum MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available.

6.4 Financial Responsibility for Dual-Eligible Members

6.4.1 For Medicare Part A and Medicare Part B claims in which the dental portion of the Covered Service is not covered by Medicare the DO shall pay up to the Medicaid allowed amount and billed on an ADA claim.

6.4.2 The DO shall not be responsible for Medicare covered services due to illness, accident or injury.

6.4.3 The DO shall pay Member Cost Sharing up to the Medicaid allowed amount for Medicare Advantage and Medicaid Covered Services in common.

6.5 Medical Cost Accruals

6.5.1 The DO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The DO shall permit the Department or its designee(s) and/or the NHID to inspect and audit any of the financial records of the DO and its Subcontractors.

6.6.2 There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The DO shall file annual and interim financial Statements in accordance with the standards set forth in this Section 6 (Financial Management) of this Agreement.

6.6.4 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the DO shall file, in the form and content prescribed by the NAIC, annual audited financial Statements that have been audited by an independent Certified Public Accountant.

6.6.5 Financial Statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in be sent encrypted, if PHI or PII is included, and PDF format or another read-only format that maintains the documents' security and integrity.

6.6.6 The DO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual Statement and reports as prescribed and adopted by the NHID.

6.6.7 The DO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 Member Liability

6.7.1 The DO shall not hold DMCM Members liable for:

6.7.1.1 The DO's debts, in the event of the DO's insolvency;

6.7.1.2 The Covered Services provided to the Member, for which the State does not pay the DO;

6.7.1.3 The Covered Services provided to the Member, for which the State, or the DO does not pay the individual or health care

Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4 Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the DO provided those services directly. [42 CFR 438.106(a)-(c); section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The DO shall provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the DO's debt if the DO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly [Section 1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; SMDL 12/30/97].

6.7.4 The DO shall cover services to Members for the period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency. [SMM 2086.6B]

6.7.5 The DO shall meet the Department's solvency standards for private health maintenance organizations, or be licensed or certified by the Department as a risk-bearing entity. [Section 1903(m)(1) of the Social Security Act; 42 CFR 438.116(b)]

6.8 Denial of Payment

6.8.1 Payments provided for under the Agreement shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS.

6.8.2 CMS may deny payment to the State for new Members if its determination is not timely contested by the DO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 Federal Matching Funds

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the DO by the Department.

6.10 Third Party Liability

6.10.1 NH Medicaid shall be the payor of last resort for all Covered Services in accordance with federal regulations.

6.10.2 The DO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.3 The Department and the DO shall cooperate in implementing cost avoidance and cost recovery activities.

6.10.4 The DO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.10.5 The Department shall conduct two (2) TPL policy and procedure audits of the DO and its Subcontractors per Agreement year.

6.10.6 Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

6.10.7 The DO shall have one (1) dedicated contact person for the Department for TPL.

6.10.8 The Department and/or its actuary shall identify a market-expected median TPL percentage amount and deduct an appropriate amount from the gross medical costs included in the Department Capitation Payment rate setting process.

6.10.9 All cost recovery amounts, even those greater than identified in the rate cells, shall be retained by the DO.

6.10.10 The DO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.10.10.1 42 CFR 433.138;

6.10.10.2 42 CFR 433.139; and

6.10.10.3 RSA 167:14-a.

6.10.11 Cost Avoidance

6.10.11.1 The DO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 42 U.S.C. 1396a(a)(25) plans and workers compensation.

6.10.11.2 The DO shall establish claims edits and deny payment of claims when active Medicare Advantage Plans with dental or active private insurance exists at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.10.11.3 The DO shall deny payment on a claim that has been denied by Medicare Advantage Plan dental or private insurance when the reason for denial is the Provider or Member's failure to follow prescribed procedures including, but not limited to, failure to obtain Prior Authorization or timely claim filing.

6.10.11.4 The DO shall establish claim edits to ensure claims with Medicare Advantage Plans with dental or private insurance denials are properly denied by the DO.

6.10.11.5 The DO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance or Medicare Advantage Plans if either:

6.10.11.5.1 The primary payer does not cover the services and the DO does; or

6.10.11.5.2 The service was denied as not Medically Necessary and the Provider followed the dispute resolution and/or Appeal Process of the private insurance or Medicare and the denial was upheld.

6.10.11.6 If a claim is denied by the DO based on active Medicare Advantage Plan or active private insurance, the DO shall provide the Medicare Advantage Plan or private insurance information to the Provider.

6.10.11.7 To ensure the DO is cost avoiding, the DO shall implement a file transfer protocol between the Department MMIS and the DO's MCIS to send new, terminated, and changed private insurance information and other information as required pursuant to 42 CFR 433.138.

6.10.11.8 The DO shall implement a nightly file transfer protocol with its Subcontractors to ensure Medicare, private health insurance, ERISA, 42 U.S.C. 1396a(a)(25) plans, and workers compensation policy information is updated and utilized to ensure claims are properly denied for Medicare or private insurance.

6.10.11.9 The DO shall establish, and shall ensure its Subcontractors utilize, monthly electronic Confidential Data matches with private insurance companies (Dental) that sell insurance in the State to obtain current and accurate private insurance information for their Members in accordance with this Agreement. This provision may be satisfied by a contract with a third-party vendor to the DO or its Subcontractors. Notwithstanding the above, the DO remains solely responsible for meeting the requirement.

6.10.11.10 Upon audit, the DO shall demonstrate with written documentation that good faith efforts were made to establish Confidential Data matching agreements with insurers selling in the State who have refused to participate in Confidential Data matching agreements with the DO. All communication with the insurer relating to and including the Confidential data matching agreements shall be in writing and in accordance with this Agreement

6.10.11.11 The DO shall maintain the following private insurance Confidential Data within their system for all insurance policies that a Member may have and include for each policy:

6.10.11.11.1 Member's first and last name;

6.10.11.11.2 Member's policy number;

6.10.11.11.3 Member's group number, if available;

6.10.11.11.4 Policyholder's first and last name;

6.10.11.11.5 Policy coverage type to include at a minimum, Dental coverage,

6.10.11.11.6 Begin date of insurance; and

6.10.11.11.7 End date of insurance (when terminated).

6.10.11.12 The DO shall submit any new, changed, or terminated private insurance Confidential Data to the Department through file transfer on a weekly basis.

6.10.11.13 The DO shall not cost avoid claims for preventive pediatric services (including EPSDT), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3).

6.10.11.14 The DO shall pay all preventive pediatric services and collect reimbursement from private insurance after the claim adjudicates.

6.10.11.15 The DO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the DO Provider contract allowable.

6.10.11.16 On a quarterly basis, the DO shall submit a cost avoidance summary, as described in Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

6.10.11.17 This report shall reflect the number of claims and billed dollar amount avoided by private insurance for all types of dental coverage.

6.10.12 Post Payment Recovery

6.10.12.1 Definitions

6.10.12.1.1 Pay and Chase means recovery of claims paid in which the Medicare Advantage Plan or private insurance was not known at the time the claim was adjudicated.

6.10.12.1.2 Subrogation means personal injury, liability insurance, automobile/home insurance, or accident indemnity insurance where a third party may be liable.

6.10.13 Pay and Chase Private Insurance

6.10.13.1 If private insurance exists for services provided and paid by the DO, but was not known by the DO at time the claim was adjudicated, then the DO shall pursue recovery of funds expended from the private insurance company.

6.10.13.2 The DO shall submit quarterly recovery reports, in accordance with Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements.

6.10.13.3 These reports shall reflect detail and summary information of the DO's collection efforts and recovery from Medicare Advantage Plans and private insurance for all types of dental coverage.

6.10.13.4 DO shall have eight (8) months from the original paid date to initiate recovery of funds from private insurance.

6.10.13.4.1 If the claim is not on the Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements TPLCOB.02 or TPLCOB.03 report for recovery within 8 months of the paid date, the Department has the sole and exclusive right to pursue, collect, and retain funds from private insurance.

6.10.13.4.2 If a recovery is closed on the Exhibit O: Quality and Oversight Reporting Requirements: Quality and Oversight Reporting Requirements TPLCOB.02 or TPLCOB.03 report for any reason, the Department has the right to initiate collections from private insurance, after the DO closure, and retain any funds recovered.

6.10.13.5 The DO shall treat funds recovered from private insurance as offsets to the claims payments by posting within the claim system.

6.10.13.5.1 The DO shall post all payments to claim level detail by Member.

6.10.13.5.2 Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.10.13.5.3 Amounts beyond a Member's outstanding claims shall be returned to the Member.

6.10.13.6 The DO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.10.13.7 The DO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is

established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.14 Subrogation Recoveries

6.10.14.1 The Department shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.10.14.2 The DO shall send any information from insurance carriers or attorneys regarding potential subrogation cases to the Department, designated TPL contact, within five (5) business days of the notification in accordance with this Agreement.

6.10.14.3 The DO shall send any claims history report via excel format to the Department upon request. The DO shall submit the claims history within five (5) business days of the date of the Department's request.

6.10.14.4 The claims history shall have the following information:

6.10.14.4.1 Member's first and last name

6.10.14.4.2 Member's Medicaid ID

6.10.14.4.3 Claim Identification Number

6.10.14.4.4 Billing Provider Name

6.10.14.4.5 Billing Provider NPI

6.10.14.4.6 Date of service

6.10.14.4.7 Date claim paid

6.10.14.4.8 Procedure Code

6.10.14.4.9 Procedure Code Description

6.10.14.4.10 Billed amount

6.10.14.4.11 Paid amount

6.10.14.5 Amount recovered when the DO settles a subrogation case and accepts a settlement amount without written authorization from the Department.

6.10.14.6 DO shall pay any wrap around services not covered by Medicare that are Covered Services under the Medicaid State Plan Amendment and this Agreement.

6.10.15 Estate Recoveries

6.10.15.1 The Department shall be solely responsible for estate recovery activities and shall retain all funds recovered through these activities.

7 TERMINATION OF AGREEMENT

7.1 Termination for Cause

7.1.1 The Department shall have the right to terminate this Agreement, in whole or in part, without liability to the State, if the DO:

7.1.1.1 Takes any action or fails to prevent an action that threatens the health, safety or welfare of any Member, including significant Marketing abuses;

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

7.1.1.3 Has its certification suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement agreement;

7.1.1.4 Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of the Department's notice and written request for compliance;

7.1.1.5 Violates State or federal law or regulation;

7.1.1.6 Fails to carry out a substantive term or terms of this Agreement that is not cured within twenty (20) business days of the Department's notice and written request for compliance;

7.1.1.7 Becomes insolvent;

7.1.1.8 Fails to meet applicable requirements in Sections 1932, 1903 (m) and 1905(t) of the Social Security Act.; [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

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

7.1.1.10 Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily under Title 11 of the U.S. Code.

7.2 Termination for Other Reasons

7.2.1 The DO shall have the right to terminate this Agreement if the Department fails to make agreed-upon payments in a timely manner or fails to comply with any material term or condition of this Agreement, provided that, the Department has not cured such deficiency within sixty (60) business days of its receipt of written notice of such deficiency.

7.2.2 This Agreement may be terminated for convenience by either the DO or the Department as of the last day of any month upon no less than one-hundred twenty (120) business days prior written notice to the other party.

7.2.3 Notwithstanding Section 7.2.2, this Agreement may be terminated immediately by the Department if federal financial participation in the costs hereof becomes unavailable or if State funds sufficient to fulfill its obligations of the Department hereunder are not appropriated by the Legislature. In either event, the Department shall give DO prompt written notice of such termination.

7.2.4 Notwithstanding the above, the DO shall not be relieved of liability to the Department or damages sustained by virtue of any breach of this Agreement by the DO.

7.2.5 Upon termination, all documents, data, and reports prepared by the DO under this Agreement shall become the property of and be delivered to the Department immediately on demand.

7.2.6 The Department may terminate this Agreement, in whole or in part, and place Members into a different DO or provide Medicaid benefits through other Medicaid State Plan Authority, if the Department determines that the DO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.7 In such event, Section 4.7.8 (Access to Providers During Transition of Care) shall apply.

7.3 Claims Responsibilities

7.3.1 The DO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The DO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.5.4 (Service Authorization/Continuity of Care) below, or if the service is provided through the date of discharge.

7.4 Final Obligations

7.4.1 The Department may withhold payments to the DO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the DO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the DO's outstanding final financial obligations.

7.4.2 If all financial obligations of the DO have been satisfied, amounts due to the DO for unpaid premiums, risk settlement, High Dollar Stop Loss, shall be paid to the DO within one (1) year of date of termination of the Agreement.

7.5 Survival of Terms

7.5.1 Termination or expiration of this Agreement for any reason shall not release either the DO or the Department from any liabilities or obligations set forth in this Agreement that:

7.5.1.1 The parties have expressly agreed shall survive any such termination or expiration; or

7.5.1.2 Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration, or obliges either party by law or regulation.

7.5.2 Service Authorization/Continuity of Care

7.5.2.1 Effective fourteen (14) calendar days prior to the last day of the closeout period, the DO shall work cooperatively with the Department and/or its designee to process service authorization requests received.

7.5.2.1.1 Disputes between the DO and the Department and/or its designee regarding service authorizations shall be resolved by the Department in its sole discretion.

7.5.2.2 The DO shall give written notice to the Department of all service authorizations that are not decided upon by the DO within fourteen (14) calendar days prior to the last day of the closeout period.

7.5.2.2.1 Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

7.5.2.3 The Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for the period referenced in Section 4.7.8 (Access to Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new DO's network of Participating Providers.

7.5.2.4 The Member shall be referred to appropriate Participating Providers.

7.5.2.5 The DO that was previously serving the Member, fully and timely complies with requests for historical utilization Confidential Data from the new DO in compliance with State and federal law.

7.5.2.6 Consistent with State and federal law, the Member's new Provider(s) are able to obtain copies of the Member's medical records, as appropriate.

7.5.2.7 Any other necessary procedures as specified by the HHS Secretary to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

7.5.2.8 The Department shall make any other transition of care requirements publically available.

7.6 State Owned Devices, Systems and Network Usage

7.6.1 If Contractor End Users, as defined in Exhibit K: DHHS Information Security Requirements are authorized by the Department's Information Security Office to use a State issued device (e.g. computer, tablet, mobile telephone) and/or access the State' network or system in the fulfilment of this Agreement, each individual being granted access must:

7.6.1.1 Sign and abide by applicable Department and NH Department of Information Technology (DOIT) use agreements, policies, standards, procedures and/or guidelines, and complete applicable trainings as required;

7.6.1.2 Use the information that they have permission to access solely for conducting official Department or State business. All other use or access is strictly forbidden including, but not limited, to personal or other private and non-State use, and that at no time must they access or attempt to access information without having the express authority of the Department to do so;

7.6.1.3 Not access or attempt to access information in a manner inconsistent with the approved policies, standards, procedures, and/or agreement relating to system entry/access;

7.6.1.4 Not copy, share, distribute, sub-license, modify, reverse engineer, rent, or sell software licensed, developed, or being evaluated by the Department, and at all times must use utmost care to protect and keep such software strictly confidential in accordance with the license or any other agreement executed by the Department or State;

7.6.1.5 Only use equipment, software or subscription(s) authorized by the Department's Information Security Officer or designee;.

7.6.1.6 Not install non-standard software on any equipment unless authorized by the Department's Information Security Officer or designee;

7.6.1.7 Agree that email and other electronic communication messages created, sent, and received on a State-issued email system are the property of the State of New Hampshire and to be used for business purposes only. Email is defined as "internal email systems" or "state-funded email systems."

7.6.1.8 Agree that use of email must follow Department and NH DoIT policies, standards, and procedures and:

7.6.1.9 When utilizing the State's email system, the DO must;

7.6.1.9.1 Only use a State email address assigned to them with a "@ affiliate.DHHS.NH.Gov".

7.6.1.9.2 Include in the signature lines information identifying the End User as a non-state workforce member; and

7.6.1.9.3 Ensure the following confidentiality notice is embedded underneath the signature line:

CONFIDENTIALITY NOTICE: "This message may contain information that is privileged and confidential and is intended only for the use of the individual(s) to whom it is addressed. If you receive this message in error, please notify the sender immediately and delete this electronic message and any attachments from your system. Thank you for your cooperation."

7.6.2 If applicable in 7.6.1, Contractor End Users with a State issued email, access or potential access to Confidential Information, as defined in Exhibit K: DHHS Information Security Requirements, and/or workspace in a Department building/ facility must:

7.6.2.1 Complete the Department's online Annual Information Security & Compliance Awareness Training prior to accessing, viewing, handling, hearing or transmitting State Data or Confidential Information.

7.6.2.2 Sign the Department's Business Use and Confidentiality Agreement and Asset Use Agreement, and the NH DoIT Statewide Computer Use Policy upon execution of the agreement and annually throughout the Contract term.

7.6.2.3 Agree End User's will only access the State's intranet to view the Department's Policies and Procedures and Information Security webpages.

7.6.2.4 If any End User is found to be in violation of any of the above-stated terms and conditions of the Contract, said End User may face removal from the State Contract, and/or criminal or civil prosecution, if the act constitutes a violation of law.

7.7 Website And Social Media

7.7.1 The Contractor must agree, if performance of services on behalf of the Department involve using social media or a website for marketing or to solicit information of individuals, or Confidential Information, the Contractor shall work with the Department's Communications Bureau to ensure that any social media or website designed, created, or managed on behalf of the State meets all of the Department's and NH Department of Information

Technology's website and social media requirements and policies as prioritized and approved by the New HEIGHTS Project Manager.

7.7.2 The Contractor must agree protected health information (PHI), personally identifiable information (PII), or other Confidential Information solicited either by social media or the website maintained, stored or captured shall not be further disclosed unless expressly provided in the Contract. The solicitation or disclosure of PHI, PII, or other Confidential Information shall be subject to the Department's Exhibit K: Information Security Requirements, Exhibit I: Health Insurance Portability and Accountability Act Business Associate Agreement, the IT Requirements Workbook, and all applicable State rules and State and federal law. Unless specifically required by the Contract and unless clear notice is provided to users of the website or social media, the Contractor agrees that site visitation will not be tracked, disclosed or used for website or social media analytics or marketing.

7.8 Privacy Impact Assessment

7.8.1 Upon request, the Contractor and its End Users must allow and assist the Department to conduct a Privacy Impact Assessment (PIA) of the Contractor's Applications/Systems/Websites/Web Portals or as applicable, Department applications/systems/websites/web portals hosted by the Contractor if Personally Identifiable Information (PII) is collected, used, accessed, shared, or stored. To conduct the PIA the Contractor must provide the State access to the aforementioned applicable systems and documentation sufficient to allow the State to assess, at minimum, the following:

7.8.1.1 How PII is gathered and stored;

7.8.1.2 Who will have access to PII;

7.8.1.3 How PII will be used in the system;

7.8.1.4 If federal PII is being gathered and stored:

7.8.1.5 How individual consent will be achieved and revoked; and

7.8.1.6 Privacy practices.

7.8.2 The Department may conduct follow-up PIA's in the event there are either significant process changes or new technologies impacting the collection, processing or storage of PII.

Dental Medicaid Care Management Services
Exhibit N
Liquidated Damages Matrix

Liquidated damages shall be assessed based on the violation or non-compliance set forth in this Matrix. While Exhibit O measures compliance in a specific timeframe, typically monthly, the liquidated damages shall be assessed based on the timeframe below. For example, if the DO fails to meet a monthly requirement set forth in Exhibit O, and according to this Exhibit the liquidated damages are assessed weekly, then the liquidated damages shall be assessed for each week within the month that was found to be in violation.

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
1. LEVEL 1 DO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program.	1.1 Failure to substantially provide medically necessary covered services	$5,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	Up to $20,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$5,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$2,000 per violation up to a maximum of $25,000 or double the amount of the excess charges (whichever is greater) (DHHS will return the overcharge to the Member)
	1.5 Failure to meet minimum care management and care coordination requirements (Section 4.10).	$5,000 per week of violation
	1.6 Failure to meet the Agreement's Time and Distance Standards and Timely Access to Service Delivery Standards (without an approved exception) at Program Start and/or through the contract term (without an approved exception)	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan $20,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.7 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation
	1.8 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$2,000 per month of violation (for each month that DHHS determines that the DO is not substantially in compliance)

Dental Medicaid Care Management Services
Exhibit N
Liquidated Damages Matrix

	1.10 Continuing failure to resolve individual member appeals and grievances within specified timeframes	$1,000 per appeal or grievance that continues to not meet specified timeframes; per month
	1.11 Failure to submit timely, accurate, and/or complete encounter data submission in the required file format *(For submissions more than 30 calendar days late, DHHS reserves the right to withhold 5% of the aggregate capitation payments made to the DO in that month until such time as the required submission is made)*	$1,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$5,000 per violation
	1.13 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 2 violation	$5,000 per violation
	1.14 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled, $500 per additional day provider is not suspended once DO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.15 Failure to notify a member of DHHS senior management within twelve (12) hours of a report by the Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the DO, its Subcontractor or a Provider	$10,000 per violation
	1.16 Two or more Level 1 violations within a contract year	$15,000 per occurrence
2. LEVEL 2 DO action(s) or inaction(s) that jeopardize the integrity of the managed care program, but	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the DO until deficiencies in the DO's readiness activities are rectified)
	2.2 Failure to maintain the privacy and/or security of data containing protected health information (PHI) which results in a breach of the security	$20,000 per violation

Dental Medicaid Care Management Services
Exhibit N
Liquidated Damages Matrix

does not necessarily jeopardize member(s) health, safety, and welfare or access to care.	of such information and/or timely report violations in the access, use, and disclosure of PHI	
	2.3 Failure to meet prompt payment requirements and standards	$5,000 per violation
	2.4 Failure to cost avoid, inclusive of private insurance, Medicare or subrogation, at least 1% of paid claims in the first year of the contract, 1.2% in the second year, and 1.5% in contract years 3, 4, and 5; or failure to provide adequate information to determine cost avoidance percentage as determined by DHHS	$10,000 per violation
	2.5 Failure to cost avoid claims of known third party liability (TPL)	$250 per member and total claim amount paid that should have been cost avoided
	2.6 Failure to collect overpayments for waste and abuse in the amount of 0.06% of paid claim amounts in the first year of the contract, 0.08% in the second year, and 0.10% in years 3, 4, and 5	$10,000 per violation
	2.7 [Amendment #4] Failure to refer at least 5 ~~20~~ potential instances of subcontractor or provider fraud, waste, or abuse to DHHS annually	$2,000 unless good cause determined by Program Integrity
	2.8 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation
	2.9 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	2.10 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 3 violation	$5,000 per week of violation
	2.11 Failure to suspend or terminate providers in which it has been determined by DHHS that the provider has committed a violation or is under fraud investigation by MFCU when instructed by DHHS	$500 per day of violation
	2.12 Failure to timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.13 Failure to meet performance standards in the contract which include, but are not limited to:	$1,000 per violation

Dental Medicaid Care Management Services
Exhibit N
Liquidated Damages Matrix

	2.13.1 Care management measures (Sections 4.10.2.8, 4.10.2.10, and 4.10.2.11); 2.13.2 Claims processing (Sections 4.17.1.5, 4.17.1.6, 4.17.2.3, 4.17.2.4, 4.17.3.2, 4.17.4.2, and 4.17.5.2; 2.13.3 Call center performance (Sections 4.3.1.9.3.1, 4.3.1.9.4.2, 4.12.4.1.11.1, 4.12.4.1.11.2, 4.12.4.1.11.3, and 4.12.4.1.14.); 2.13.4 Non-emergency medical transportation (Section 4.1.12.3); and 2.13.5 Service authorization processing (Sections 4.8.1.4.2 - 4.8.1.4.8, 4.8.7.3.4, and 4.16.1.3.7)	
	2.14 Failure to meet 97% of claims financial accuracy requirements (Section 4.17.4.2), and 95% of post service authorization processing requirements (Section 4.8.7.3.4)	$1,000 per violation
	2.15 Two or more Level 2 violations within a contract year	$10,000 per occurrence
	2.16 Failure to comply with subrogation timeframes established in RSA 167:14-a	$3,000 per occurrence
3. LEVEL 3 DO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring DHHS review and/or approval or as requested by an audit	$2,000 per violation
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	$2,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	$2,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$2,000 per violation

DS
Contractor Initials TR
Date 6/5/2025

Dental Medicaid Care Management Services
Exhibit N
Liquidated Damages Matrix

	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$5,000 per violation
	3.7 Failure to submit and obtain DHHS review and approval for applicable Subcontracts	$5,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$2,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 4 violation	$5,000 per week of violation
	3.10 Two or more Level 3 violations within a contract year	$20,000 per occurrence
4. LEVEL 4 DO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete, measure, report or deliverable (excludes encounter data and other financial reports). The violation shall apply to resubmissions that occur in contract years following the initial submission due date.	$1,000 for each of the first ten occurrences each contract year, $5,000 for each additional occurrence in same contract year. The number of occurrences in a contract year shall be the aggregate of all issues subject to liquidated damages in this Section 4.1.
	4.2 Failure to comply with timeframes for distributing (or providing access to) beneficiary handbooks, identification cards, provider directories, and educational materials to beneficiaries (or potential members)	$5,000 per violation
	4.3 Failure to meet minimum requirements requiring coordination and cooperation with external entities (e.g., the New Hampshire Medicaid Fraud Control Unit, Office of the Inspector General) as described in the contract	$5,000 per violation
	4.4 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence
	4.5 Failure to meet staffing requirements	$5,000 per violation
	4.6 Failure to ensure provider agreements include all required provisions	$2,000 per violation

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on June 30, 1961. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **69014**

Certificate Number: **0007182675**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 16th day of May A.D. 2025.

David M. Scanlan

Secretary of State

Northeast Delta Dental
www.nedelta.com

CERTIFICATE OF AUTHORITY

I, Sara M. Brehm, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of the Delta Dental Plan of New Hampshire.

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on October 12, 2022, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Thomas Raffio, President & Chief Executive Officer is duly authorized on behalf of Delta Dental Plan of New Hampshire to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority was **valid thirty (30) days prior to and remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: May 15, 2025

Signature of Elected Officer
Name: Sara M. Brehm
Title: Corporate Secretary
Delta Dental Plan of New Hampshire

DELTDEN-01 MSNELL

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 1/31/2025

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 have ADDITIONAL INSURED provisions or 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 Davis & Towle Morrill & Everett, Inc. 115 Airport Road Concord, NH 03301	CONTACT NAME: Mary Ellen Snell, CIC PHONE (A/C, No, Ext): (603) 715-9754 FAX (A/C, No): (603) 225-7935 E-MAIL ADDRESS: msnell@davistowle.com
INSURED Delta Dental Plan of NH Inc DBA Northeast Delta Dental PO Box 2002 Concord, NH 03302-2002	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Acadia Insurance Company — 31325 INSURER B : MEMIC Indemnity Co. INSURER C : TDC Specialty Insurance Co. INSURER D : Travelers Insurance — 19046 INSURER E : INSURER F :

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

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	[X] COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR			CPA5622974	1/1/2025	1/1/2026	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	[ ] POLICY [X] PRO-JECT [X] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	[ ] OTHER:						EMPLOYEE BENEFI	$ 1,000,000
A	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[X] ANY AUTO			CAA5622975	1/1/2025	1/1/2026	BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	[X] UMBRELLA LIAB [X] OCCUR						EACH OCCURRENCE	$ 10,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE			CUA5622976	1/1/2025	1/1/2026	AGGREGATE	$ 10,000,000
	[ ] DED [X] RETENTION $ 10,000							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						[X] PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N]	N/A		3102801427	1/1/2025	1/1/2026	E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
C	Errors & Ommissions			MCP007492404	7/27/2024	7/27/2025		3,000,000
D	Crime			106224556	1/1/2025	1/1/2026		3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Named Insured includes the following entities:
Delta Dental Plan of ME DBA Northeast Delta Dental
Delta Dental Plan of VT DBA Northeast Delta Dental
Combined Services, LLC - CS One Benefit Solutions
New England Dental Administrators, LLC
Red Tree Holdings, Inc.
Red Tree Insurance Company, Inc. Management Liability - D&O/EPLI
SEE ATTACHED ACORD 101

CERTIFICATE HOLDER

State of New Hampshire
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

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
Mary Ellen Snell

AGENCY CUSTOMER ID: DELTDEN-01 MSNELL

LOC #: 1

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Davis & Towle Morrill & Everett, Inc.	Delta Dental Plan of NH Inc DBA Northeast Delta Dental PO Box 2002 Concord, NH 03302-2002
POLICY NUMBER SEE PAGE 1	
CARRIER: SEE PAGE 1 / NAIC CODE: SEE P 1	EFFECTIVE DATE: SEE PAGE 1

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: ACORD 25 FORM TITLE: Certificate of Liability Insurance

Description of Operations/Locations/Vehicles:
PreViser Corporation
Northeast Delta Dental Foundation, Inc.
University of Vermont
Mutual of Omaha Insurance Company

Policy # MMP012612200 - TDC Specialty Insurance Company
7/27/2024 to 7/27/2025
D&O Shared Limits
Per Claim: $4,000,000
Aggregate: $5,000,000
Retention: $125,000
EPLI Shared Limits
Per Claim: $4,000,000
Aggregate: $5,000,000
Retention: $125,000
Antitrust Violations Limit: $1,000,000

Fiduciary
Policy # 107675796 - Travelers
7/27/2024 to 7/27/2025
Employee Theft: $1,000,000
$10,000 deductible

Northeast Delta Dental

Our Business, Mission, Vision and Values

Our Business: Northeast Delta Dental is a not-for-profit organization focused on developing and administering the highest quality dental and wellness benefits solutions. We are a leader in the insurance marketplace in New Hampshire, Maine and Vermont because of our investment in people, systems and communities, as well as a commitment to high quality service. All of this is underpinned by:

Our commitment to earning the loyalty of all our stakeholders, including employee colleagues, customers, participating dentists, brokers, and communities we serve;

Our consistent award-winning recognition as a top employer of choice, which confirms our employee colleagues' resolve to provide world-class service to our stakeholders and each other;

Our guarantee of outstanding claims processing and personal service provided by dedicated employee colleagues and supported by our investment in technology to build efficiency, accuracy, and security;

Our participating dentists' commitment to excellence;

Our high quality, innovative dental and wellness benefits solutions that set us apart from other insurers;

Our dedication to dental health and wellness for the people in our communities because everyone deserves a healthy smile;

Our commitment to hold down administrative costs while ensuring we have the financial strength to weather crises and make ongoing investments in our communities.

Our Mission: To advance the dental health and overall wellness of our customers and the communities we serve.

Our Vision: To be recognized as the dental and wellness benefits company that provides innovative products and timely service to all our stakeholders and that brings healthy smiles to everyone in our communities.

Approved on 9/14/2023

Our Values:

We believe that effective ***communication*** is essential to earning the continued designation as one of the best places to work and being a valued business partner for all customers, dentists, brokers, non-profits, and service providers.

We believe that ***teamwork*** is key to working effectively toward our mission, being committed to giving 100% and to working collaboratively with shared responsibility and accountability.

We believe that ***quality*** is necessary to effectively deliver on our mission and goals, achieve excellence in all that we do, and foster a consistent feeling of pride in our work.

We believe that ***integrity*** is imperative to building and maintaining the trust, respect, and admiration of all our stakeholders.

Approved on 9/14/2023

BAKER NEWMAN NOYES

Delta Dental Plan of New Hampshire, Inc.

Audited Statutory Financial Statements

Years Ended December 31, 2024 and 2023
With Independent Auditors' Report

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

BAKER NEWMAN NOYES

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HLB WE ARE AN INDEPENDENT MEMBER OF THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

INDEPENDENT AUDITORS' REPORT

Board of Directors
Delta Dental Plan of New Hampshire, Inc.

Report on the Audit of the Financial Statements

Opinions

We have audited the statutory financial statements of Delta Dental Plan of New Hampshire, Inc. (the Corporation), which comprise the statutory statements of admitted assets, liabilities, and surplus as of December 31, 2024 and 2023, and the related statutory statements of operations and changes in surplus and cash flows for the years then ended, and the related notes to the statutory financial statements.

Unmodified Opinion on Regulatory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the admitted assets, liabilities, and surplus of the Corporation as of December 31, 2024 and 2023, and the results of its operations and its cash flows for the years then ended in accordance with the basis of accounting described in note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Corporation as of December 31, 2024 and 2023, or the results of its operations or its cash flows thereof for the years then ended.

Basis for Opinions

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Corporation and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in note 2 of the financial statements, the financial statements are prepared by the Corporation using accounting practices prescribed or permitted by the New Hampshire Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between these statutory accounting practices described in note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material and pervasive.

Board of Directors
Delta Dental Plan of New Hampshire, Inc.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting practices prescribed or permitted by the New Hampshire Insurance Department. Management is also responsible for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern for a period of within one year after the date that the financial statements are issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Corporation's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Board of Directors
Delta Dental Plan of New Hampshire, Inc.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the statutory financial statements as a whole. The accompanying supplementary information included in the Supplemental Investment Risks Interrogatories is presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and is not a required part of the statutory financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the statutory financial statements. The information has been subjected to the auditing procedures applied in the audits of the statutory financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory financial statements or to the statutory financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the statutory financial statements as a whole.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 28, 2025

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

STATUTORY STATEMENTS OF ADMITTED ASSETS, LIABILITIES AND SURPLUS

December 31, 2024 and 2023

	2024	2023
ADMITTED ASSETS		
Admitted assets:		
Investments	$64,788,337	$60,568,846
Investment in affiliate	3,817,683	3,407,431
Cash and short-term investments	9,265,214	12,975,087
Accounts receivable	6,582,325	6,600,985
Accounts receivable – related parties	671,843	884,505
Real estate, net of accumulated depreciation of $9,009,952 and $8,551,472 in 2024 and 2023, respectively	3,896,848	3,985,928
Computer equipment – admitted	894,473	818,474
Accrued investment income	223,615	206,063
Total admitted assets	$90,140,338	$89,447,319
LIABILITIES AND SURPLUS		
Liabilities:		
Subscribers' claims payable and related accrued expenses (including assumed subscribers' claims payable of $354,875 and $366,766 at December 31, 2024 and 2023, respectively)	$ 2,418,575	$ 2,305,965
Accounts payable and accrued expenses	7,762,063	8,288,087
Accounts payable – related parties	96,984	533,786
Unearned revenue and advances	5,745,023	5,019,763
Accrued refunds	559,127	540,686
Total liabilities	16,581,772	16,688,287
Commitments and contingencies (notes 2, 4, 5, 7 and 9)		
Surplus	73,558,566	72,759,032
Total liabilities and surplus	$90,140,338	$89,447,319

See accompanying notes to statutory financial statements.

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

STATUTORY STATEMENTS OF OPERATIONS AND CHANGES IN SURPLUS

Years ended December 31, 2024 and 2023

	2024	2023
Revenues:		
Premiums earned (including assumed premiums of $5,909,266 in 2024 and $5,492,485 in 2023)	$ 89,446,725	$ 85,541,440
Management fee	100,000	100,000
Total revenues	89,546,725	85,641,440
Net losses and expenses incurred:		
Risk claims incurred (including assumed claims of $5,310,159 in 2024 and $4,891,800 in 2023)	70,977,010	65,591,870
Gross underwriting expenses	53,869,195	48,541,632
Less fees attributable to administrative service contracts (net of dental claims paid of $372,489,264 in 2024 and $339,258,913 in 2023)	(31,840,396)	(30,105,909)
Underwriting expenses, net	22,028,799	18,435,723
Net losses and expenses incurred	93,005,809	84,027,593
(Deficiency) excess of revenues over losses and expenses incurred	(3,459,084)	1,613,847
Net investment and rental real estate income	2,976,948	2,297,943
(Loss) gain on disposal of fixed assets	(1,851)	5,000
Net (loss) income	(483,987)	3,916,790
Change in net unrealized appreciation on investments	1,198,161	1,793,819
Change in non-admitted assets	85,360	683,553
	1,283,521	2,477,372
Net increase in surplus	799,534	6,394,162
Surplus – beginning of year	72,759,032	66,364,870
Surplus – end of year	$ 73,558,566	$ 72,759,032

See accompanying notes to statutory financial statements.

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

STATUTORY STATEMENTS OF CASH FLOWS

Years Ended December 31, 2024 and 2023

	2024	2023
Cash flows from operations:		
Premium and other income collected	$ 89,394,427	$ 84,863,652
Subscribers' claims paid	(70,872,500)	(65,525,785)
Net underwriting expenses paid	(20,149,659)	(15,935,298)
Investment and rental real estate income, net	1,962,997	1,674,182
Net cash provided by operations	335,265	5,076,751
Cash flows from investing activities:		
Proceeds from long-term investments sold or matured:		
Bonds	9,727,341	9,046,744
Equity mutual funds	2,099,645	1,708,973
Total investment proceeds	11,826,986	10,755,717
Cost of long-term investments acquired:		
Bonds	(11,366,546)	(11,089,142)
Fixed income exchange-traded funds	(2,580,456)	(1,285,035)
Equity mutual funds	(210,767)	(204,991)
Total long-term investments acquired	(14,157,769)	(12,579,168)
Net cash used by long-term investing activities	(2,330,783)	(1,823,451)
Cash flows from financing and miscellaneous sources:		
Purchase of capital assets	(1,714,355)	(1,471,907)
Net cash used by financing and miscellaneous sources	(1,714,355)	(1,471,907)
Net (decrease) increase in cash and short-term investments	(3,709,873)	1,781,393
Cash and short-term investments – beginning of year	12,975,087	11,193,694
Cash and short-term investments – end of year	$ 9,265,214	$ 12,975,087

See accompanying notes to statutory financial statements.

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

NOTES TO STATUTORY FINANCIAL STATEMENTS

December 31, 2024 and 2023

1. Organization

Delta Dental Plan of New Hampshire, Inc. (the Corporation) is a nonprofit, tax-exempt organization which provides programs of dental care rendered by licensed dentists, to businesses, associations, unions and individuals located primarily in New Hampshire that become subscribers to the programs. Dental services are provided under written contracts and benefits are paid up to a maximum amount per covered individual, as defined by the various programs. The Corporation also provides billing and claims processing, marketing and other administrative services to Delta Dental Plan of Vermont, Inc. (DDPVT), Maine Dental Service Corporation d/b/a Delta Dental Plan of Maine (DDPME), New England Dental Administrators, LLC (NEDA), and Red Tree Insurance Company, Inc. (RTI). The Corporation also provides administrative services to Combined Services, LLC d/b/a csONE Benefit Solutions (CSLLC), PreViser Corporation (PreViser) and Red Tree Holdings, Inc. (RTH). See also notes 4 and 7.

2. Summary of Significant Accounting Policies

Basis of Presentation

These statutory financial statements are prepared in conformity with statutory accounting practices of the National Association of Insurance Commissioners (NAIC) as prescribed or permitted by the New Hampshire Insurance Department.

Statutory accounting practices vary in certain respects from generally accepted accounting principles in the United States of America (U.S. GAAP) for nonprofit organizations. The most significant differences applicable to the Corporation include the following:

(1) Statutory accounting requires that policy acquisition costs be charged to current income as incurred. Under U.S. GAAP, policy acquisition costs would be deferred and then amortized ratably over the periods covered by the policies;

(2) Under statutory accounting, certain assets designated as "non-admitted assets" (principally premiums receivable over 90 days past due, and certain software and office furniture and equipment) are charged directly to surplus. U.S. GAAP would require the Corporation to record accounts receivable based on amounts deemed to be collectible. Office furniture and equipment would be capitalized and depreciated over their estimated useful lives;

(3) Under statutory accounting, investments in individual debt securities are generally carried at amortized cost. Under U.S. GAAP, debt securities held by a nonprofit organization are classified as available for sale and are recorded at fair value; changes in unrealized gains and losses are recorded in the statement of operations. Investments in individual equity securities are carried at fair value under both statutory accounting and U.S. GAAP; changes in unrealized gains and losses are reflected in change in net unrealized appreciation on investments through surplus under statutory accounting and are recorded through operations under U.S. GAAP;

(4) For cash flow purposes, included as cash and cash equivalents are short-term investments which mature within one year of original purchase date as opposed to three months as required by U.S. GAAP, and a reconciliation of operating cash flows to the indirect method is not provided under statutory accounting;

2. **Summary of Significant Accounting Policies (Continued)**

(5) Under statutory accounting, operating results for investments held under the equity method (such as the investment in RTH) are reflected in change in net unrealized appreciation (depreciation) on investments. Under U.S. GAAP, operating results would be reflected in investment income;

(6) Under statutory accounting, net administrative fee income earned under self-funded group contracts reduces underwriting expenses. Under U.S. GAAP, gross administrative fee revenue would be included in total revenues; and

(7) Under statutory accounting, all leases are treated as operating leases with no corresponding asset or liability reflected in the balance sheet. Under U.S. GAAP, leases are recorded as an operating lease or finance lease, based on certain criteria, and a corresponding right-of-use asset and lease liability is recorded on the balance sheet.

Cash and Short-Term Investments

In accordance with statutory requirements, the Corporation classifies all investments with maturities of less than one year when purchased as short-term investments. Short-term investments are included with cash and are carried at the lower of amortized cost using the interest method or fair value.

The Corporation maintains cash balances with financial institutions that may exceed federal depository insurance limits; however, management believes the credit risk related to these financial institutions is minimal. The Corporation has not experienced any losses in such accounts and management believes the Corporation is not exposed to any significant risk at December 31, 2024.

Valuation of Investment Securities

Bonds, equity mutual funds, fixed income exchange-traded funds, and equity securities are valued in accordance with the laws of the State of New Hampshire or the valuations prescribed by the Committee on Valuation of Securities of the National Association of Insurance Commissioners. Generally, bonds not backed by other loans are stated at amortized cost; mortgage-backed securities are stated at amortized value using the retrospective adjustment method of valuation; and equity mutual funds and fixed income exchange-traded funds are stated at NAIC fair value. Equity security at December 31, 2024 and 2023 consists of an investment in a publicly traded corporation. Unrealized gains and losses on equity mutual funds, fixed income exchange-traded funds, and equity securities are credited or charged to surplus. The Corporation evaluates the creditworthiness of its bond portfolio by internally evaluating credit exposure and by referring to ratings of widely accepted credit rating services. Noninvestment grade bonds, i.e., bonds with an NAIC rating of "3" through "6," are stated at the lower of amortized cost or fair value. Declines in bond, equity mutual fund, fixed income exchange-traded fund, and equity securities fair values which are determined to be other than temporary are recorded as realized losses. See also note 3.

2. **Summary of Significant Accounting Policies (Continued)**

Realized gains and losses are determined using the first-in-first-out basis for individual bonds, mutual funds and fixed income exchange-traded funds at the time of disposition. Realized gains and losses are identified on a specific identification basis for other securities. Interest income is recognized on the accrual basis and dividends are recognized on an ex-dividend basis.

Non-admitted Assets

The Corporation's assets are included in the statutory statement of admitted assets, liabilities, and surplus at "admitted asset value" and "non-admitted assets" (including accounts receivable past due more than 90 days, prepaid expenses, certain software, furniture and equipment) are excluded through a charge against surplus.

Investment in Affiliate

The Corporation accounts for its investment in RTH on the equity basis in accordance with statutory accounting principles. Operating results, less any dividend distributions, for this investment are reflected within change in net unrealized appreciation on investments, and changes in value due to permanent impairment are recorded in net investment and rental real estate income in the accompanying statutory statements of operations and changes in surplus. See also notes 3 and 4.

Accrued Refunds

The terms of certain specific group contracts require underwriting gains in excess of a fixed administration fee to be refunded to the group. Underwriting losses, including a fixed administration fee, that are less than a certain percentage of premiums are not refunded to the Corporation. The accumulated net underwriting gain due to this group as of December 31, 2024 and 2023 has been reflected in the accompanying statutory statements of admitted assets, liabilities and surplus as accrued refunds. The group is paid interest on the monthly accrued refund balance based on the 90-day U.S. Treasury rate (4.37% at December 31, 2024 and 5.20% at December 31, 2023).

Revenue Recognition and Accounts Receivable

The Corporation earns income from short duration contracts for regular premiums and administrative services contracts. The Corporation does not incur underwriting risk associated with the administrative services contracts. Regular premiums are billed in advance of the coverage month and recognized as receivables and revenue at the commencement of the coverage month.

Fees attributable to and dental claims paid under administrative services contracts also include revenues and related claims from providing premium and claims processing, marketing and other administrative services to DDPVT and DDPME (note 7).

2. **Summary of Significant Accounting Policies (Continued)**

Normally, advance deposits are required for administrative services contracts as these contracts are billed either weekly or monthly on a paid claims basis. Under the Corporation's administrative services contracts, the Corporation charges self-funded groups a monthly service fee for administering the dental program and recognizes these amounts as revenue as the services are performed. For the years ended December 31, 2024 and 2023, net losses and expenses incurred are reduced by $9,239,212 and $8,849,225, respectively, of service fees related to administrative services contracts from unrelated parties (see note 7 for service fees related to administrative service contracts from related parties). Costs of acquiring and renewing business are charged to expense as incurred.

At December 31, 2024 and 2023, the Corporation had admitted assets of $6,582,325 and $6,600,985, respectively, for accounts receivable. The Corporation routinely evaluates the collectibility of these receivables. Based upon Corporation experience, there were no uncollectible accounts as of December 31, 2024 and 2023, and, therefore, no additional provision for uncollectible amounts has been recorded. The potential for any loss is not believed to be material to the Corporation's financial condition.

In April 2023, the Corporation entered into an agreement with DentaQuest USA Insurance Company, Inc. (DentaQuest), whereby the Corporation administers dental benefits to adults on Medicaid through a contract with the State of New Hampshire Department of Health and Human Services (Department of Medicaid Services). DentaQuest arranges to provide dental services to members enrolled in the New Hampshire Dental Medicaid Care Management Program. The Corporation pays DentaQuest a capitation per member per month fee equal to the funds received by the State of New Hampshire, and retains a 0.4% administration fee through August 2023, a 0.8% administration fee thereafter, and 2% for the monthly estimated premium tax. The contract term ends on March 31, 2026. The Corporation recognized $1,065,242 and $1,070,116 of revenue, including administration fees, allowance for premium taxes and estimated gain from maintaining a dental loss ratio of less than 85%, for which profits are split between DentaQuest and the Corporation for the amount between 85% and 90%, respectively, for the years ended December 31, 2024 and December 31, 2023, which amounts are recorded in premiums earned in the accompanying statutory statements of operations and changes in surplus. There was $940,000 and $500,000, respectively, recorded in accounts receivable in the accompanying statutory statement of admitted assets, liabilities, and surplus at December 31, 2024 and 2023.

Advertising Costs

Advertising costs are charged to operations when the advertising is placed. Total advertising costs for the years ended December 31, 2024 and 2023 were $2,755,110 and $2,481,571, respectively.

Depreciation and Amortization

Depreciation and amortization on fixed assets is determined using the straight-line method over the estimated useful lives of the assets. Estimated lives range from 3 to 30 years. Within fixed assets, most software and office furniture and equipment are non-admitted assets.

2. **Summary of Significant Accounting Policies (Continued)**

Reinsurance

The Corporation, DDPME and DDPVT have each entered into reinsurance agreements whereby they assumed a portion of the risk for various dental benefit contracts. The Corporation has reinsurance agreements with Delta Dental of California (three in 2024 and 2023) to reinsure approximately 0.84% of the risk and expenses associated with these specific dental benefit contracts. Premiums are recognized as revenue over the policy term, and claims, including an estimate of claims incurred but not reported, are recognized as they are incurred. Claims incurred but not reported related to reinsurance agreements at December 31, 2024 and 2023 are reported in subscribers' claims payable and related accrued expenses (see also note 8).

Income Taxes

The Corporation is generally exempt from federal and state income taxes under the provisions of Section 501(c)(4) of the Internal Revenue Code. However, the Corporation may still be subject to certain income taxes on net income generated from activities deemed to be unrelated business income. Management has evaluated the Corporation's tax positions taken on its filed tax returns and concluded that the Corporation has maintained its tax-exempt status.

Prior to January 1, 2012, the Corporation transferred a one-third interest held in New England Dental Administrators, LLC (NEDA) to RTH. NEDA, which was treated as a partnership for federal income tax purposes, had incurred pre-2018 net losses since its inception. As of December 31, 2024 and 2023, the Corporation's share of net operating loss carryforwards relating to NEDA was approximately $140,500 and $208,500 respectively, for income tax purposes, expiring in 2024 through 2030. Additionally, the Corporation's share of post-2017 net operating loss carryforwards relating to NEDA are approximately $14,000 as of the date of these financial statements, expiring in 2043. No amounts have been recorded in the accompanying statutory financial statements related to these net operating loss carryforwards. Net operating losses are used by the Corporation when the Corporation generates unrelated business income. Any net income or losses incurred by NEDA subsequent to the transfer of the Corporation's interest to RTH do not affect the net operating loss carryforwards of the Corporation.

Use of Estimates

The preparation of statutory financial statements in conformity with accounting practices prescribed or permitted by the New Hampshire Insurance Department and the National Association of Insurance Commissioners requires management to make estimates and assumptions that affect the reported amounts of admitted assets and liabilities and disclosure of contingent assets and liabilities at the date of the statutory financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimate required in the preparation of the statutory financial statements relates to subscribers' claims payable and related accrued expenses.

Subscribers' claims payable represent anticipated claims based upon past paid claims experience. The related accrued expenses consist of the estimated expenses, which will be incurred in connection with processing and paying these claims. Such estimates may be more or less than the amount ultimately paid when claims are settled. There is at least a reasonable possibility that the recorded estimates will change by a material amount in the near future.

2. Summary of Significant Accounting Policies (Continued)

Pending Statutory Accounting Principle

In August 2024, the NAIC revised *Statement of Statutory Accounting Principles* (SSAP) No. 26, *Bonds*, to clarify what qualifies as a bond for statutory accounting purposes by emphasizing the substance of an investment rather than its legal form, excluding certain securities like structured notes or equity-like investments that previously may have been considered bonds and directing those to be reporting under SSAS No. 21, *Other Admitted Assets*. These changes are effective for the Corporation on January 1, 2025. The Corporation is currently evaluating the impact that this new accounting principle will have on its statutory financial statements.

Subsequent Events

Events occurring after the date of the statements of admitted assets, liabilities and surplus are evaluated by management to determine whether such events should be recognized or disclosed in the statutory financial statements. Management of the Corporation has evaluated subsequent events through February 28, 2025, which is the date the statutory financial statements were available to be issued.

3. Investments

Investments are composed of the following at December 31:

	Amortized Cost	Fair Value	Carrying Value
2024			
U.S. Government obligations	$ 8,890,197	$ 8,186,904	$ 8,890,197
Government-sponsored entities' bonds	12,508,002	11,922,194	12,508,002
Corporate bonds and notes	9,712,288	9,160,865	9,712,288
Fixed income exchange-traded funds	22,170,172	21,032,792	21,032,792
Equity mutual funds	4,869,113	12,615,933	12,615,933
Equity security	50,220	29,125	29,125
	$58,199,992	$62,947,813	$64,788,337
2023			
U.S. Government obligations	$ 8,278,041	$ 7,741,470	$ 8,278,041
Government-sponsored entities' bonds	11,531,137	11,205,864	11,531,137
Corporate bonds and notes	10,134,330	9,456,551	10,134,330
Fixed income exchange-traded funds	19,588,755	18,490,711	18,490,711
Equity mutual funds	5,185,927	12,083,620	12,083,620
Equity security	50,220	51,007	51,007
	$54,768,410	$59,029,223	$60,568,846

3. Investments (Continued)

As of December 31, 2024 and 2023, the Corporation is not invested in any single investment over 10% of total investments carrying value.

The carrying value, aggregate fair value, and gross unrealized gains and losses of investments in debt securities are as follows at December 31:

	Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Aggregate Fair Value
2024				
U.S. Government obligations	$ 8,890,197	$ 1,232	$ (704,525)	$ 8,186,904
Government-sponsored entities' bonds	12,508,002	41,793	(627,601)	11,922,194
Corporate bonds and notes	9,712,288	33,793	(585,216)	9,160,865
	$31,110,487	$ 76,818	$(1,917,342)	$29,269,963
2023				
U.S. Government obligations	$ 8,278,041	$ 44,130	$ (580,701)	$ 7,741,470
Government-sponsored entities' bonds	11,531,137	162,432	(487,705)	11,205,864
Corporate bonds and notes	10,134,330	62,103	(739,882)	9,456,551
	$29,943,508	$268,665	$(1,808,288)	$28,403,885

The carrying value and fair value of debt securities at December 31, 2024 by contractual maturity is shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Carrying Value	Fair Value
Due in one year or less	$ 274,793	$ 273,894
Due after one year through five years	3,370,332	3,314,723
Due after five years through ten years	8,905,781	8,508,165
Due after ten years	18,559,581	17,173,181
	$31,110,487	$29,269,963

Proceeds from sales and maturities of investments in debt securities during 2024 and 2023 were $9,727,341 and $9,046,744, respectively. For the years ended December 31, 2024 and 2023, the Corporation realized gross gains of $29,781 and $24,765 and gross losses of $(640,743) and $(553,330), respectively, from the sale of debt securities. Included in net investment income are $(610,962) and $(528,565) of net realized losses in 2024 and 2023, respectively.

Changes in asset values are adjusted and reflected on the Corporation's statutory statement of operations to the extent such changes reflect other than temporary declines in fair value or if there is an intent to sell such securities at a loss.

3. Investments (Continued)

The cost, aggregate fair value, and gross unrealized gains and losses of equity mutual funds, fixed income exchange-traded funds, and equity security were as follows at December 31:

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Aggregate Fair Value
2024				
Fixed income exchange-traded funds	$22,170,172	$ 76,066	$(1,213,446)	$21,032,792
Equity mutual funds	4,869,113	7,747,412	(592)	12,615,933
Equity security	50,220	–	(21,095)	29,125
	$27,089,505	$7,823,478	$(1,235,133)	$33,677,850
2023				
Fixed income exchange-traded funds	$19,588,755	$ 31,647	$(1,129,691)	$18,490,711
Equity mutual funds	5,185,927	6,901,634	(3,941)	12,083,620
Equity security	50,220	787	–	51,007
	$24,824,902	$6,934,068	$(1,133,632)	$30,625,338

Proceeds from sales of equity mutual funds during 2024 and 2023 were $2,099,645 and $1,708,973, respectively. The Corporation had gross realized gains of $1,575,161 and $1,205,887 on the sale of equity mutual funds for the years ended December 31, 2024 and 2023, respectively, and gross realized losses of $(2,136) and $(1,705) for the years ended December 31, 2024 and 2023, respectively. The net realized gains of $1,573,025 and $1,204,182 for the years ended December 31, 2024 and 2023, respectively, are included in net investment income.

There were no proceeds from sales of fixed income exchange-traded funds or realized gains (losses) which are included in net investment income during 2024 and 2023.

The following summarizes the Corporation's gross unrealized losses and fair value, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position, at December 31, 2024 and 2023:

	Less than 12 Months		More than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
2024						
U.S. Government obligations	$ 5,604,428	$(236,766)	$ 2,536,483	$ (467,759)	$ 8,140,911	$ (704,525)
Government-sponsored entities' bonds	6,311,661	(171,869)	2,473,041	(455,732)	8,784,702	(627,601)
Corporate bonds and notes	1,932,077	(42,487)	4,557,311	(542,729)	6,489,388	(585,216)
Fixed income exchange-traded funds	4,419,790	(31,352)	13,263,463	(1,182,094)	17,683,253	(1,213,446)
Equity mutual funds	40,457	(592)	–	–	40,457	(592)
Equity security	29,125	(21,095)	–	–	29,125	(21,095)
	$18,337,538	$(504,161)	$22,830,298	$(2,648,314)	$41,167,836	$(3,152,475)

3. Investments (Continued)

	Less than 12 Months		More than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
2023						
U.S. Government obligations	$4,382,355	$(107,701)	$ 1,943,907	$ (473,000)	$ 6,326,262	$ (580,701)
Government-sponsored entities' bonds	1,596,326	(13,339)	3,594,389	(474,366)	5,190,715	(487,705)
Corporate bonds and notes	458,591	(4,011)	7,326,209	(735,871)	7,784,800	(739,882)
Fixed income exchange-traded funds	148,356	(1,004)	15,457,744	(1,128,687)	15,606,100	(1,129,691)
Equity mutual funds	3,716	(6)	79,505	(3,935)	83,221	(3,941)
	$6,589,344	$(126,061)	$28,401,754	$(2,815,859)	$34,991,098	$(2,941,920)

The following table shows the number of investments with unrealized losses at December 31, 2024 and 2023 and the length of time with unrealized losses:

	2024		2023	
	Less Than 12 Months	More Than 12 Months	Less Than 12 Months	More Than 12 Months
U.S. Government obligations	12	6	28	20
Government-sponsored entities' bonds	22	26	8	33
Corporate bonds and notes	34	62	11	103
Fixed income exchange-traded funds	4	5	14	270
Equity mutual funds	2	–	11	26
Equity security	1	–	–	–

The primary cause for unrealized losses within U.S. Government obligations, government-sponsored entities' bonds, corporate bonds and notes and fixed income exchange-traded funds is the impact movements in the market interest rates have had in comparison to the underlying yields on these securities. The primary cause for unrealized losses within equity mutual funds and equity security is general market fluctuations. Management of the Corporation, in addition to considering current trends and economic conditions that may affect the quality of individual securities within the Corporation's investment portfolio, also considers the Corporation's ability and intent to hold such securities to maturity or recovery. Management does not believe any of the Corporation's securities with unrealized losses as described above are other than temporarily impaired based on assessments performed at December 31, 2024 and 2023.

3. Investments (Continued)

The components of net investment and rental real estate income for the years ended December 31 are as follows:

	2024	2023
Interest and dividends, net of amortization/accretion	$2,302,061	$1,918,862
Realized gains on sales of investments, net	962,063	675,617
Investment fees and expenses	(165,608)	(162,869)
Rental income	146,686	127,086
Rental expense	(267,294)	(260,753)
Total net investment and rental real estate income	$2,977,908	$2,297,943

See also note 5 for additional discussion of net rental real estate income.

Provisions of the NAIC *Accounting Practices and Procedures Manual* require the Corporation to present the following investment information for 2024 and 2023:

2024	Carrying Value	% Total Investments, Cash and Short-Term Investments and Investment in Affiliate
Fixed income:		
U.S. Government obligations	$ 8,890,197	11.4%
Government-sponsored entities' bonds	12,508,002	16.1
Corporate bonds and notes	9,712,288	12.5
Fixed income exchange-traded funds	21,032,792	27.0
Equity interests:		
Equity mutual funds	12,615,933	16.2
Equity security	29,125	0.0
Investment in affiliate (note 4)	3,817,683	4.9
Cash and short-term investments	9,265,214	11.9
Total invested assets	$77,871,234	100.0%

3. Investments (Continued)

2023	Carrying Value	% Total Investments, Cash and Short-Term Investments and Investment in Affiliate
Fixed income:		
U.S. Government obligations	$ 8,278,041	10.8%
Government-sponsored entities' bonds	11,531,137	15.0
Corporate bonds and notes	10,134,330	13.2
Fixed income exchange-traded funds	18,490,711	24.0
Equity interests:		
Equity mutual funds	12,083,620	15.7
Equity security	51,007	0.1
Investment in affiliate (note 4)	3,407,431	4.4
Cash and short-term investments	12,975,087	16.8
Total invested assets	$76,951,364	100.0%

Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Corporation uses various methods including market, income and cost approaches. Based on these approaches, the Corporation often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Corporation utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the Corporation is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. An active market is considered to be a market in which several trades are made as of the measurement date. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer, or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

3. Investments (Continued)

For the years ended December 31, 2024 and 2023, the application of valuation techniques applied to similar assets and liabilities has been consistent. The following is a description of the valuation methodologies used for instruments measured and/or disclosed at fair value on a recurring basis:

Equity Mutual Funds, Fixed Income Exchange-Traded Funds, Equity Security, U.S. Government Obligations, Government-Sponsored Entities' Bonds, and Corporate Bonds and Notes

The fair value of equity mutual funds, fixed income exchange-traded funds, equity security, U.S. Government obligations, government-sponsored entities' bonds, and corporate bonds and notes is the market value based on quoted market prices, when available, or market prices provided by recognized broker dealers. If listed prices or quotes are not available, fair value is based upon externally developed models that use unobservable inputs due to the limited market activity of the instrument.

The following summarizes investments measured and/or disclosed at fair value at December 31, 2024 and 2023:

2024	Total	Level 1	Level 2	Level 3
Investments carried at fair value:				
Equity mutual funds – domestic	$12,615,933	$12,615,933	$ –	$ –
Equity security	29,125	29,125	–	–
Fixed income exchange-traded funds:				
Inflation-protected bonds	6,602,780	6,602,780	–	–
Intermediate term bonds	14,430,012	14,430,012	–	–
Investments carried at amortized cost:				
U.S. Government obligations	8,186,904	–	8,186,904	–
Government-sponsored entities' bonds	11,922,194	–	11,922,194	–
Corporate bonds and notes:				
Communications	699,888	–	699,888	–
Conglomerates	367,700	–	367,700	–
Consumer goods	524,757	–	524,757	–
Energy	321,913	–	321,913	–
Financial	4,589,786	–	4,589,786	–
Healthcare	215,001	–	215,001	–
Insurance	743,395	–	743,395	–
Industrial	755,808	–	755,808	–
Services	60,116	–	60,116	–
Public utilities	799,562	–	799,562	–
Technology	28,575	–	28,575	–
Utilities	54,364	–	54,364	–
	$62,947,813	$33,677,850	$29,269,963	$ –

3. Investments (Continued)

2023	Total	Level 1	Level 2	Level 3
Investments carried at fair value:				
Equity mutual funds – domestic	$12,083,620	$12,083,620	$ –	$ –
Equity security	51,007	51,007	–	–
Fixed income exchange-traded funds:				
Inflation-protected bonds	5,834,359	5,834,359	–	–
Intermediate term bonds	12,656,352	12,656,352	–	–
Investments carried at amortized cost:				
U.S. Government obligations	7,741,470	–	7,741,470	–
Government-sponsored entities' bonds	11,205,864	–	11,205,864	–
Corporate bonds and notes:				
Communications	333,215	–	333,215	–
Conglomerates	384,137	–	384,137	–
Consumer goods	1,121,342	–	1,121,342	–
Energy	549,622	–	549,622	–
Financial	4,037,458	–	4,037,458	–
Healthcare	225,472	–	225,472	–
Insurance	871,080	–	871,080	–
Industrial	454,740	–	454,740	–
Services	385,207	–	385,207	–
Public utilities	583,594	–	583,594	–
Technology	412,020	–	412,020	–
Utilities	98,664	–	98,664	–
	$59,029,223	$30,625,338	$28,403,885	$ –

There were no fair value measurements using significant unobservable units (Level 3) during the years ending December 31, 2024 and 2023.

4. Investment in Affiliate

During 2009, the Corporation, DDPVT and DDPME formed RTH, a holding company for other investments. The corporations equally own RTH's outstanding common stock and each contributed an initial investment of $1,415,000 in RTH.

4. Investment in Affiliate (Continued)

On January 21, 2016, the Board of Directors of RTH authorized and approved the acquisition of all outstanding stock of PreViser for $8,100,000, with two additional earn out provisions as defined in the purchase and sale agreement. On January 21, 2016, the Board of Trustees/Directors of the Corporation, DDPME and DDPVT authorized and approved each making a capital contribution to RTH of $2,700,000 to fund the acquisition of PreViser. From 2018 through 2020, the Corporation, DDPME, and DDPVT made additional capital contributions to RTH to further support the operations of PreViser totaling $1,908,900. No additional capital contributions were made to RTH in 2024 or 2023. RTH has an 81.4% ownership interest in PreViser at December 31, 2024 and 2023. PreViser is an information technology company, founded by dental clinicians, with a mission to improve oral health outcomes. PreViser provides digital risk assessment and oral health management software and services. Since its inception, PreViser has devoted substantially all of its efforts to programming and development, recruiting management and staff, and raising capital. Management believes that PreViser is performing consistently with its business plan.

RTH wholly owns a subsidiary, RTI, which operates as a licensed vision insurance company in the states of New Hampshire, Maine and Vermont. In December 2019, the Board of Directors voted to make an additional capital contribution of up to $600,000 to RTH in 2020. Ultimately, $400,000 was contributed to RTI on October 24, 2020. This additional capital was necessary for RTI to become an insurer in the state of Vermont, which was effective January 1, 2021, enabling RTI to offer vision plans in that state.

RTH has the sole membership interest of CSLLC. CSLLC provides employee benefit insurance brokerage services, flexible employee benefit plan administration services and COBRA administration services to its customers. CSLLC is also the Corporation's general agent amongst the insurance brokers that market the Corporation's dental benefit plans to employers and individuals.

The Corporation has recorded its investment in RTH ($3,817,683 and $3,407,431 at December 31, 2024 and 2023, respectively) on the equity method. The Corporation has recorded its estimated share of RTH's gains in 2024 of $410,252 and in 2023 of $344,083.

As of December 31, summarized financial information for Red Tree Holdings, Inc. and Subsidiaries, which subsidiaries include CSLLC, RTI, PreViser and NEDA, is as follows:

	2024	2023
	(in thousands)	
Total assets	$21,835	$18,966
Total liabilities	10,761	8,925
Total equity	11,074	10,040
Non-controlling interest in consolidated subsidiary	(356)	(262)
Net income attributable to Red Tree Holdings, Inc. and Subsidiaries	1,065	990
Comprehensive income attributable to Red Tree Holdings, Inc. and Subsidiaries	1,128	1,139

5. Commitments

The Corporation has entered into a renewable employment contract with its President and CEO through June 2028 that provides for a minimum annual salary, reviewed annually, and incentives based on the attainment of specified goals. The total commitment over the next three and one half years, excluding incentives, is approximately $2,429,000.

The Corporation has entered into various operating leases for office equipment. Total lease expense recognized under these agreements for the years ended December 31, 2024 and 2023 was $62,501 and $71,012, respectively. The lease payments to be made under these lease agreements for their remaining terms as of December 31, 2024 are as follows:

2025	$10,238

The Corporation leases a portion of its premises to unrelated parties under three separate lease agreements, qualifying as operating leases, with monthly payments ranging from $500 to $777. Additionally, the Corporation has a lease agreement with CSLLC, whereby CSLLC leases certain office space from the Corporation. Monthly payments were $10,800 to $12,000 for the duration of the lease term. Rental income earned from CSLLC under this lease agreement during 2024 and 2023 was $140,400 and $118,800, respectively. Property on lease to third parties at December 31, 2024 consists of portions of a building and certain improvements with an original cost and admitted value of $1,924,621 and $347,589, respectively. Minimum lease payments to be received under these leases for their remaining terms as of December 31, 2024 are as follows:

2025	$56,364

The net rental real estate loss included in net investment and rental real estate income in the accompanying 2024 and 2023 statutory statements of operations and changes in surplus is composed of occupancy and related expenses that management of the Corporation has allocated to rental activities as follows:

	2024	2023
Rental income	$ 146,686	$ 127,086
Depreciation expense	(104,400)	(104,400)
Other occupancy expenses	(162,894)	(156,353)
Net rental real estate loss	$(120,608)	$(133,667)

The Corporation entered into an agreement for the naming rights of a professional baseball stadium, as well as additional marketing benefits, as defined. Amounts incurred under this agreement are charged to advertising expense as incurred, and totaled $400,000 and $325,000 in 2024 and 2023, respectively. The agreement expires on October 31, 2030, with an option to renew the contract for an additional five years through October 31, 2035. Future minimum payments due under this agreement are as follows:

2025	$400,000
2026	400,000
2027	400,000
2028	400,000
Thereafter	750,000

6. Retirement Plans

The Corporation has a Discretionary Plan and Trust (the Plan) which is a defined contribution plan. The Corporation is required to make a minimum contribution of at least 3% of eligible compensation to the Plan. The Plan also has an elective contribution determined by the Board of Directors. Eligible employees can make elective contributions to the Plan. The Corporation's total contributions to the Plan for 2024 and 2023 were $1,202,115 and $1,260,799, respectively. The Corporation's policy is to fund the amounts accrued. Employee participation in the Plan is based upon length of service with the Corporation. Substantially all employees are eligible for an employer contribution after completing one year of employment and attaining the age of 21.

7. Related Party Transactions

The President and CEO of the Corporation is also the President and CEO of DDPVT, DDPME, NEDA, RTH, PreViser and RTI, and is the sole member of the management committee of CSLLC.

The Corporation provides premiums and claims processing, marketing and other administrative services to DDPVT and DDPME. The amount of fees attributable and related to administrative services contracts involving these related parties is as follows for the years ended December 31, 2024 and 2023:

	2024	2023
Fees attributable to administrative services contracts:		
Vermont	$ 101,367,149	$ 91,654,436
Maine	177,815,012	161,655,462
	279,182,161	253,309,898
Less related dental claims paid under administrative services contracts:		
Vermont	93,714,308	84,502,200
Maine	163,997,234	148,517,941
	257,711,542	233,020,141
	$ 21,470,619	$ 20,289,757

The Corporation provides claims processing and other administrative services for NEDA. Fees attributable to administrative services contracts include the amounts earned for providing these services of $10,032 and $8,868 for 2024 and 2023, respectively.

The Corporation also provides premiums processing, marketing and other administrative services to RTI, marketing and administrative services to PreViser, and provides administrative services to RTH. Fees attributable to these administrative services contracts include the amounts earned for providing these services of $1,120,533 and $958,060 for 2024 and 2023, respectively.

The Corporation purchased a vision insurance policy for its employees from RTI. Total premiums paid under this contract were $23,845 and $23,587 in 2024 and 2023, respectively.

7. **Related Party Transactions (Continued)**

The Corporation provides dental insurance to CSLLC and PreViser. Total premiums received under these contracts were $64,928 and $62,486 in 2024 and 2023, respectively.

The above related entities also reimbursed the Corporation $1,936,703 and $1,777,535 for the years ended December 31, 2024 and 2023, respectively, for certain payroll costs and other operating expenses. These monies have been reflected as a reduction of the applicable operating expense in the accompanying statutory financial statements. As of December 31, 2024 and 2023, $1,118,861 and $1,299,370, respectively, was due from related entities for the reimbursement of payroll and other operating expenses and net processing settlements, which includes non-admitted accounts receivable – related parties of $449,708 and $417,300 at December 31, 2024 and 2023, respectively. Additionally, $2,960 and $2,435 was due from CSLLC as of December 31, 2024 and 2023, respectively.

CSLLC is the Corporation's general agent amongst the insurance brokers that market the Corporation's dental benefit plans to employers and individuals. CSLLC also provides COBRA administration and flexible benefit administration services to the Corporation. Total commissions and fees earned by CSLLC ($474,766 and $638,751 in 2024 and 2023, respectively) have been recorded as commissions and employee benefits expenses within underwriting expenses. Amounts owed to CSLLC totaled $96,984 and $99,399 at December 31, 2024 and 2023, respectively. The Corporation has a service agreement with CSLLC, whereby the Corporation provides management and related services to CSLLC in exchange for a management fee. The agreement expires December 31, 2024. Under the terms of the agreement, the annual management fee will vary based on the management service needs of CSLLC. For the years ended December 31, 2024 and 2023, CSLLC paid the Corporation $100,000 for such services. The Corporation also leases office space to CSLLC (see note 5). CSLLC employees are eligible to participate in the Corporation's retirement plan described in note 6.

DDPME has provided a guarantee to increase RTI's shareholders' equity to a minimum of $2,000,000 if it falls below this amount. This guarantee is required by the Maine Bureau of Insurance. Although not required by the Maine Bureau of Insurance, the Boards of DDPNH and DDPVT have voted to share in any additions to shareholders' equity needed to meet the minimum requirements should that become necessary. A similar guarantee was required by the New Hampshire Insurance Department that the Corporation, DDPME and DDPVT increase RTI's shareholders' equity to $1,000,000 if it falls below this level.

The Corporation, DDPME and DDPVT make elective annual charitable contributions to the Northeast Delta Dental Foundation (the Foundation) equal to 0.075% in 2024 and 2023 of the budgeted gross billings, plus 10% in 2024 and 2023 of the actual increase in surplus from operations for each respective year. The Corporation's contributions to the Foundation in 2024 and 2023 were $161,366 and $583,600, respectively, and are included in underwriting expenses in the accompanying statutory statements of operations and changes in surplus. The contributions due to the Foundation and unpaid at December 31, 2024 and 2023 were $0 and $434,387, respectively. The Foundation is a 501(c)(3) not-for-profit organization dedicated to making a positive impact on the quality of life of Maine, New Hampshire and Vermont residents, placing special emphasis on oral health. The Foundation also receives contributions from individuals and through fundraising activities.

8. Subscribers' Claims Payable and Related Accrued Expenses

Activity in the liability for subscribers' claims and related claim adjustment expenses for the years ended December 31 is summarized as follows:

	2024	2023
Subscribers' claims payable	$ 2,232,965	$ 2,166,880
Related accrued expenses	73,000	69,000
Balance at January 1	2,305,965	2,235,880
Risk claims incurred (including assumed claims of $5,310,159 in 2024 and $4,891,800 in 2023)	70,977,010	65,591,870
Change in related accrued expenses	8,100	4,000
Total incurred	70,985,110	65,595,870
Paid claims related to:		
Current year	(68,717,872)	(63,446,712)
Prior years	(2,154,628)	(2,079,073)
Total paid	(70,872,500)	(65,525,785)
Subscribers' claims payable (including assumed claims of $354,875 in 2024 and $366,766 in 2023)	2,337,475	2,232,965
Related accrued expenses	81,100	73,000
Balance at December 31	$ 2,418,575	$ 2,305,965

Subscribers' claims payable and related accounts receivable under administrative service contracts of $12,793,100 and $12,177,200 at December 31, 2024 and 2023, respectively, have been netted within the accompanying statutory statement of admitted assets, liabilities and surplus. Claims related accrued expenses under administrative service contracts are recorded within accounts payable and accrued expenses and totaled approximately $210,100 at December 31, 2024 and $198,500 at December 31, 2023.

9. Contingencies

The Corporation may be subject to complaints, claims and litigation arising from the normal course of business. In addition, the Corporation is subject to examinations by certain state government agencies to assure compliance with applicable laws.

9. Contingencies (Continued)

The Corporation, along with the Delta Dental Plans Association (DDPA), DeltaUSA, and the other independent DDPA member companies, is defending a collection of antitrust lawsuits that have been filed in numerous jurisdictions. To date, 27 substantially similar complaints have been filed in 10 different federal jurisdictions. In March, 2020 all of the Delta Dental antitrust cases filed around the country were consolidated into a single action in the Northern District of Illinois. All the complaints are substantially similar and each allege that numerous DDPA rules and practices violate the Sherman Antitrust Act and related state laws. The lawsuits were filed by individual dentists (the American Dental Association had been a plaintiff, but its complaint was dismissed as duplicative of those asserted by individual dentists), and seek damages on behalf of a putative class of dental providers that provided dental goods or services within the United States to Delta Dental subscribers from 2015 through the present. Northeast Delta Dental denies the allegations in the lawsuits and has retained outside counsel to defend against all allegations. Northeast Delta Dental anticipates the antitrust complaints will not be resolved in the near future. Northeast Delta Dental has not yet determined the potential damages (if any) that could be awarded in the various antitrust complaints or the effect that any adverse judgment could have on the Northeast Delta Dental insurance holding company system.

10. Major Contracts

The Corporation earned approximately 11% of its premiums earned under the terms of one contract during 2024. There were no concentrations of premiums earned during 2023. Additionally, one customer comprised approximately 11% of the Corporation's accounts receivable at December 31, 2024. One customer comprised approximately 13% of the Corporation's accounts receivable at December 31, 2023.

11. External Support

In 2024, the Corporation voluntarily provided approximately $2,061,000 of supplemental payments to dentists in the State of New Hampshire, which amounts are recorded as underwriting expenses in the accompanying 2024 statement of operations and changes in surplus. There were no voluntary supplemental payments during 2023.

12. Statutory Insurance Accounting Practices Reconciliations (Unaudited)

The Corporation prepares its financial statements using accounting practices prescribed or permitted by the New Hampshire Insurance Department, as further described in note 2. A reconciliation of surplus reported in these financial statements as of December 31 to the estimated net assets determined in accordance with U.S. GAAP follows:

	2024	2023
Total surplus based on statutory insurance accounting practices – end of year	$73,558,566	$72,759,032
Add:		
Net unrealized (losses) gains on debt securities	(1,840,524)	(1,539,623)
Fixed assets not allowed using statutory accounting principles	2,650,939	3,086,026
Prepaid expenses	858,833	541,300
Accounts receivable – related parties over 90 days	449,708	417,300
Accounts receivable, miscellaneous	1,651	1,865
Net assets based on U.S. GAAP – end of year	$75,679,173	$75,265,900

In addition to the above monetary differences, there are other monetary, presentation and disclosure differences between U.S. GAAP and statutory insurance accounting practices.

SUPPLEMENTAL INFORMATION

SCHEDULE

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

December 31, 2024

1. Reporting entity's total admitted assets as reported on the annual statement $90,140,338

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	Federal National Mortgage Association	MBS	$6,662,617	7.4%
2.02	Federal Home Loan Mortgage Corporation	MBS	5,064,105	5.6
2.03	Red Tree Holding, Inc.	Holding Co	3,817,683	4.2
2.04	Citigroup Inc.	Bonds	568,912	0.6
2.05	Bank of America Corporation	Bonds	403,046	0.4
2.06	Florida Power & Light Company	Bonds	363,345	0.4
2.07	Wells Fargo & Company	Bonds	276,992	0.3
2.08	The Goldman Sachs Group, Inc.	Bonds	251,180	0.3
2.09	The Walt Disney Company	Bonds	224,194	0.2
2.10	MetLife, Inc.	Bonds	211,133	0.2

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2
3.01	NAIC-1	$49,730,220	55.2%
3.02	NAIC-2	2,413,059	2.7
3.03	NAIC-3	–	0.0
3.04	NAIC-4	–	0.0
3.05	NAIC-5	–	0.0
3.06	NAIC-6	–	0.0

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

	Preferred Stocks		**3**	**4**
3.07	P/RP-1	$	–	0.0%
3.08	P/RP-2		–	0.0
3.09	P/RP-3		–	0.0
3.10	P/RP-4		–	0.0
3.11	P/RP-5		–	0.0
3.12	P/RP-6		–	0.0

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [X]	No [ ]
4.02	Total admitted assets held in foreign investments	$	–	0.0%
4.03	Foreign-currency-denominated investments		–	0.0
4.04	Insurance liabilities denominated in that same foreign currency		–	0.0

If response to 4.01 above is yes, responses are not required for interrogatories 5-10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

			1	**2**
5.01	Countries rated NAIC-1	$	–	0.0%
5.02	Countries rated NAIC-2		–	0.0
5.03	Countries rated NAIC-3 or below		–	0.0

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

	Countries rated NAIC-1:		**1**	**2**
6.01	Country 1:	$	–	0.0%
6.02	Country 2:		–	0.0
	Countries rated NAIC-2:			
6.03	Country 1:	$	–	0.0%
6.04	Country 2:		–	0.0

SCHEDULE

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

	Countries rated NAIC-3 or below:	1	2
6.05	Country 1:	$ –	0.0%
6.06	Country 2:	–	0.0

		1	2
7.	Aggregate unhedged foreign currency exposure	$ –	0.0%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries rated NAIC-1	$ –	0.0%
8.02	Countries rated NAIC-2	–	0.0
8.03	Countries rated NAIC-3 or below	–	0.0

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

	Countries rated NAIC-1:	1	2
9.01	Country 1:	$ –	0.0%
9.02	Country 2:	–	0.0
	Countries rated NAIC-2:		
9.03	Country 1:	$ –	0.0%
9.04	Country 2:	–	0.0
9.05	Country 1:	–	0.0
9.06	Country 2:	–	0.0

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

10. Ten largest non-sovereign (i.e., non-governmental) foreign issues:

	1 Issuer	2 NAIC Rating	3	4
10.01			$ –	0.0%
10.02			–	0.0
10.03			–	0.0
10.04			–	0.0
10.05			–	0.0
10.06			–	0.0
10.07			–	0.0
10.08			–	0.0
10.09			–	0.0
10.10			–	0.0

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ –	0.0%
11.03	Canadian-currency-denominated investments	–	0.0
11.04	Canadian-denominated insurance liabilities	–	0.0
11.05	Unhedged Canadian currency exposure	–	0.0

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions:	$ –	0.0%
	Largest 3 investments with contractual sales restrictions:		
12.03		–	0.0
12.04		–	0.0
12.05		–	0.0

13. Amounts and percentages of admitted assets held in the largest 10 equity interests:

13.01 Are assets held in equity interest less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1 Name of Issuer	2	3
13.02	Fidelity Concord Street Trust – Fidelity 500 Index Fund	$6,085,236	6.8%
13.03	Vanguard Index Funds – Vanguard Mid-Cap ETF	4,394,854	4.9
13.04	Red Tree Holdings, Inc.	3,817,683	4.2
13.05	Vanguard Index Funds – Vanguard S&P 500 ETF	2,135,843	2.4
13.06	Armata Pharmaceuticals Inc.	29,125	0.0
13.07		–	0.0
13.08		–	0.0
13.09		–	0.0
13.10		–	0.0
13.11		–	0.0

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of interrogatory 14.

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities:	$ –	0.0%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		–	0.0
14.04		–	0.0
14.05		–	0.0

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	iShares Trust – iShares 0-5 Year TIPS Bond ETF	$6,602,780	$6,602,780	$ –
14.07	Vanguard Bond Index Funds – Vanguard Short-Term Bond ETF	6,210,035	6,210,035	–
14.08	V Fidelity Concord Street Trust – Fidelity 500 Index Fund	6,085,236	6,085,236	–
14.09	iShares Trust – iShares Core U.S. Aggregate Bond EFT	4,642,382	4,642,382	–
14.10	Vanguard Index Funds – Vanguard Mid-Cap ETF	4,394,854	4,394,854	–
14.11	Vanguard Bond Index Funds – Vanguard Total Bond Market ETF	3,577,594	3,577,594	–
14.12	Vanguard Index Funds – Vanguard S&P 500 ETF	2,135,843	2,135,843	–
14.13	First American Funds, Inc. – Treasury Obligation Fund	628,267	628,267	–
14.14		–	–	–
14.15		–	–	–

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests:	$ –	0.0%
	Largest 3 investments in general partnership interests:		
15.03		–	0.0
15.04		–	0.0
15.05		–	0.0

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ –	0.0%
16.03		–	0.0
16.04		–	0.0
16.05		–	0.0
16.06		–	0.0
16.07		–	0.0
16.08		–	0.0
16.09		–	0.0
16.10		–	0.0
16.11		–	0.0

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

16.12	Construction loans	$ –	0.0%
16.13	Mortgage loans over 90 days past due	–	0.0
16.14	Mortgage loans in the process of foreclosure	–	0.0
16.15	Mortgage loans foreclosed	–	0.0
16.16	Restructured mortgage loans	–	0.0

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

Loan-to-Value		Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ –	0.0%	$ –	0.0%	$ –	0.0%
17.02	91% to 95%	–	0.0	–	0.0	–	0.0
17.03	81% to 90%	–	0.0	–	0.0	–	0.0
17.04	71% to 80%	–	0.0	–	0.0	–	0.0
17.05	below 70%	–	0.0	–	0.0	–	0.0

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 18.01 above is yes, responses are not required for the remainder of interrogatory 18.

	Description	2	3
18.02	Home Office One Delta Dr Concord NH	$2,105,944	2.3%
18.03	Home Office Two Delta Dr Concord NH	773,838	0.9
18.04	Home Office Two Delta Dr Concord NH	185,966	0.2
18.05	Rental Space Two Delta Dr Concord NH	347,589	0.4
18.06	Home Office 107 Commercial St Concord NH	483,511	0.5

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in mezzanine real estate loans.

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's admitted assets? Yes [X] No [ ]

	Description	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans	$ –	0.0%
	Largest 3 investments held in mezzanine real estate loans:		
19.03		–	0.0
19.04		–	0.0
19.05		–	0.0

SCHEDULE

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
20.01	Securities lending (do not include assets held as collateral for such transactions)	$ –	0.0%	$ –	$ –	$ –
20.02	Repurchase agreements	–	0.0	–	–	–
20.03	Reverse repurchase agreements	–	0.0	–	–	–
20.04	Dollar repurchase agreements	–	0.0	–	–	–
20.05	Dollar reverse repurchase agreements	–	0.0	–	–	–

21. Amounts and percentages indicated below for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ –	0.0%	$ –	0.0%
21.02	Income generation	–	0.0	–	0.0
21.03	Other	–	0.0	–	0.0

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ –	0.0%	$ –	$ –	$ –
22.02	Income generation	–	0.0	–	–	–
22.03	Replications	–	0.0	–	–	–
22.04	Other	–	0.0	–	–	–

DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES (CONTINUED)

December 31, 2024

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

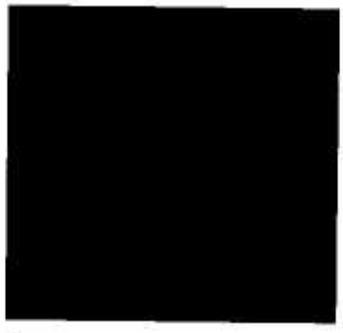
		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ –	0.0%	$ –	$ –	$ –
23.02	Income generation	–	0.0	–	–	–
23.03	Replications	–	0.0	–	–	–
23.04	Other	–	0.0	–	–	–

Delta Dental Plan of New Hampshire OFFICERS & BOARD OF DIRECTORS 2025-2026

Cookson, Matthew, Chair (H) [redacted] (W): Cookson Communications, 722 Pine Street, Manchester, NH 03104 Cell: [redacted]	Work: 603-782-8192 E-Mail: [redacted]
St. Jean, James (Jim), Vice Chair (H & M) [redacted] Cell: [redacted]	[redacted] E-Mail: [redacted]
*Raffio, Thomas, President & CEO (Ellen) (H): [redacted] (W & M): NEDD, One Delta Drive, PO Box 2002, Concord, NH 03302-2002	Work: 603-223-1300 Fax: 603-223-1299 Home: [redacted] E-Mail: [redacted]
*Bienefeld, Laurie, Treasurer (H): [redacted] (W & M): NEDD, One Delta Drive, PO Box 2002, Concord, NH 03302-2002 Cell: [redacted]	Work: 603-223-1139 Fax: Home: [redacted] E-Mail: [redacted]
*Brehm, Sara M., Corporate Secretary (H): [redacted] (W & M): NEDD, One Delta Drive, PO Box 2002, Concord, NH 03302-2002	Work: 603-223-1185 Fax: 603-223-1299 E-Mail: [redacted]
Boswell, Colin, DDS (H & M): [redacted] (W): Monlshire Pediatric Dentistry, 165 Winchester Street, Keene, NH 03431 Cell: [redacted]	Work: [redacted] Fax: E-Mail: [redacted]
Carelli, Joseph (H) [redacted] (W) Citizens Bank Cell: 603-494-6517	Work: [redacted] Fax: E-Mail: [redacted]
Carew, Karen, CPA, CFE (H) [redacted] (W & M) Carew & Wells, PLLC, 104 North State Street, Concord, NH 03301 Cell: [redacted]	Work: 603-224-3950 Fax: 603-224-9009 E-Mail: [redacted]
Claybaugh, Tracy (H) [redacted] (W) Plymouth State University, 17 High St, Plymouth, NH 03264 Cell: [redacted]	Work: 603-535-2550 Fax: 603-535-2465 E-Mail: [redacted]
Forbes, Rachel, DMD (H&M): [redacted] (W): Seacoast Endodontic Associates, 158 Rout 108, Dover, NH 03820	Work: 603-742-2200 Home: 617-699-8604 E-Mail: [redacted]
Gilkie, Jennifer (H & M) [redacted] (W) Dartmouth Health, One Medical Center Drive, Lebanon, NH 03756 Cell: [redacted]	Work: 603-629-1280 Home: [redacted] E-Mail: [redacted]
Goode, Whitney, DMD (H) [redacted] (W) Greater Seacoast Community Health, 311 Routh 108 Somersworth, NH 03878 Cell: [redacted]	Work: 603-749-2346 Ext. 2767 Home: Email: [redacted]
Gutati, Harish (Harry), DMD (H & M) [redacted] Cell: [redacted]	Work: Home: Email: [redacted]
Huang-Yue, Silvia, DDS (H & M) [redacted] (W). 33 Broad Street, Nashua, NH 03064 Cell: [redacted]	Work: 603/889-0601 Home: Email: [redacted]
Mandera, Praveen, DMD (H&M) [redacted] (W) NH Family Dentistry, 2626 Brown Ave. Manchester, NH 03101 Cell: [redacted]	Work: 603-625-1877 E-Mail: [redacted]
Marquis, Matthew (Matt), DMD. (H & M) [redacted] (W) 2 Madison Ave., Hooksett, NH 03106 [redacted]	Work: 603/668-5333 Home: Fax: Email: [redacted]
Shapleigh, Cydney (H) [redacted] (W) NHTrust, 89 N. Main St., Concord, NH 03301 Cell: [redacted]	Work: Fax E-Mail: [redacted]
Smith, Leesa (H & M) [redacted] (W) Freudenberg Filtration Technologies- Hickory, NC Cell: [redacted]	[redacted] E-Mail: [redacted]

*Officer Only W – Work Address H – Home Address M – Preferred Mailing Address Updated 4-11-2025

Tom Raffio, CEO
Northeast Delta Dental



Thomas Raffio assumed the role of president & CEO of Northeast Delta Dental, a role he has held since 1995. Before that, he was Senior Vice President of Delta Dental of Massachusetts and Director of Group Healthcare Management Reporting at John Hancock Insurance. Northeast Delta Dental is a tax-exempt, nonprofit organization (dental insurance company) with high brand recognition and a reputation of providing world-class customer service. It's located at Two Delta Drive, Concord, New Hampshire and has been in business for over 50 years. Northeast Delta Dental includes offices in Concord, New Hampshire (headquarters), Saco, Maine, and Burlington, Vermont.

Accomplishment Highlights

In 1995, the company administered the dental benefits of more than 1,005,000 with a retention rate of 98%. Revenue has grown from $57 million to more than $422 million in 2021. Tom's commitment to the principles of continuous quality improvement led to the creation of its Guarantee Of Service Excellence℠ (GOSE) program, backing up seven facets of service with customer refunds—the first such comprehensive program in Northern New England. The company evolved into an industry leader recognized for its outstanding business practices. Under its CEO's leadership, Northeast Delta Dental has grown from 50 to 200 employees, earning a reputation as "Employer of Choice" based on best practices and numerous awards. It's certified for offering flexible work schedules and being age friendly, and offers a thorough onboarding of new employees and development opportunities, including tuition reimbursement. It was named one of the 25 Best Small Companies to Work for in America for five consecutive years, and one of the Best Companies to Work For in New Hampshire for nine years.

Tom is a hands-on leader, regularly meeting with new and seasoned employees for "Coffee with the Coach" to get their feedback. During Tom's presidency, the Northeast Delta Dental network of participating dentists grew from 935 in 1995 to 1,798 in 2022. He spearheaded the creation of the Northeast Delta Dental Foundation, which supports oral health programs in Maine, New Hampshire, and Vermont, each year by investing several hundred thousand dollars. To address a shortage of dentists in under-served communities, he stimulated the funding of scholarship programs at two schools of dental medicine, and annual contributions to dental education loan repayment programs encouraging dental students to practice in Northern New England.

Civic Leadership

Tom is an engaged civic leader. He is currently a member of the Board of Trustees of Dartmouth-Hitchcock, member of the Delta Dental Plans Association Board of Directors, Chair of the New Hampshire Coalition for Business and Education, Chair of the Arthritis Leadership Council of Northern New England, a member of the Business and Industry Association, a Board Member and former Chair of the Board of Early Learning New Hampshire, Chair of the Franklin Pierce College of Business Advisory Board, and a member of the Conference Board's Committee for Economic Development. He is Incorporator and Chair of the Board of ExcellenceNorth Alliance, Board Member and Chair of New Hampshire Business Committee for the Arts, Chair of the Bow Schools Foundation, member of the New Hampshire Scholars Leadership Board — which he also serves as a Champion — and member of the Fisher Cats Foundation.

Tom is a member of the Safety Alerts for Education (SAFE) Foundation, a member of the Executive Leadership Council for Making Strides Against Breast Cancer, and a member of the Mt. Washington Hall of Fame Committee. He is also an active Big Brother for Big Brothers Big Sisters of New Hampshire.

Tom served as former Chair of the New Hampshire State Board of Education and former Chair of the New Hampshire Symphony Orchestra. Prior board memberships include the New Hampshire Historical Society's Democracy Project Advisory Committee, the State Workforce Investment Board, Groundwork Concord, American Red Cross, NH Comets, Opera NH, New Hampshire Foundation for Teaching and Learning, New Hampshire Humanities, and The Palace Theatre. He also served as Campaign Chair for the United Way of Merrimack County and the following Advisory Committees: The Capital Area Race Series, Brattleboro Retreat, Bow Alcohol and Drug Coalition, I-93 Task Force, Pittsfield School District's Community Advisory Council, New Hampshire Food Bank, Concord Area Colleges, NH Forum on the Future, Friends of the Bridges House, and the NH Institute of Politics at St. Anselm College.

Awards and Recognition

- Arthritis Foundation's Champion Award **(2022)**
- Campus Compact for New Hampshire Presidents' Community Partner Award **(2022)**
- Easterseals New Hampshire awarded Tom the David P. Goodwin Lifetime Commitment Award for his dedication to the community **(2020)**
- The Baldrige Foundation, the Foundation for the Malcolm Baldrige National Quality Award, bestowed a Leadership Excellence Award in his name of the Healthcare Sector **(2020)**
- *New Hampshire Business Review* included Tom in the first edition of *New Hampshire 200,* a publication spotlighting the 200 most influential people in New Hampshire's private sector **(2019)**
- City Year New Hampshire awarded its Lifetime of Service Award **(2014)**
- Juvenile Diabetes Research Foundation (JDRF) honored Tom at its 13th annual Granite Gala, and the Business and Industry Association of New Hampshire presented its *Above and Beyond* award **(2014)**

- University System of New Hampshire awarded its Granite State Award at Granite State College's commencement **(2011)**
- Massachusetts College of Pharmacy and Health Sciences awarded a Doctor of Science, honoris causa **(2011)**
- The Association of Chamber of Commerce Executives and *Business NH Magazine* named him Business Leader of the Year **(2004)** and Business Leader of the Decade **(2010)**
- NHTI, Concord's Community College awarded an honorary associate of science degree, and New England College awarded an honorary Doctor of Humane Letters degree **(2010)**
- Daniel Webster Council Boy Scouts of America presented its Distinguished Citizen of the Year Award **(2010)**
- Greater Concord Chamber of Commerce named Tom Outstanding Citizen of the Year **(2009)** and Governor Lynch proclaimed **November 16, 2009**, as "Tom Raffio Day."
- Pastoral Counseling Services of Manchester awarded a Good Samaritan Award **(2008)**
- National Alliance on Mental Illness (NAMI-NH) awarded the Samuel Adams Community Leadership Award **(2007)**
- New Hampshire Business Committee for the Arts awarded the Leadership in the Arts Award **(2005)**
- Patrick Jackson Award — by the Yankee Chapter (Maine, New Hampshire, and Vermont) of the Public Relations Society of America for the successful use of public relations principles by an individual not in the public relations field **(2004)**

Publications

- Tom Raffio with Diane Schmalense, *Prepare For Crisis - Plan To Thrive*, 2021
- Tom Raffio, "The Baldrige and I," *Baldrige Foundation Institute for Performance Excellence White Paper* 2021-01, May 15, 2021
- Annabel C. Beerel and Tom Raffio, *Mindfulness: A Better Me; a Better You; a Better World*. Self, 2018
- Tom Raffio with Barbara McLaughlin and Dave Cowens, *There Are No Do-Overs; The Big Red Factors for Sustaining a Business Long Term*. Curran Pendleton Press, 2013

Education/Training

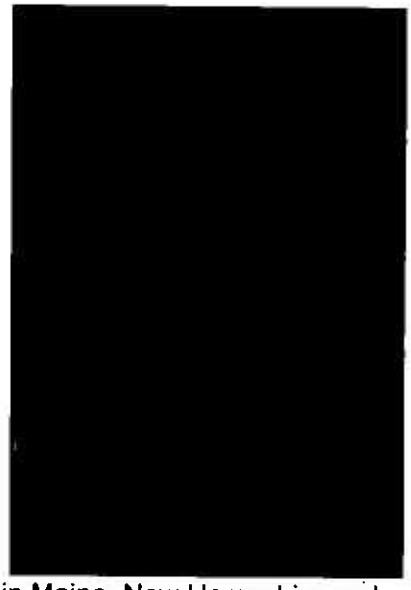
Tom earned an undergraduate degree at Harvard University, an MBA from Babson College, and designation as a Fellow of the Life Management Institute (FLMI). He is proud to be a 1997 graduate of Leadership New Hampshire.

[redacted]

BRIAN DUFFY, ESQ.

Contract Manager

Vice President and General Counsel Northeast Delta Dental



LOCATION

Concord, New Hampshire

Brian oversees the corporate, regulatory, government relations, and compliance initiatives of a complex organization that insures or administers dental benefits for over 1,000,000 people in Maine, New Hampshire and Vermont.

EXPERIENCE

Vice President and General Counsel
Northeast Delta Dental
2021 – Present

- Draft, amend, and review, corporate documents
- Draft, amend, and review contracts, leases, and agreements
- Advise business units on compliance with applicable laws
- Advise Boards of Directors and corporate leadership on legal issues
- Oversee enterprise risk assessment and compliance

Associate General Counsel
Northeast Delta Dental
2016 – 2021

Provided legal support to northern New England's largest dental insurer and its subsidiaries by:

- Drafting and amending corporate documents, including articles of incorporation, bylaws and shareholder agreements
- Drafting and amending board documents, including resolutions, memoranda, summaries and updates
- Drafting amending contracts, leases, licenses and other contracts
- Advising business units on compliance with applicable state and federal laws
- Preparing regulatory filings with state departments of insurance

Associate
Nixon Peabody LLP
2008 – 2015

- Represented clients in federal and state courts in a variety of jurisdictions in multiple types of litigation, including insurance defense, title insurance defense, employment, contract and corporate disputes, commercial foreclosure, and product liability
- Assisted insurance entities in complying with state regulations relating to broker licensure, permissible investments, and corporate structure in New York and New Hampshire
- Advised third party administrators, pharmacy benefits administrators, and dental administrators on licensing and regulatory compliance issues
- Advised local and national clients on the regulation of extended warranties and home protection plans

EDUCATION

Juris Doctor
University of New Hampshire Franklin Pierce School of Law, Concord, New Hampshire

Bachelor of Arts, German and French
University of Massachusetts, Amherst, Massachusetts

Tracy Gilman, CDA, MSM
Contract Manager

Director, Government Programs
Northeast Delta Dental

[redacted]

Tracy oversees the Medicaid contract that we have with the New Hampshire Department of Health and Human Services and the subcontract agreement with DentaQuest serving over 90,000 members.

EXPERIENCE
Director, Government Programs
Northeast Delta Dental
2023 – Present

- Medicaid Contract manager, New Hampshire Adult Medicaid Program serving over 90,000 members.
- Management of compliance, day-to-day work, issue resolution and relationships with the state client, community partners, internal stakeholders and subcontractor, DentaQuest.
- Project manager- Medicare Advantage / Medicaid

Regional Director, MassHealth / Health Safety Net / Children's Medical Security Plan Dental Contract
DentaQuest
2011-2022

- Managed the MassHealth client relationship and oversaw contractual and regulatory compliance for the dental program serving over 2.3 million members.
- Managed the provider relations team serving a network of over 2,200 dental providers.
- Managed the State Board of Hearings support process and team of dental consultants representing program decisions.
- Managed the Outreach and Member / Provider Intervention teams.
- Developed and maintained strong external relationships with community partners statewide through work and leadership within the community.

Account Manager, Massachusetts Public Employee Contract
Delta Dental of Massachusetts
2015-2017
(Dual role)

- Managed the relationship with the MPE Fund and the core team serving over 69,000 members.
- Oversaw the MPE contractual standards surrounding claims adjudication, payment, customer service, provider training and member service.

Dental Network Manager
Blue Cross Blue Shield of Massachusetts
2005-2011

- Managed the commercial dental network for Western and North Central Massachusetts expanding provider access points from 961 providers to over 1,300.
- Increased the technology adoption rate within my territory by 72%.
- Conducted over 1,000 annual in-office visits to dental providers.

- Lead a multi-year Dental Provider Contract Revision Project to streamline administration, ensure compliance with health care reform legislation and increase flexibility for market driven competition.
- Lead biannual dental office site assessments within my territory to monitor for OSHA, OSAP, and HIPAA compliance

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Tom Raffio	President and CEO	$694,000	0	0
Brian Duffy, Esq	Vice President and General Counsel	$299,140	0	0
Tracy Gilman	Director, Government Programs	$159,120	0	0

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Lori A. Weaver
Commissioner

Henry D. Lipman
Director

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

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

February 4, 2025

Her Excellency, Governor Kelly A. Ayotte
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into a **Retroactive** amendment an existing contract with Delta Dental Plan of New Hampshire, Inc. (VC#174101), Concord, NH, to continue providing dental services to eligible and enrolled Medicaid members age 21 and older through New Hampshire's Medicaid Care Management Program, by increasing the price limitation by $1,086,162 from $49,445,550 to $50,531,712 with no change to the contract completion date of March 31, 2026, effective retroactive to July 1, 2024 upon Governor and Council approval. 72% Federal Funds. 28% Other Funds (Centene Settlement Funds).

The original contract was approved by Governor and Council on November 2, 2022, item #9A; amended with Governor and Council approval on October 18, 2023, item #21 and most recently amended with Governor and Council approval on June 26, 2024 item # 18A.

05-95-47-470010-43080000- HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DEPT, HHS,: OFC MEDICAID SERVICES, ADULT DENTAL PROGRAM

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increase / (Decrease)	Revised Budget
2023	101-500728	Dental Providers	47017100	$2,947,145		$2,947,145
2024	101-500728	Dental Providers	47017100	$11,788,580		$11,788,580
2025	101-500728	Dental Providers	47017100	$6,999,105	$980,388	$7,979,493
2026	101-500728	Dental Providers	47017100	TBD		TBD
			Sub-total	$21,734,830	$980,388	$22,715,218

05-95-47-470010 23580000 HEALTH AND SOCIAL SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFC OF MEDICAID SERVICES, DIVISION OF MEDICAID SERVICES, NH GRANITE ADV HEALTH CARE TRUST FUND

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount	Increase / (Decrease)	Revised Budget
2023	101-500728	Dental Providers	47017120	$3,749,805		$3,749,805
2024	101-500728	Dental Providers	47017120	$14,999,219		$14,999,219
2025	101-500728	Dental Providers	47017120	$8,961,696	$105,774	$9,067,470
2026	101-500728	Dental Providers	47017120	TBD		TBD
			Sub-total	$27,710,720	$105,774	$27,816,494
			Total Funds	$49,445,550	$1,086,162	$50,531,712

EXPLANATION

This request is **Retroactive** because the Center for Medicare and Medicaid Services (CMS) required the Department to adjust the dental services component of the capitation rates for services effective retroactive to July 1, 2024. This is the third-rate amendment to the original contract, which allows the Department to fulfill its statutory obligations to implement a comprehensive adult dental benefit. Through this third amendment, the Department will continue providing a comprehensive adult dental benefit to eligible and enrolled Medicaid members aged 21 and older through New Hampshire's Medicaid dental care management program. To date, the benefit has served more than 18,500 individuals.

The purpose of this request is to comply with CMS rate requirements regarding dental loss ratios and to calibrate the capitation rates accordingly. This request covers the rating period of July 1, 2024, through June 30, 2025.

The contract requires a minimum dental loss ratio of 85%, meaning that at least 85% of the paid capitation must be spent on dental services. Since the dental provider network and provider capacity has run below the originally expected actuarial utilization, under the second amendment, the Department made a 40% downward adjustment to the dental services component of the capitation payments. The 40% adjustment was made to better align with the program's development and network growth and reduce the amount of funds paid in capitation that will ultimately return to the Department. The Centers for Medicare and Medicaid Services reviewed the 40% downward adjustment, and after engaging the Department's actuary and program team, advised the Department that to approve the capitation rates a 30% downward adjustment be used instead. The Centers for Medicare and Medicaid Services requested this change in the event the program's development and network growth proceeds faster than the Department's expectation. This amendment changes the downward adjustment to the dental services component of the capitation payments from 40% to 30% to comply with the Centers for Medicare and Medicaid Services requirements for capitation rate setting, which are necessary to claim federal match on the dental capitation rates.

The Department will continue to monitor the Contractor's performance by:

- Operationalizing Exhibit O: Quality and Oversight Reporting Requirements – the performance monitoring program.
- Levying financial penalties through its Exhibit N: Liquidated Damages Matrix, when appropriate.
- Weekly review of data on network recruitment efforts, service access metrics, and impacts of the mobile dental services unit deployed in areas of relative access gaps to deliver covered services.

- Use of the External Quality Review Contractor for contractual and quality requirements specified in the Contract and required by CMS regulations; incentives for program performance, and a provider Alternative Payment Model (APM).
- Meeting regularly with Delta Dental leadership and other staff to provide contract oversight and discuss plan performance.

To draw a federal match on dental capitation rates, the Department must secure CMS approval of the actuarial rate filing. Should the Governor and Council not authorize this specific request, the Department may not be able to draw matching federal funds and would need to negotiate another amendment version which would incur additional costs from the Department's contracted actuary, not meet CMS requirements, and potentially cause a temporary gap in coverage.

Area served: Statewide

Source of Federal Funds: Assistance Listing Number #93.778, FAIN #2505NH5MAP

Respectfully submitted,

Lori A. Weaver
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #3

This Amendment to the DO Services Agreement is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Delta Dental Plan of New Hampshire, Inc. ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on November 2, 2022 (Item #9A), as amended on October 18, 2023 (Item #21) and June 26, 2024 (Item #18A), 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, pursuant to Form P-37, General Provisions, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; 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 to amend as follows:

1. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $50,531,712

2. Modify Exhibit B Scope of Services, Amendment #1, Section 6.3.5 Risk Mitigation, Subsection 6.3.5.1 to read:

   6.3.5.1 A minimum dental medical loss ratio (MLR) provision shall be implemented.

   6.3.5.1.1 The DMCM capitation rates reflect a target MLR which measures the projected dental service costs as a percentage of the total at-risk DO capitation rates.

   6.3.5.1.2 The minimum MLR will limit DO gains if the actual MLR is lower than the minimum MLR.

   6.3.5.1.3 The minimum MLR is set on a program-wide basis for all populations combined, such that maximum profit achievable is 3.5%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.0%). Based on the target MLR, the minimum MLR shall be 85.0%.

3. Modify Exhibit C, Payment Terms, Section 2.2, to read:

   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.

   This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit B Scope of Services. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category who enroll with this Contractor for covered services. Capitation rates were developed based on a 12-month period through June 30, 2025, the end of State Fiscal Year (SFY) 2025.

   Capitation payment rates are as follows:

Rate Cell Cohort	Rate Cell Name	Age	Base Category of Eligibility Code	Waiver Special Eligibility Code	Nursing Home Level of Care	July 1,2024 - June 30,2025
CHTDA1	Qualified Waiver Population - Base Rate	21+	Any Full Medicaid Eligible category including MGIA and MGIM	AA, AB, AC, AD, BB, BC, BE, DE, ED, EE, EC, EF, EG	N	$19.78
CHTDA2	Qualified Waiver Population - Denture Rate	21+	Any Full Medicaid Eligible category including MGIA or MGIM	AA, AB, AC, AD, BB, BC, BE, DE, ED, EE, EC, EF, EG	N	$0.62
CHTDA3	Non-Qualified Waiver Population NF - Base Rate	21+	Any Full Medicaid Eligible category not MGIA or MGIM	N	L2, L3, L4, L6	$19.78
CHTDA4	Non-Qualified Waiver Population NF - Denture Rate	21+	Any Full Medicaid Eligible category not MGIA or MGIM	N	L2, L3, L4, L6	$0.62
CHTDA5	Non-Qualified Waiver Population (STD MCAID)	21+	Any Full Medicaid Eligible category not MGIA or MGIM	N	N	$18.37
CHTDA6	Non-Qualified Waiver Population (Mcaid Expansion)	21+	MGIA, MGIM	N	N	$15.38

For each of the subsequent years of the Agreement, actuarially sound per member per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

Any rate adjustments shall be subject to the availability of State appropriations.

DS
TR
Contractor Initials
Date 1/31/2025

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be effective retroactive to July 1, 2024, upon Governor and 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

2/3/2025
Date

DocuSigned by:
Henry D. Lipman
CF5B1ADAF70D1E4...
Name: Henry D. Lipman
Title: Medicaid Director

Delta Dental Plan of New Hampshire, Inc.

1/31/2025
Date

DocuSigned by:
Tom Raffio
BD6D9FD927BE410...
Name: Tom Raffio
Title: President + CEO/Northeast Delta Dental

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

OFFICE OF THE ATTORNEY GENERAL

2/3/2025
Date

DocuSigned by:
Robyn Guarino
74873484494 1460
Name: Robyn Guarino
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:

AIRC

18A

Lori A. Weaver
Commissioner

Henry D. Lipman
Director

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

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

June 13, 2024

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to amend an existing contract with Delta Dental Plan of New Hampshire, Inc. (VC#174101), Concord, NH, to continuing providing dental services to eligible and enrolled Medicaid members age 21 and older through New Hampshire's Medicaid Care Management Program, by increasing the price limitation by $15,960,801 from $33,484,749 to $49,445,550 with no change to the contract completion date of March 31, 2026, effective July 1, 2024 upon Governor and Council approval. 72% Federal Funds. 28% Other Funds (Centene Settlement Funds).

The original contract was approved by Governor and Council on November 2, 2022, item #9A and most recently amended with Governor and Council approval on October 18, 2023, item #21.

05-95-47-470010-43080000- HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DEPT, HHS,: DIVISION OF MEDICAID SERVICES OFC MEDICAID SERVICES, ADULT DENTAL PROGRAM

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increase / (Decrease)	Revised Budget
2023	101-500728	Dental Providers	47017100	$2,947,145		$2,947,145
2024	101-500728	Dental Providers	47017100	$11,788,580		$11,788,580
2025	101-500728	Dental Providers	47017100	$0	$6,999,105	$6,999,105
2026	101-500728	Dental Providers	47017100	TBD		TBD
			Sub-total	$14,735,725	$6,999,105	$21,734,830

05-95-47-470010-23580000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DEPT., DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, GRANITE ADV HEALTH CARE TRUST FUND

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount	Increase / (Decrease)	Revised Budget
2023	101-500728	Dental Providers	47017120	$3,749,805		$3,749,805
2024	101-500728	Dental Providers	47017120	$14,999,219		$14,999,219
2025	101-500728	Dental Providers	47017120	$0	$8,961,696	$8,961,696
2026	101-500728	Dental Providers	47017120	TBD		TBD
			Sub-total	$18,749,024	$8,961,696	$27,710,720
			Total Funds	$33,484,749	$15,960,801	$49,445,550

EXPLANATION

This is the first-rate amendment to the original contract which fulfilled the Department's statutory obligations to implement a comprehensive adult dental benefit by April 1, 2023. The Department will continue providing a comprehensive adult dental benefit to eligible and enrolled Medicaid members aged 21 and older through New Hampshire's Medicaid managed care program. To date, the benefit has served more than 14,000 individuals.

The purpose of this request is to calibrate the capitation rates to reflect updated actuarial source data and emerging experience demonstrating that the potential pent-up demand originally forecasted has not yet materialized due in part to the extent of network thus far in place. This request covers the rating period of July 1, 2024 through June 30, 2025. The proposed rates reflect emerging experience, network development underway and the service utilization and access until there is further ramp-up.

The dental provider network and provider capacity has run below the originally expected actuarial utilization and, as a result, the projected medical loss ratio will result in a material return of funds from Delta Dental to the Department. The contract requires a minimum medical loss ratio of 85%, meaning that at least 85% of the paid capitation must be spent on dental services. Under this amendment, there is a 40% downward adjustment to the dental services component of the capitation payments to align with the program's development and network growth.

The Department will continue to monitor the Contractor's performance by:

- Utilizing the vendor contract and subsequent amendments to ensure contract compliance. This includes leveraging the External Quality Review Organization to conduct reviews of vendor compliance which are currently underway and are required by the Centers for Medicare and Medicaid Services as a condition of operating a managed care program, inclusive of a dental plan.
- Reviewing all required reporting on measures, measure sets, logs, and narrative reports and addressing any need for corrective action.
- In particular, reviewing weekly and monthly data on network recruitment efforts, service access metrics, and impacts of the fully equipped and staffed mobile dental services unit which will continue to be deployed in areas of relative access gaps to deliver covered services.
- Meeting regularly with Delta Dental leadership and other staff to provide contract oversight and discuss plan performance, as provided in the contract under Exhibits N and O.

Should the Governor and Council not authorize this specific request, the Department would need to negotiate another amendment version which could potentially cause a temporary gap in coverage.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number #93.778, FAIN #2405NH5MAP.

Respectfully submitted,

Ann Ch. W. Landry for:

Lori A. Weaver
Commissioner

ARC

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

Lori A. Weaver
Commissioner

Henry D. Lipman
Director

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

October 3, 2023

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into a Retroactive amendment to an existing contract with Delta Dental Plan of New Hampshire, Inc. (VC#174101), Concord, NH, to modify the scope of services for the Dental Medicaid program in accordance with Centers for Medicaid and Medicare Services requirements,, with no change to the price limitation of $33,484,749 and no change to the contract completion date of March 31, 2026, effective retroactive to April 1, 2023, upon Governor and Council approval.

The original contract was approved by Governor and Council on November 2, 2022, item #9A.

EXPLANATION

The Centers for Medicare and Medicaid Services (CMS) notified the Department of required modifications to the Medicaid Care Management Dental Services following Governor and Council approval of the original contract. This request is Retroactive as these contract modifications are required to be effective retroactive to the Medicaid Care Management Dental Services program start date of April 1, 2023.

The purpose of this request is to modify the Scope of Services with regard to definitions, member appeals process, and Dental Organization's records and documents access, in accordance with CMS requirements. The Contractor will continue to provide a comprehensive adult dental benefit to eligible and enrolled Medicaid members age 21 and older through New Hampshire's Medicaid managed care program.

The Department will continue to monitor the Contractor's performance by:

- Utilizing the vendor contract and subsequent amendments to ensure contract compliance.
- Reviewing all required reporting on measures, measure sets, logs, and narrative reports and addressing any need for corrective action.
- Meeting regularly with Delta Dental leadership and other staff to provide contract oversight and discuss plan performance, as appropriate.

Should the Governor and Council not authorize this request, the Department will not be in compliance with CMS requirements, which may have financial implications to the Department.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number 93.778, FAIN 2305NH5MAP.

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

Respectfully submitted,

Lori A. Weaver
Commissioner

ARC

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9A

Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

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

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

October 24, 2022

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into a contract with Delta Dental Plan of New Hampshire, Inc. (VC#174101), Concord, NH, in the amount of $33,484,749 to provide dental services to eligible and enrolled Medicaid members age 21 and older through New Hampshire's Medicaid managed care program, with the option to renew for up to two (2) additional years, effective upon Governor and Council approval through March 31, 2028. 72% Federal Funds. 28% Other Funds (Centene Settlement Funds).

Funds are available in the following accounts for State Fiscal Year 2023, and are anticipated to be available in State Fiscal Years 2024, 2025, and 2026, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified. The initial capitation funds incorporated herein are for a fifteen (15) month period, April 1, 2023 through June 30, 2024.

05-95-47-470010-43080000- HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DIVISION OF MEDICAID SERVICES, ADULT DENTAL PROGRAM

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	101-500728	Dental Providers	47017100	$2,947,145
2024	101-500728	Dental Providers	47017100	$11,788,580
2025	101-500728	Dental Providers	47017100	TBD
2026	101-500728	Dental Providers	47017100	TBD
			Subtotal	$14,735,725

05-95-47-470010-23580000- HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DIVISION OF MEDICAID SERVICES, NH GRANITE ADV HEALTH CARE TRUST FUND

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	101-500728	Dental Providers	47017120	$3,749,805
2024	101-500728	Dental Providers	47017120	$14,999,219
2025	101-500728	Dental Providers	47017120	TBD
2026	101-500728	Dental Providers	47017120	TBD
			Subtotal	$18,749,024
			Total	$33,484,749

EXPLANATION

The purpose of this request is to fulfill the State legislative obligation of the Department of Health and Human Services (the "Department"). On July 1, 2022, HB 103 and SB 422 were signed into law by the Governor. The laws require the Department to implement a comprehensive adult dental benefit by April 1, 2023.

The completion date reflected in the price limitation is for the period June 30, 2024; therefore, at current assumptions the total price limitation is estimated at $62 million through March 31, 2026. The non-federal share is expected to be funded using Centene settlement dollars at least through SFY 2025.

The enacted law specifies:

- The Department is charged with planning and operationalizing an adult dental benefit that includes diagnostic, preventive, limited periodontic, restorative, and oral surgery services for all Medicaid eligible adults age 21 and older.
- The benefit must include support for beneficiaries in improving their oral health through a combination of care management and transportation, while also fostering personal responsibility in the form of cost sharing (excluding costs for diagnostic and preventive services) for members above a specified annual household income.

  Legislative requirements include:

  - Delivery of dental care services in a value-based care model that includes innovative programs to improve access and care, while meeting the state's objectives for value, quality, efficiency, patient education, and savings.
  - Service delivery model may be achieved through existing or novel contracting arrangements with managed care organizations.
  - Limited removable dentures to eligible adults who participate in the Developmental Disability, Acquired Brain Disorder, and Choices for Independence Waivers, as well as nursing facility residents.
  - A $1,500 yearly member benefit limit (excluding costs for preventive services).
- Adult dental services must be in effect by April 1, 2023.

Through a procurement process which included a Request for Information (RFI) to inform the program model,[1] and a competitive Request for Proposal (RFP) process, the Contractor, Delta Dental Plan of New Hampshire, Inc. (Delta Dental), was selected from two (2) RFP respondents. The organization will work with the State, Providers, stakeholders, and beneficiaries to provide high-quality, value-based dental services on a statewide basis, including:

- Diagnostic and preventive dental services including an annual comprehensive oral examination, necessary x-rays or other imaging, prophylaxis, topical fluoride, oral hygiene instruction, behavior management and smoking cessation counseling, and other services as determined by the annual update of Current Dental Terminology (CDT) codes D0100-D0899 and D1000-D1999;
- Comprehensive restorative dental services necessary to prevent or treat oral health conditions.
- Limited periodontic dental services.
- Oral surgery dental services necessary to relieve pain, eliminate infection or prevent imminent tooth loss.
- Transportation to dental appointments.
- Support for oral health through care management and care coordination.
- Removable prosthodontic coverage for the following individuals who qualify for specialized Medicaid services:
    - Developmental Disability (DD) Waiver
    - Acquired Brain Disorder (ABD) Waiver
    - Choices for Independence (CFI) Waiver
    - Nursing facility residents
- Beneficiary cost sharing for individuals above 100% Federal Poverty Level (FPL) at ten percent (10%) of allowed charges for services performed during a visit up to five percent (5%) of annual household income (excluding costs for diagnostic and preventive services, and excluding populations specified under terms of the State's Medicaid Cost Sharing State Plan Amendment pursuant to 42 CFR 447.50 through 42 CFR 447.82).
- $1,500 yearly limit on dental services (excluding costs for preventive services).

The Dental Organization (DO), Delta Dental Plan of New Hampshire, will arrange for the provision of adult dental services to approximately 88,000 Medicaid beneficiaries aged 21 years and older.

[1] Through the RFI process, six (6) vendors submitted responses detailing the options of delivering adult dental services through either the three current Medicaid Managed Care Organizations (MCOs) or procuring a single DO. Upon reviewing the RFI responses, the Department concluded that a single DO is best suited to achieve programmatic priorities, including access, provider participation, and administrative efficiency.

Key contract requirements include:

Component	Description
Access, Network Adequacy, and Provider Capacity	• Compliance with network adequacy standards for Primary Dental Providers (PDP); • Compliance with all New Hampshire Health Insurance Department (NHID) network adequacy rules; and • Network requirements for Participating Providers in sufficient numbers and expertise for all Covered Dental Services.
Care Coordination and Care Management	• Responsibility for the management, coordination, and Continuity of Care for all beneficiaries; and • Implementation of Care Coordination and Care Management strategies to improve beneficiary care and oral health outcomes, Improve Continuity of Care, reduce inappropriate utilization of Emergency Services, reduce unmet resource needs related to determinants of health, decrease total cost of care, and increase Member satisfaction with their oral health care experience.
Utilization Management	• Development of an effective Utilization Management program with defined structures, policies, and procedures.
Alternative Payment Models	• Requirements to adopt Alternative Payment Strategy (APM) strategies to promote New Hampshire priorities; • Development of an APM strategy using "Qualifying APMs" aligned with the Health Care Payment Learning & Action Network (HCP-LAN) APM framework Category 2B or above; and • Delivery of a comprehensive performance management methodology with respect to quality performance targets, including APM data-sharing and reporting requirements; and
Quality management	• Delivery of quality dental care with the primary goal of Improving the oral health status of beneficiaries; • Development of comprehensive Quality Assessment and Performance Improvement (QAPI) programs that reflect New Hampshire's priorities, including projects that address disparities in the quality of and access to dental care; and • Achievement of URAC Health Plan Accreditation.
In Lieu Of Services and Value-Added Services	• At the Contractor's option and approval by DHHS, introduction of: o "In lieu of" services or settings that are more medically appropriate, cost-effective substitutes for State Plan Services; and o Beneficiary value-added services to help improve their health and reduce costs.

Component	Description
Member Education and Incentives	• Development of an oral health education program and an incentive program(s), including a healthy behavior incentive program designed to support member responsibility to gain improved oral health.
Withhold & Incentive Program	• Participation in the Department's Withhold and Incentive Program, designed to advance the vendor's accountability against a select set of priority interventions.
Program Integrity	• Compliance with program integrity policies and procedures that guide the vendor and its officers, employees, agents, and Subcontractors to comply with federal and State laws and regulations; and • Requirements to identify and investigate fraud, waste and abuse (FWA) and recover overpayments when appropriate.
Medical Loss Ratio	• Requirements to meet a minimum 85% Medical Loss Ratio (MLR); in the event the Contractor's MLR is below that minimum, the Contractor is required to refund the Department the difference between the actual MLR and the dollar amount corresponding to an 85% MLR. *The minimum MLR limits the Contractor's profits and requires the Contractor to spend at least 85-cents of every dollar to fund the delivery of covered oral health services.*

The Department will monitor the vendor's performance by:

- Utilizing the vendor contract and subsequent amendments to ensure contract compliance.
- Reviewing all required reporting on measures, measure sets, logs, and narrative reports and addressing any need for corrective action.
- Meeting regularly with Delta Dental leadership and other staff to provide contract oversight and discuss plan performance, as appropriate.

The Department selected the Contractor after conducting an RFI process as explained previously, and following a competitive bid process using a Request for Proposals (RFP) that was posted on the Department's website from August 25, 2022 through September 30, 2022. During the RFP phase, the current Medicaid MCOs were eligible to submit an RFP. The Department received two (2) proposals from DOs that were reviewed and scored by a team of qualified individuals. The Scoring Sheet is attached.

As referenced in Exhibit A - Revisions to Standard Agreement Provisions of the attached agreement, the parties have the option to extend the agreement for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and Governor and Council approval.

Should the Governor and Council not authorize this request Medicaid adult dental services would not be available in accordance with enacted State law.

Area served: Statewide

Source of Federal Funds: Assistance Listing Number #93.778, FAIN #2305NH5MAP

Respectfully submitted,

DocuSigned by:
Lori A. Shibinette
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Lori A. Shibinette
Commissioner

New Hampshire Department of Health and Human Services
Division of Finance and Procurement
Bureau of Contracts and Procurement
Scoring Sheet

Project ID # RFP-2023-DMS-06-MEDIC

Project Title Medicaid Care Management Dental Services

	Maximum Points Available	MCNA DENTAL	Northeast Delta Dental
Technical			
1. Organization Overview and Overview of Relevant Experience	70	66	65
2. Subcontractors	26	25	22
3. Covered Populations and Services	25	21	23
4. Member Services	28	24	25
5. Member Grievances and Appeals	26	20	25
6. Provider Appeals	15	7	10
7. Network Adequacy for Access to Dental Services	60	35	40
8. Utilization Management	30	28	30
9. Member Education and Incentives	70	60	68
10. Care Coordination and Care Management	120	98	100
11. Quality Management	35	25	32
12. Network Management	70	60	68
13. Alternative Payment Models	40	25	35
14. Provider Payments	10	8	10
15. Claims Quality Assurance and Reporting	10	8	9
16. Oversight and Accountability	30	25	20
17. Third Party Liability/Coordination of Benefits	50	30	43
Subtotal - Technical	700	640	626
Cost			
1. Managed Care Savings Opportunities	50	35	46
2. Third Party Liability, Coordination of Benefits and Cost Avoidance	15	15	14
3. Program Integrity – Fraud, Waste, and Abuse	10	10	10
4. Administrative Efficiencies	15	11	10
5. Cost Savings	10	4	10
Subtotal - Cost	100	75	90
TOTAL POINTS	800	715	716
TOTAL PROPOSED VENDOR COST**			

Reviewer Name	Title
1 Sarah Finnie	Dental Medicaid Director
2 Athena Gagnon	Medicaid Finance Director
3 Shirley Iacopino	Administrator IV
4 Christen Lavers	Attorney
5 Laura Dillon	Administrator I
6 Jessica Co	Information Technology Mgr V

** The Department published Appendix H (Cost Development Rate Sheet) with the solicitation. Final rates can be found in Exhibit C (Payment Terms).

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

October 19, 2022

Lori Shibinette, Commissioner
Department of Health and Human Services
State of New Hampshire
29 Hazen Drive
Concord, NH 03301

Dear Commissioner Shibinette:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a contract with Delta Dental Plan of New Hampshire, Inc., as described below and referenced as DoIT No. 2023-025.

The purpose of this request is enter into a contract with Delta Dental Plan of New Hampshire, Inc. to provide statewide dental services to eligible and enrolled Medicaid members age 21 and older through New Hampshire's Medicaid managed care program, known as New Hampshire Medicaid Care Management.

The price limitation will be $33,484,749, effective upon Governor and Executive Council approval through March 31, 2026, with the option to renew for up to two (2) additional years.

A copy of this letter must accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/jd
DoIT #2023-025

cc: Mike Williams, IT Manager