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DEC 17 2025

Lori A. Weaver
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

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December 10, 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 existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA, Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan, Manchester, NH, and Granite State Health Plan Inc. d/b/a New Hampshire Healthy Families, Bedford, NH to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by $25,535,136 which is made up of $135,937 in general funds, $4,869,404 in non-federal funds and $20,529,795 in federal funds. The price limitation change moves from $2,743,228,328 to $2,768,763,464 (an increase of 0.9% in total funds) covering the first two contract periods with no change to the contract completion dates of August 31, 2029, effective upon Governor and Council approval.

The original three (3) contracts were approved by Governor and Council on January 10, 2024 (Tabled item #33), amended on July 10, 2024 (Item #11A), amended on December 18, 2024 (Item 13A), and most recently amended on June 25, 2025 (Item #199A).

Funds are available in the following accounts in the fiscal detail table for State Fiscal Years 2026 and 2027 and are anticipated to be available in State Fiscal Years 2028 and 2029 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.

Please see attached fiscal details.

EXPLANATION

The purpose of this request is to update the MCM program costs for July 1, 2025, through June 30, 2026, rating period to actuarially reflect appropriately the emerging claims experience of increasing acuity and cost as eligibility policies returned to pre-PHE policies by July 1, 2025, and the resulting impact on enrollment levels of generally retaining individuals with a high illness burden.

Other material changes in amendment #4 include:

- Further updates to the SFY 2026 projected enrollment to reflect changes to enrollment due to the return to pre-PHE eligibility policies

- A downward adjustment to the rate for the elimination of coverage of GLP-1s for weight loss only use as of January 1, 2026 (NH's Medicaid program does not stand alone in modifying its GLP-1s for weight-loss)
- Implementing the actual Diagnostic Related Group reimbursement weights for acute inpatient hospital services and the actual FQHC fee schedule updates that were not yet in final federal regulations covering the period as of Amendment #3
- Implementation of lowest net drug costs legislation from HB2, with MCM compliance to adherence targets, allowing Medicaid to prefer brand drugs over a generic drug where the net cost to the Medicaid program is less
- Updated and increased costs for the high-cost pharmacy risk pool pipeline drug list to reflect an updated estimate of new medication and gene therapies anticipated for adoption
- Increase inpatient labor and delivery maternity payment rates for Critical Access Hospitals
- A readjustment of ABA therapy supervision codes.

The Centers for Medicare and Medicaid Services (CMS) generally require that managed care rate certifications be done on a 12-month rating period demonstrating actuarial soundness thereby necessitating at least annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates are updated as necessary for changes enacted federally, by the NH Legislature, and for regulatory changes by the Centers for Medicare and Medicaid Services.

The Department will monitor services by:

- Continuing review of performance of the Exhibit O: Quality and Oversight Reporting Requirements, the MCM Program's performance monitoring program;
- Levying financial penalties through its Exhibit N: Liquidated Damages Matrix, when appropriate;
- Use of the External Quality Review contractor for contractual and quality requirements specified in the MCOs' contract and required by CMS regulations; incentives for program performance via a MCO capitation withhold program, performance-based auto assignment of beneficiaries, and a provider Alternative Payment Model (APM); and
- Supporting regular MCO meetings to review program and contract performance.

The Department has determined that the Contractors are in good standing with the Secretary of State's Office, have secured the required levels of insurance, and have provided evidence of authority to execute and be bound by the contract. The Department also requested and received approval from the Commissioner of Department of Information Technology, 2024-020D. Documents supporting these assertions are available at the agency, for review upon request.

Should the Governor and Executive Council not authorize this request, enhanced federal match could be at risk for funding benefits to beneficiaries and providers.

Area served: Statewide

Source of Federal Funds: Assistance Listing Number formerly CFDA# 93.778, FAIN #2605NH5MAP

Respectfully submitted,

For Lori A. Weaver
Commissioner

Medicaid Care Management Services Contracts
Fiscal Details for Rate Year 2026

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2025	101-500729	Medical Payments to Providers	$515,269,429	$0	$515,269,429
SFY 2026	101-500729	Medical Payments to Providers	$665,169,437	$12,730,477	$677,899,914
SFY 2027	101-500729	Medical Payments to Providers	TBD	TBD	TBD
SFY 2028	101-500729	Medical Payments to Providers	TBD	TBD	TBD
SFY 2029	101-500729	Medical Payments to Providers	TBD	TBD	TBD
		Sub-Total	$1,180,438,866	$12,730,477	$1,193,169,343

05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM

State Fiscal Year	Class/ Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2025	101-500729	Medical Payments to Providers	$103,019,829		$103,019,829
SFY 2026	101-500729	Medical Payments to Providers	$136,833,557	-$5,899,861	$130,933,696
SFY 2027	101-500729	Medical Payments to Providers	TBD	TBD	TBD
SFY 2028	101-500729	Medical Payments to Providers	TBD	TBD	TBD
SFY 2029	101-500729	Medical Payments to Providers	TBD	TBD	TBD
		Sub-Total	$239,853,386	($5,899,861)	$233,953,525

05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICIAD SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT

State Fiscal Year	Class/ Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2025	101-500729	Medical Payments to Providers	$590,134,461	$0	$590,134,461
SFY 2026	101-500729	Medical Payments to Providers	$732,801,615	$18,704,520	$751,506,135
SFY 2027	101-500729	Medical Payments to Providers	TBD	TBD	TBD
SFY 2028	101-500729	Medical Payments to Providers	TBD	TBD	TBD
SFY 2029	101-500729	Medical Payments to Providers	TBD	TBD	TBD
		Sub-Total	$1,322,936,076	$18,704,520	$1,341,640,596
		Total Funds	**$2,743,228,328**	**$25,535,136**	**$2,768,763,464**

Medicaid Care Management Services Contracts
Fiscal Details for Rate Year 2026

	Federal	Other / Agency Income	General
Granite Advantage Health Care Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	65%	1%	34%
Standard Medicaid Population (Medicaid Care Management)	51%	40%	9%

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY

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

Denis Goulet, *Commissioner*

December 5, 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 AmeriHealth Caritas New Hampshire Inc., Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan, and Granite State Health Plan Inc. d/b/a New Hampshire Healthy Families, as described below and referenced as DoIT No. 2024-020D.

The purpose of this request is to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management.

The Total Price Limitation shall increase by $25,535,136 for a New Total Price Limitation of $2,768,763,464, effective upon Governor and Council approval with no change to the contract end date of August 31, 2029.

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 #2024-020D

cc: Ken Gagne, IT Manager, DoIT

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

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

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on January 10, 2024 (Tabled Item 33), as amended on July 10, 2024 (Item #11A), as amended on December 18, 2024 (Item #13A) and most recently amended on June 25, 2025 (Item # 199A) 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:

   $2,768,763,464

2. Modify Exhibit B Scope of Services, Amendment #3 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 Scope of Services, Amendment #4 are outlined below:

3. Modify Exhibit B, Section 4.1.2.4, Summary of Covered Services by indicating Psychiatric Residential Treatment Facility Services are “Not Included in Managed Care (DHHS Covered).

4. Modify Exhibit B, Section 4.1.4.2.1 through 4.1.4.2.4, to read:

   4.1.4.2.1 A Copayment of four dollars ($4.00) shall be required for each preferred prescription drug and each refill of a preferred prescription drug; and

   4.1.4.2.2 A Copayment of four dollars ($4.00) shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug.

   4.1.4.2.3 Intentionally left blank.

   4.1.4.2.4 Intentionally left blank.

5. Modify Exhibit B, by adding Section 4.1.4.3.7, to read:

   4.1.4.3.7 Recommended medications, services, and items graded A or B by the U.S. Preventive Services Task Force, including nicotine cessation products and oral and injectable formulations of Pre-Exposure Prophylaxis (PrEP) for persons who are at high risk of HIV acquisition.

6. Modify Exhibit B, Section 4.1.4.4.6, to read:

   4.1.4.4.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within twelve (12) months after the month the pregnancy ended;

7. Modify Exhibit B, Section 4.1.9.3.2, to read:

   4.1.9.3.2 Has undergone a satisfactory safety inspection in accordance with the mutually agreed comprehensive safety checklist at the time of transportation provider enrollment into the Subcontractor's network, at least annually thereafter, and when a safety issue is

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reported for the transportation provider vehicle; and

8. Modify Exhibit B, Section 4.1.9.8.1, by adding Section 4.1.9.8.1.9, to read:

   4.1.9.8.1.9 Any vehicles used for the purpose of transporting individuals with disabilities must meet the requirements set forth in the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles. [49 CFR 38]

9. Modify Exhibit B, Section 4.2.3.1, by adding Sections 4.2.3.1.1 through 4.2.3.1.3, to read:

   4.2.3.1.1 In addition to the MCO's PDL compliance obligations under this Agreement, the MCO shall achieve Department specified minimum adherence targets for specific Department identified drugs' initial adherence targets measured from January 1, 2026 through June 30, 2026. The Department may update adherence targets annually and shall be maintained by the MCO annually thereafter as described in separate guidance.

   4.2.3.1.2 The MCO shall provide quarterly reporting on MCO's adherence targets in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

   4.2.3.1.3 Failure to meet adherence to targets will subject the MCO to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

10. Modify Exhibit B, Section 4.4.13, by adding Section 4.4.13.6, to read:

    4.4.13.6 Beginning March 31, 2026 and annually thereafter, the MCO shall report prior authorization data from the prior calendar year in accordance with Exhibit O: Quality and Oversight Reporting Requirements, excluding any and all drugs covered by the MCO. In addition, the MCO shall make this data accessible by posting the information on its website. [42 CFR 210(f)]

11. Modify Exhibit B, Section 4.5.1, by adding Section 4.5.1.14, to read:

    4.5.1.14 Beginning March 31, 2026, the MCO shall report for the prior calendar year publicly accessible prior authorization data on its plan website, excluding data on any and all drugs covered by the MCO. [42 CFR 438.210]

12. Modify Exhibit B, Section 4.5.3.5, to read:

    4.5.3.5 The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

13. Modify Exhibit B, Section 4.5.6.1, by adding Section 4.5.6.1.1, to read:

    4.5.6.1.1 Effective July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), in accordance with the timeframes established in 42 CFR 438.210(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information) as if such requirements applied directly to the MCO according to the decision timeframes in 42 CFR 438.210(d). [42 CFR 438.242(b)(8)]

14. Modify Exhibit B, Section 4.5.7.3, to read:

    4.5.7.3 Beginning July 1, 2026, for standard service authorization decisions, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed seven (7) calendar days following the date of receipt of 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 from the date of receipt of the request for service is permissible, if:

15. Modify Exhibit B, Section 4.5.9.2, to read:

    4.5.9.2 Under no circumstances may the MCO extend the appeal determination be[illegible]ty-four (44) calendar days from the day the MCO receives the appeal request [illegible]he

MCO does not have all the information necessary to make the decision.

16. Modify Exhibit B, Section 4.7, by adding Section 4.7.12 through 4.7.12.1, to read:

    4.7.12 Rural Health Care

    4.7.12.1 Beginning as early as January 1, 2026, the MCO shall support the Department's Rural Health Care activities authorized through the 2025 federal budget reconciliation bill as described in separate guidance. [H.R. 1; P.L. 119-21]

17. Modify Exhibit B, Section 4.8.4.3.1, to read:

    4.8.4.3.1 Beginning July 1, 2026 the determination of all other authorizations for per-service benefits (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed seven (7) fourteen calendar days for ninety-five percent (95%) of standard requests after the receipt of a request. [42 CFR 438.210(d)]

18. Modify Exhibit B, Section 4.8.4.3.2, to read:

    4.8.4.3.2 Beginning July 1, 2026, an extension of up to fourteen (14) calendar days after receiving the request is permissible for if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

19. Modify Exhibit B, Section 4.8.4.3.3, to read:

    4.8.4.3.3 Intentionally left blank.

20. Modify Exhibit B, Section 4.8.4.3.4, to read:

    4.8.4.3.4 Beginning July 1, 2026 notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than seven (7) calendar days after the earlier of:

21. Modify Exhibit B, Section 4.8.4.3.7, to read:

    4.8.4.3.7 Beginning July 1, 2026, the MCO shall notify the requesting provider, and give the enrollee written notice of any decision as expeditiously as the Member's condition requires, but may not exceed seven (7) calendar days after receiving the request for service.

22. Modify Exhibit B, Section 4.8.4.3.7, by adding Section 4.8.4.3.7.1, to read:

    4.8.4.3.7.1 Beginning July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), the MCO shall provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request to the MCO. [42 CFR 438.210(d)] Reasons may be communicated via portal (may include existing payer messaging portal), fax, email, mail, or phone. [42 CFR 438.242(b)(8)]

23. Modify Exhibit B, Section 4.11.2.2.2, to read:

    4.11.2.2.2 Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care

24. Modify Exhibit B, Section 4.11.4.2, to read:

    4.11.4.2 Intentionally left blank.

25. Modify Exhibit B, Section 4.14.3.8.1, to read:

    4.14.3.8.1 For PCPs, (and mental health providers effective January 1, 2026), within))

Initial SkN

calendar days of receipt of clean and complete credentialing applications; RSA 420-J:4, I(h)

26. Modify Exhibit B, Section 4.15.14.3.1.1, to read:

    4.15.14.3.1.1 Appropriate use of emergency departments relative to low acuity non-emergent visits.

27. Modify Exhibit B, Section 4.15.14.3.1.6, to read:

    4.15.14.3.1.6 Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing preferred drug prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing Polypharmacy, as described in Section 4.2.6 (Medication Management);

28. Modify Exhibit B, Section 4.15.15.3.3, to read:

    4.15.15.3.3 Effective July 1, 2026, all of MCO's Physician Incentive Plans to a Provider must adhere to the following requirements: (i) have defined performance period that can be tied to the applicable MLR reporting periods; (ii) the Provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCO; (iii) the physician incentive contract with the Provider must include a specific dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including an expected date of payment for meeting the required metrics; and (iv) the physician incentive contracts with the Provider must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e. defined and linked to an applicable MLR reporting period or periods). [42 438.608(e); 42 CFR 438.3(i)(3) and (4)]

29. Modify Exhibit B, Section 4.16.1.11, to read:

    4.16.1.11 The MCO shall implement and maintain arrangements or procedures for prompt reporting within 30 calendar days of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste or Abuse, to the Department. [42 CFR 438.608(a)(2)]

30. Modify Exhibit B, Section 4.18.8.2.1, by adding Sections 4.18.8.2.1.1 through 4.18.8.2.1.1.3 to read:

    4.18.8.2.1. Effective July 1, 2026, implement and maintain a Patient Access Application Programming Interface (API) required in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the MCO, and:

        4.18.8.2.1.1. Include all encounter data, including encounter data from any network providers compensated by the MCO based on capitation payments and adjudicated claims and encounter data from any Subcontractors.

        4.18.8.2.1.2 Exclude covered outpatient drugs as defined in section 1927(k)(2) of the Act.

        4.18.8.2.1.3 Report metrics specified in 42 CFR 431.60(f) (total members whose data are transferred to an API and total members whose data were transferred more than once). [42 CFR 438.242(b)(5)]

31. Modify Exhibit B, Section 5.3.2.2.5, to read:

    5.3.2.2.5 A provision for the prompt reporting within 30 calendar days of all Overpayments identified and recovered, specifying the Overpayments due to potential 42

CFR 438.608(a)(2)]

32. Modify Exhibit B, Section 5.3.3.6, to read:

5.3.3.6 The Department may recover Overpayments that are not recovered by or returned to the MCO within ninety (90) calendar days of the end of the appeal timeframe unless the MCO has a recovery agreement with the Provider, or is actively recovering through claims recoupment. The Department will notify MCO if the Department has plans to pursue recovery.

33. Modify Exhibit B, Section 5.3.6.4.2, to read:

5.3.6.4.2 The MCO shall report at least annually to the Department and as otherwise required by this Agreement on all Overpayments identified and recovered. 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

34. Modify Exhibit B, by adding Section 5.4.8, to read:

5.4.8 In accordance with RSA 126-A:3, the Department will seek to implement an outpatient procedure incentive program beginning as early as January 1, 2026, subject to review and approval from the fiscal committee of the general court.

35. Modify Exhibit B, Section 6.2.16.9, to read:

6.2.16.9 Beginning for services effective January 1, 2025, for the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each of three (3) new kick payments to cover juveniles and adults who are incarcerated to comply with new service requirements as part of the implementation of the expansion of its Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance Treatment and Recovery Access 1115 Demonstration Waiver

36. Modify Exhibit B, Section 6.3.4.2.11.1.3, to read:

6.3.4.2.11.1.3 For the July 1, 2025 through June 30, 2026 rating period, the capitation rates reflect an average target MLR, which measures the projected medical service costs as a percentage of the total at-risk capitation rates. The minimum MLR will limit MCO gains if the actual MLR is lower than the minimum MLR. The maximum MLR will limit MCO losses if the actual MLR is higher than the maximum MLR. The average target MLR for at-risk services is 91.2% for Standard Medicaid and 90.3% for GAHCP based on the SFY 2026 projected enrollment distribution. The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs for the rating period, the minimum MLR will be 88.7% for the Standard Medicaid population and 87.8% for the GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCO will have a maximum loss of 2%. Based on the target MLRs for the rating period, the average maximum MLR will be 94.7% for the Standard Medicaid population and 93.8% for the GAHCP population.

37. Modify Exhibit B, Section 6.4. by adding Section 6.4.1.1, to read:

6.4.1.1 For both Medicare Part A and Part B Claims, if the Member responsibility amount is “0” then the MCO shall make no payment.

38. Modify Exhibit B, Section 6.3.4.2.10, to read:

6.3.4.2.10 The MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available. At the Department’s discretion, a final rev R settlement calculation may occur upon completion of an MLR audit for t d,

if applicable, to consider any adjustments identified during the MLR audit impacting the final MLR settlement calculation.

39. Modify Exhibit B, Section 6.4.2.3, to read:

    6.4.2.3 Intentionally left blank.

40. Modify Exhibit B, Section 6.4.4, to read:

    6.4.4 For all claims (medical and pharmacy) with other insurance or Medicare Advantage plans, the MCO shall follow coordination of benefits processes described in the entirety of this Section 6.4, unless otherwise stipulated in this Agreement.

41. Modify Exhibit B, Section 6.4.4.2, to read:

    6.4.4.2 Beginning March 1, 2026, the MCO shall pay as primary payer for Medicare Part A and Part B claims when the provider is not enrolled with Medicare on the Date of service.

42. Modify Exhibit B, Section 6.4. by adding Section 6.4.4.3, to read:

    6.4.4.3 Beginning March 1, 2026, the MCO is responsible for Member Cost Sharing, (e.g., Copayment, deductible) (excluding Medicare Part D medications), as applicable, when other insurance, Medicare Part A or Part B, or Medicare Advantage pays as primary for a Covered Service via an automated crosswalk table or other methodology to effectuate payment regardless of whether the primary payer uses a different billing code for the same Covered Service.

43. Modify Exhibit B, Section 6.4. by adding Section 6.4.5, to read:

    6.4.5 The MCO shall not pay Member Cost Sharing for Medicare Part D covered medications regardless of whether the Member has one or both Medicare Part A and/or Medicare Part B.

44. Modify Exhibit B, Section 6.10.11.4, to read:

    6.10.11.4 The MCO shall have five (5) months from the original paid date to bill private insurance. The MCO shall have six (6) years to recover funds with the following exceptions:

45. Modify Exhibit B, Section 6.10.11.4 by adding Section 6.10.11.4.3, to read:

    6.10.11.4.3 The Department may directly bill and recover the private insurance amount paid by the MCO if the MCO has not billed the private insurance within five (5) months from the MCO original paid date. The Department shall inform the MCO in writing of any claims in which the Department plans to pursue Pay and Case recovery and retain any recovered funds.

46. Modify Exhibit C Payment Terms, Amendment #3 by replacing it in its entirety with Exhibit C Payment Terms, Amendment #4, which is attached hereto and incorporated by reference herein.

47. Modify Exhibit N Liquidated Damages Matrix, Amendment #2 by replacing it in its entirety with Exhibit N Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

48. Modify Exhibit O: Quality and Oversight Reporting Requirements, Amendment #3 by replacing it in its entirety with Exhibit O: Quality and Oversight Reporting Requirements Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

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 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

12/5/2025
Date

DocuSigned by:
Henry D. Lipman
CF5D44D4F70D4E4...

Name: Henry D. Lipman
Title: Medicaid Director

AmeriHealth Caritas New Hampshire, Inc.

12/5/2025
Date

Signed by:
Sonya K Nelson
751E61A043654BE...

Name: Sonya K Nelson
Title: DIvision President

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

OFFICE OF THE ATTORNEY GENERAL

12/5/2025
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:

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Medicaid Care Management

EXHIBIT B – AMENDMENT #4

SCOPE OF SERVICES

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1 INTRODUCTION

1.1 Purpose

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

1.2 Term

1.2.1. The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed MCM Agreement or, if the MCO 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 MCO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.1.1 If the MCO 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 MCO.

1.2.2. The Program Start Date shall begin September 1, 2024, and the Agreement term shall continue through August 31, 2029.

1.2.3. The MCO's participation in the MCM program is contingent upon approval by the Governor and Executive Council, the MCO'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.

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

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

2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 Abuse

2.1.1.1. Practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program or in reimbursement for goods services that are not medically necessary or that fail to meet professionally recognized standards for care; or recipient practices that result in unnecessary cost to the Medicaid program.

2.1.2 Adults with Special Health Care Needs

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2.1.2.1. 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.

2.1.2.2. This includes but is not limited to Members diagnosed 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**

2.1.3.1. 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**

2.1.4.1. 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 MCO to act on a grievance or an appeal within the time limits defined in this Agreement.

2.1.5 **Affordable Care Act**

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

2.1.6 **Agreement**

2.1.6.1. This entire written Agreement between the Department and the MCO duly executed and legally binding.

2.1.7 **Alternative Payment Model (APM)**

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

2.1.8 **Alternative Payment Model Implementation Plan**

2.1.8.1. A MCO's plan for meeting the APM requirements described in this Agreement.

2.1.9 **American Society of Addiction Medicine (ASAM) Criteria**

2.1.9.1. The National set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

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2.1.10 **Americans with Disabilities Act (ADA)**

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

2.1.11 **Area Agency**

2.1.11.1. An entity established as a nonprofit corporation in the State of New Hampshire which is established by rules adopted by the Commissioner to provide services to developmentally disabled persons in the area as defined in RSA 171-A:2.

2.1.12 **ASAM Level of Care**

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

2.1.13 **Assertive Community Treatment (ACT)**

2.1.13.1. The evidence-based practice of delivering comprehensive and effective services to Members with SMI by a multidisciplinary team primarily in Member homes, communities, and other natural environments.

2.1.14 **Automatic Assignment (or Auto-Assign)**

2.1.14.1. The enrollment of an eligible Medicaid recipient, for whom enrollment is mandatory, in a MCO chosen by the Agency or its agent, and/or the assignment of a new enrollee to a PCP chosen by the MCO. In addition, Auto-Assignment may occur based on MCO performance as described in Section 4.3.4 (Auto-Assignment).

2.1.15 **Auxiliary Aids**

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

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

2.1.16 **Behavioral Health Services**

2.1.16.1. Mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.17 **Bright Futures**

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2.1.17.1. A National health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.18 **Capitation Payment**

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

2.1.18.2. Capitation payments are made only for Medicaid-eligible Members and retained by the MCO 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]

2.1.19 **Care Coordination**

2.1.19.1. A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a Member's physical, behavioral health and psychosocial needs using communication, closed-loop referral processes, and all available resources to promote quality cost-effective outcomes.

2.1.20 **Care Management**

2.1.20.1. Direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.21 **Care Manager**

2.1.21.1. A qualified and trained individual who is primarily responsible for providing Member supportive services as defined by this Agreement.

2.1.22 **Care Plan**

2.1.22.1. A document prepared and updated by a Member's Provider and interdisciplinary Care Team with input from the Member which summarizes the Member's health conditions, specific care needs, and current treatments. The Care Plan outlines what is needed to manage the Member's care needs and helps organize and prioritize care and treatment, including referrals relative to health-related social needs as defined in this Agreement.

2.1.23 **Care Team**

2.1.23.1. Chosen and/or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships. The care team shall include the PCP.

2.1.24 **Case Management**

2.1.24.1. Service provided for supervising or coordinating care on behalf of Members, including gaining access to needed waivers and other Medicaid

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State Plan services, as well as monitoring the continuity of patient care services. 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.

2.1.25 **Centers for Medicare & Medicaid Services (CMS)**

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

2.1.26 **Certified Community Behavioral Health Clinic (CCBHC)**

2.1.26.1. [Amendment #2:] A state certified clinic that is responsible for providing all required CCBHC services in a manner that meets or exceeds CCBHC criteria. CCBHCs must either directly or through its Designated Collaborating Organizations (DCOs) provide, in a manner reflecting person-centered and family-centered care: crisis services; screening, assessment, and diagnosis; person-centered and family-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management services; psychiatric rehabilitation services; peer supports and family/caregiver supports; and community care for uniformed service members and veterans. CCBHCs may also be a CMH Program if authorized to deliver the comprehensive array of services described in He-M 426, and is designated to cover a region as described in He-M 425.

2.1.27 **Children with Special Health Care Needs**

2.1.27.1. Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

2.1.27.2. [Amendment #1:] This includes, but is not limited to, children or infants; infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children, Youth and Families (DCYF), including those in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.28 **Children's Health Insurance Program (CHIP)**

2.1.28.1. A program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.29 **Choices for Independence (CFI)**

2.1.29.1. Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors

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and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

2.1.29.2. 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.

2.1.30 **Chronic Condition**

2.1.30.1. A physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.31 **Clean Claim**

2.1.31.1. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a health plan's claims system. 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).

2.1.32 **Cold Call Marketing**

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

2.1.33 **Community Mental Health Services**

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

2.1.34 **Community Mental Health Program (“CMH Program”)**

2.1.34.1. Synonymous with Community Mental Health Center, means a program established and administered by the State of New Hampshire, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, Case Management, and psychotherapy services, [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.35 **Community Mental Health Provider (“CMH Provider”)**

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

2.1.36 **Comprehensive Assessment**

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2.1.36.1. A person-centered assessment to help identify a Member's health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.37 **Comprehensive Medication Review (CMR)**

2.1.37.1. A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber.

2.1.37.2. The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other qualified individual, such as a prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve a patient's knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements; identify, and address problems or concerns the patient may have, and empower them to self-manage their medications and health conditions.

2.1.38 **Confidential Information and Confidential Data**

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

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

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

2.1.40 **Continuity of Care**

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

2.1.41 **Continuous Quality Improvement (CQI)**

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

2.1.42 **Copayment**

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

2.1.43 **Corrective Action Plan (CAP)**

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2.1.43.1. Plan that the MCO 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.

2.1.44 **Cost Sharing**

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

2.1.45 **Covered Services**

2.1.45.1. Health care services as defined by the Department and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, including authorized In Lieu of Services and Value-Added Services and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.46 **Cultural Competence**

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

2.1.47 **Data**

2.1.47.1. 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.

2.1.48 **Data Breach**

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

2.1.49 **Designated Receiving Facility (DRF)**

2.1.49.1. A hospital-based psychiatric unit or a non-hospital-based residential treatment program designated by the Commissioner to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system as defined in He-M 405. A DRF may also provide care for persons admitted to the facility voluntarily.

2.1.50 **Determinants of Health/Health-related Social Needs**

2.1.50.1. 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.

2.1.51 **Disenrollment**

2.1.51.1. 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.

2.1.52 **Data Certification**

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2.1.52.1. Encounter Data submitted to the Department, which must be certified by one of the following: MCO's CEO, CFO, or an individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO [42 CFR 438.604; 42 CFR 438.606(a)].

2.1.53 **Dual-Eligible Members**

2.1.53.1. Members who are eligible for both Medicare and Medicaid.

2.1.54 **Emergency Medical Condition**

2.1.54.1. 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)]

2.1.54.2. With respect to a pregnant woman, an emergency medical condition exists when:

2.1.54.2.1 There is inadequate time to effect safe transfer to another Provider prior to delivery;

2.1.54.2.2 Transfer may pose a threat to the health and safety of the patient or fetus; or

2.1.54.2.3 There is evidence of onset of uterine contractions or rupture of the membranes.

2.1.55 **Emergency Services**

2.1.55.1. 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)]

2.1.56 **Encounter Data**

2.1.56.1. A record of Covered Services provided to a MCO Member. An "encounter" is an interaction between a patient and a provider (MCO, 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.

2.1.57 **Enrollment**

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

2.1.58 **Equal Access**

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

2.1.59 **Evidence-Based Supported Employment (EBSE)**

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2.1.59.1. The provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by Dartmouth Medical School to promote successful competitive employment in the community.

2.1.60 **Exclusion Lists**

2.1.60.1. 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).

2.1.61 **External Quality Review (EQR)**

2.1.61.1. 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 MCO or its Subcontractors furnish to Medicaid recipients.

2.1.62 **Facility**

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

2.1.63 **Family Planning Services**

2.1.63.1. Services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include: Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

2.1.63.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

2.1.63.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

2.1.63.4. Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

2.1.63.5. Immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine.

2.1.64 **Federally Qualified Health Centers (FQHCs)**

2.1.64.1. 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.

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2.1.65 **Fraud**

2.1.65.1. 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.

2.1.66 **Granite Advantage Members**

2.1.66.1. 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.

2.1.67 **Grievance Process**

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

2.1.68 **Home and Community Based Services (HCBS)**

2.1.68.1. 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 (IHS) waiver program.

2.1.69 **Hospital-Acquired Conditions and Provider Preventable Conditions**

2.1.69.1. 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.

2.1.70 **Implementation**

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

2.1.71 **In Lieu of Services**

2.1.71.1. An alternative medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan. The utilization and

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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. A Member cannot be required by the MCO to use the alternative service or setting.

2.1.72 **Incomplete Claim**

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

2.1.73 **Indian Health Care Provider (IHCP)**

2.1.73.1. 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)]

2.1.74 **Integrated Care**

2.1.74.1. The systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.[1]

2.1.75 **Licensed**

2.1.75.1. 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.

2.1.76 **Limited English Proficiency (LEP)**

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

2.1.77 **List of Excluded Individuals and Entities (LEIE)**

2.1.77.1. 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.

2.1.78 **Long Term Services and Supports (LTSS)**

2.1.78.1. 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).

2.1.79 **Managed Care Information System (MCIS)**

2.1.79.1. A comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides

[1] SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?"

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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.

2.1.80 **Managed Care Organization (MCO)**

2.1.80.1. 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 MCM program.

2.1.81 **Marketing**

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

2.1.82 **Marketing Materials**

2.1.82.1. Materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as Marketing to potential Members.

2.1.83 **MCO Formulary or Prescription Drug List (PDL)**

2.1.83.1. List of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the Department-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.84 **MCO Quality Assessment and Performance Improvement (QAPI) Program**

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

2.1.85 **MCO Utilization Management Program**

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

2.1.86 **Medicaid Director**

2.1.86.1. The State Medicaid Director of NH DHHS.

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2.1.87 **Medicaid Management Information System (MMIS)**

2.1.87.1. 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.

2.1.88 **Medicaid State Plan**

2.1.88.1. 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 establishes 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.

2.1.89 **Medical Loss Ratio (MLR)**

2.1.89.1. 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) for the application of the minimum federal loss ratio provision.

2.1.90 **Medically Necessary**

2.1.90.1. 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:

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

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

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

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

2.1.90.2. [Amendment #1:] For Members under twenty-one (21) years of age in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, any service that is included within the categories of

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mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.91 **Medication Assisted Treatment (MAT)**

2.1.91.1. The use of medications in combination with treatment planning, counseling and behavioral therapies or referral thereto for the treatment of Substance Use Disorder.

2.1.92 **Member**

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

2.1.93 **Member Advisory Board**

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

2.1.94 **Member Appeal Process**

2.1.94.1. 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.

2.1.95 **Member Encounter Confidential Data (Encounter Data)**

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

2.1.96 **Member Handbook**

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

2.1.97 **National Committee for Quality Assurance (NCQA)**

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

2.1.98 **NCQA Health Plan Accreditation**

2.1.98.1. MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.99 **Neonatal Abstinence Syndrome (NAS)**

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2.1.99.1. A constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.

2.1.100 **Non-Covered Service**

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

2.1.101 **Non-Emergency Medical Transportation (NEMT)**

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

2.1.102 **Non-Participating Provider**

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

2.1.103 **Non-Symptomatic Office Visits**

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

2.1.104 **Non-Urgent, Symptomatic Office Visits**

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

2.1.105 **Ongoing Special Condition**

2.1.105.1. 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; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.106 **Overpayments**

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2.1.106.1. 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.

2.1.107 **Participating Provider**

2.1.107.1. A person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the MCO to provide services to Members under the terms of this Agreement.

2.1.108 **Pay and Chase**

2.1.108.1. Recovery of claims paid in which the Standard Medicare, Medicare Advantage plan or private insurance was not known at the time the claim was adjudicated.

2.1.109 **Peer Recovery Program**

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

2.1.110 **Performance Improvement Project (PIP)**

2.1.110.1. 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)].

2.1.111 **Physician Group**

2.1.111.1. 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.

2.1.112 **Physician Incentive Plan**

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

2.1.113 **Post-Stabilization Services**

2.1.113.1. 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]

2.1.114 **Practice Guidelines**

2.1.114.1. Evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health

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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.

2.1.115 **Prescription Drug Monitoring Program (PDMP)**

2.1.115.1. The program operated by the Department that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in New Hampshire.

2.1.116 **Primary Care**

2.1.116.1. All health services and laboratory services, including periodic examinations, preventive health care services and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care by the PCP, record maintenance, and initiation and coordination of closed loop referrals to specialty providers, including but not limited to Behavioral Health Service providers, and collaboration with such providers, for maintaining continuity of the Member's care and to collaboratively support achievement of the Member's whole-person health care goals.

2.1.117 **Primary Care and Prevention Focused Care Model**

2.1.117.1. Model of Care as described in Section 4.10 of this Agreement.

2.1.118 **Primary Care Provider (PCP)**

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

2.1.119 **Prior Authorization**

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

2.1.120 **Program Start Date**

2.1.120.1. The date when the MCO is responsible for coverage of Covered Services to its Members in the MCM program, contingent upon Agreement approval by

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

2.1.121 **Post Payment Recovery**

2.1.121.1. The process of seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). Also known as "Cost Recovery" or "pay and chase".

2.1.122 **Provider Appeal Process**

2.1.122.1. The procedure for handling, processing, collecting and tracking Provider appeal requests in accordance with Section 4.6 (Provider Appeals) of this Agreement.

2.1.123 **Provider Directory**

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

2.1.124 **Psychiatric Boarding**

2.1.124.1. The continued presence of a Member experiencing a mental health crisis in a hospital emergency room while waiting for admission in a designated receiving facility.

2.1.125 **Qualified Bilingual/Multilingual Staff**

2.1.125.1. An employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that 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.

2.1.126 **Qualified Interpreter for a Member with a Disability**

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

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

2.1.127 **Qualified Interpreter for a Member with LEP**

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2.1.127.1. 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.

2.1.128 **Qualified Translator**

2.1.128.1. 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]

2.1.129 **Qualifying APM**

2.1.129.1. 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.

2.1.130 **Quality**

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

2.1.131 **Quality Assessment and Performance Improvement (QAPI) Program**

2.1.131.1. An ongoing and comprehensive program for the Covered Services the MCO furnishes to Members consistent with the requirements of this Agreement.

2.1.132 **Quality Improvement (QI)**

2.1.132.1. The process of monitoring that the delivery of oral, behavioral, and physical health care services are available, accessible, timely, and medically necessary. The MCO 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 health care outcomes for Members.

2.1.133 **Readiness Review**

2.1.133.1. The review process through which the MCO demonstrates, to the Department's satisfaction, the MCO's 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) and the terms and conditions of this Agreement.

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2.1.134 **Recovery**

2.1.134.1. A process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.[2]

2.1.135 **Referral Provider**

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

2.1.136 **Required Priority Population**

2.1.136.1. The population mandated by the Department for MCO-Delivered Care Management services as described in this Agreement (Section 4.11.2). The MCO may provide Care Management services for other Members or populations at the plan's option.

2.1.137 **Rural Health Clinic (RHC)**

2.1.137.1. 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.

2.1.138 **Second Opinion**

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

2.1.139 **Health-related Social Needs**

2.1.139.1. 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.

2.1.140 **Software**

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

2.1.141 **Specifications**

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

2.1.142 **State**

2.1.142.1. The State of New Hampshire and any of its agencies.

2.1.143 **State Data**

[2] SAMHSA, "Recovery and Recovery Support".

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2.1.143.1. 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

2.1.144 **Subcontract**

2.1.144.1. 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.

2.1.145 **Subcontractor**

2.1.145.1. 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.

2.1.146 **Substance Use Disorder**

2.1.146.1. A cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in He-W 513.02.

2.1.147 **Substance Use Disorder Provider**

2.1.147.1. All Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.

2.1.148 **System**

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

2.1.149 **Term**

2.1.149.1. The duration of this Agreement.

2.1.150 **Third Party Liability (TPL)**

2.1.150.1. 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.

2.1.150.2. 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.

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2.1.150.3. 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.

2.1.151 **Transitional Care Management**

2.1.151.1. The responsibility of the MCO 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.

2.1.151.2. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.152 **Transportation**

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

2.1.153 **Transitional Health Care**

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

2.1.154 **Transitional Home Care**

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

2.1.155 **Trauma Informed Care**

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

2.1.156 **Urgent, Symptomatic Office Visits**

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

2.1.157 **Utilization Management**

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

2.1.158 **Value-Added Services**

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

2.1.159 **Verification**

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

2.1.160 **Waste**

2.1.160.1. The thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

2.1.161 **Wellness Visit**

2.1.161.1. A PCP visit that includes health risk and social determinant of health needs assessments, evaluation of the Member's physical and behavioral health, including screening for depression, mood, suicidality, and Substance Use Disorder.

2.1.162 **Willing Provider**

2.1.162.1. A Provider credentialed as a qualified treatment provider according to the requirements of the Department and the MCO, who agrees to render Covered Services as authorized by the MCO and in compliance with terms of the MCO's Provider Agreement, including reimbursement rates and policy manual.

2.1.163 **Withhold**

2.1.163.1. [Amendment #3:] The actuarially sound amount retained as a percent of the MCO's risk adjusted total Capitation ~~for a rating period~~ which is withheld ~~annually~~ from the applicable rating period and ~~may be~~ made available for distribution to the MCO ~~in future contract years~~ through the Quality Withhold Program and upon meeting specific quality performance criteria.

2.1.164 **Work Plan**

2.1.164.1. Documentation that details the activities for the Project created in accordance with the Agreement. 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.

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2.2 Acronym List

2.2.1 AAP means American Academy of Pediatrics.
2.2.2 ABD means Acquired Brain Disorder.
2.2.3 ACT means Assertive Community Treatment.
2.2.4 ADA means Americans with Disabilities Act.
2.2.5 ADL means Activities of Daily Living.
2.2.6 ADT means Admission, Discharge and Transfer.
2.2.7 AIDS means Acquired Immune Deficiency Syndrome.
2.2.8 ANSA means Adult Needs and Strengths Assessment.
2.2.9 APM means Alternative Payment Model.
2.2.10 ARNP means Advanced Registered Nurse Practitioner.
2.2.11 ASAM means American Society of Addiction Medicine.
2.2.12 ASC means Accredited Standards Committee.
2.2.13 ASFRA means Assisted Suicide Funding Restriction Act.
2.2.14 ASL means American Sign Language.
2.2.15 BCCP means Breast and Cervical Cancer Program.
2.2.16 CAHPS means Consumer Assessment of Healthcare Providers and Systems.
2.2.17 CANS means Child and Adolescent Needs and Strengths Assessment.
2.2.18 CAP means Corrective Action Plan.
2.2.19 CAPRSS means Council on Accreditation of Peer Recovery Support Services.
2.2.20 CARC means Claim Adjustment Reason Code.
2.2.21 CCBHC means Certified Community Behavioral Health Clinic
2.2.22 CEO means Chief Executive Officer.
2.2.23 CFI means Choices for Independence.
2.2.24 CFO means Chief Financial Officer.
2.2.25 CHIP means Children's Health Insurance Program.
2.2.26 CHIS means Comprehensive Health Care Information System.
2.2.27 CMH means Community Mental Health.
2.2.28 CMO means Chief Medical Officer.
2.2.29 CMR means Comprehensive Medication Review.
2.2.30 CMS means Centers for Medicare & Medicaid Services.
2.2.31 COB means Coordination of Benefits.
2.2.32 COBA means Coordination of Benefits Agreement.

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2.2.33 CPT means Current Procedural Terminology.

2.2.34 CQI means Continuous Quality Improvement.

2.2.35 DBT means Dialectical Behavioral Therapy.

2.2.36 DCO means Designated Collaborating Organization.

2.2.37 DCYF means New Hampshire Division for Children, Youth and Families.

2.2.38 DD means Developmental Disability.

2.2.39 DEA means Drug Enforcement Administration.

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

2.2.41 DME means Durable Medical Equipment.

2.2.42 DOB means Date of Birth.

2.2.43 DOD means Date of Death.

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

2.2.45 DRA means Deficit Reduction Act.

2.2.46 DSM means Diagnostic and Statistical Manual of Mental Disorders.

2.2.47 DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.

2.2.48 DUR means Drug Utilization Review.

2.2.49 EBSE means Evidence-Based Supported Employment.

2.2.50 ECI means Elderly and Chronically Ill.

2.2.51 ED means Emergency Department.

2.2.52 EDI means Electronic Data Interchange.

2.2.53 EFT means Electronic Funds Transfer.

2.2.54 EOB means Explanation of Benefits.

2.2.55 EPSDT means Early and Periodic Screening, Diagnostic and Treatment.

2.2.56 EQR means External Quality Review.

2.2.57 EQRO means External Quality Review Organization.

2.2.58 ERISA means Employees Retirement Income Security Act of 1974.

2.2.59 EST means Eastern Standard Time.

2.2.60 ETL means Extract, Transformation and Load.

2.2.61 FAR means Federal Acquisition Regulation.

2.2.62 FCA means False Claims Act.

2.2.63 FDA means Food and Drug Administration for the United States Department of Health and Human Services.

2.2.64 FFATA means Federal Funding Accountability & Transparency Act.

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2.2.65 FFS means Fee-for-Service.

2.2.66 FPL means Federal Poverty Level.

2.2.67 FQHC means Federally Qualified Health Center.

2.2.68 HEDIS means Healthcare Effectiveness Data and Information Set.

2.2.69 HCBS means Home and Community Based Services.

2.2.70 HCBS-I means Home and Community Based Services In Home Supports.

2.2.71 HCPCS means Health Care Common Procedure Coding System.

2.2.72 HCQI means Health Care Quality Improvement.

2.2.73 HHS means United States Department of Health and Human Services.

2.2.74 HIPAA means Health Insurance Portability and Accountability Act.

2.2.75 HIPP means Health Insurance Premium Payment.

2.2.76 HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.

2.2.77 HIV means Human Immunodeficiency Virus.

2.2.78 HMO means Health Maintenance Organization.

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

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

2.2.81 IADL means Instrumental Activities of Daily Living.

2.2.82 IBNR means Incurred But Not Reported.

2.2.83 ICF means Intermediate Care Facility.

2.2.84 ID means Intellectual Disabilities.

2.2.85 IEA means Involuntary Emergency Admission.

2.2.86 IHCP means Indian Health Care Provider.

2.2.87 IHS means Indian Health Service.

2.2.88 IMD means Institution for Mental Disease.

2.2.89 IVR means Interactive Voice Response.

2.2.90 LEIE means List of Excluded Individuals & Entities.

2.2.91 LEP means Limited English Proficiency.

2.2.92 LTSS means Long-Term Services and Supports.

2.2.93 MACRA means Medicare Access and CHIP Reauthorization Act of 2015.

2.2.94 MAT means Medication Assisted Treatment.

2.2.95 MCIS means Managed Care Information System.

2.2.96 MCM means Medicaid Care Management.

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2.2.97 MCO means Managed Care Organization.

2.2.98 MED means Morphine Equivalent Dosing.

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

2.2.100 MLADCs means Masters Licensed Alcohol and Drug Counselors.

2.2.101 MLR means Medical Loss Ratio.

2.2.102 MMIS means Medicaid Management Information System.

2.2.103 NAS means Neonatal Abstinence Syndrome.

2.2.104 NCPDP means National Council for Prescription Drug Programs.

2.2.105 NCQA means National Committee for Quality Assurance.

2.2.106 NEMT means Non-Emergency Medical Transportation.

2.2.107 NH means New Hampshire.

2.2.108 NHID means New Hampshire Insurance Department.

2.2.109 NPI means National Provider Identifier.

2.2.110 NPPES means National Plan and Provider Enumeration System.

2.2.111 OB/GYN means Obstetrics/Gynecology or Obstetricians/ Gynecologists.

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

2.2.113 OTP means Opioid Treatment Program.

2.2.114 PBM means Pharmacy Benefits Manager.

2.2.115 PCA means Personal Care Attendant.

2.2.116 PCP means Primary Care Provider.

2.2.117 PDL means Preferred Drug List.

2.2.118 PDMP means Prescription Drug Monitoring Program.

2.2.119 PHI means Protected Health Information.

2.2.120 PI means Personal Information.

2.2.121 PIP means Performance Improvement Plan.

2.2.122 POS means Point of Service.

2.2.123 PRSS means Peer Recovery Support Services.

2.2.124 QAPI means Quality Assessment and Performance Improvement.

2.2.125 QI means Quality Improvement.

2.2.126 QM means Quality Management.

2.2.127 QOS means Quality of Service.

2.2.128 RARC means Reason and Remark Codes.

2.2.129 RFP means Request for Proposal.

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2.2.130 RHC means Rural Health Clinic.

2.2.131 SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.

2.2.132 SBIRT means Screening, Brief Intervention, and Referral to Treatment.

2.2.133 SED means Serious Emotional Disturbance.

2.2.134 SFY means State Fiscal Year.

2.2.135 SHIP means State's Health Insurance Assistance Program.

2.2.136 SIU means Special Investigations Unit.

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

2.2.138 SMDL means State Medicaid Director Letter.

2.2.139 SMI means Severe Mental Illness.

2.2.140 SNF means Skilled Nursing Facility.

2.2.141 SPMI means Severe or Persistent Mental Illness.

2.2.142 SSADMF means Social Security Administration Death Master File.

2.2.143 SSAE means Statement on Standards for Attestation Engagements.

2.2.144 SSI means Supplemental Security Income.

2.2.145 SSN means Social Security Number.

2.2.146 TAP means Technical Assistance Publication.

2.2.147 TDD means Telecommunication Device for Deaf Persons.

2.2.148 TPL means Third Party Liability.

2.2.149 TTY means Teletypewriter.

2.2.150 UAT means User Acceptance Testing.

2.2.151 Utilization Management means Utilization Management.

2.2.152 UDS means Urine Drug Screenings.

2.2.153 VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO.

3.1.1.2 The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and

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delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 **Representation and Warranties**

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

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

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

3.1.3.2 The MCO 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.

3.1.3.3 The Program Management Plan shall:

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

3.1.3.3.2 Describe how the MCO 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;

3.1.3.3.3 Describe how the MCO shall ensure timely notification to the Department regarding:

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

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

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

3.1.3.3.3.4. On an annual basis, the MCO 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.

3.1.4 Key Personnel Contact List

3.1.4.1 The MCO shall submit a Key Personnel Contact List to the Department that includes the positions and associated information indicated in Section 3.11.1. (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program.

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

3.2 Agreement Elements

3.2.1 [Amendment #1:] The Agreement between the parties shall consist of the following, including subsequent Amendments:

3.2.1.1. General Provisions, Form Number P-37

3.2.1.2. [Amendment #1:] Exhibit A: ~~Revisions to Standard Agreement~~ Special Provisions

3.2.1.3. Exhibit B: Scope of Services

3.2.1.4. Exhibit C: Payment Terms

3.2.1.5. [Amendment #1:] Exhibit D: ~~Certification Regarding Drug Free Workplace Requirements~~Federal Requirements

3.2.1.6. [Amendment #1:] Exhibit E: ~~Certification Regarding Lobbying~~DHHS Information Security Requirements

3.2.1.7. [Amendment #1:] Exhibit F: ~~Certification Regarding Debarment, Suspension, and Other Responsibility Matters~~Business Associate Agreement

3.2.1.8. [Amendment #1:] Exhibit G: ~~Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections~~Additional Requirements

3.2.1.9. [Amendment #1:] ~~Exhibit H: Certification Regarding Environmental Tobacco Smoke~~Reserved

3.2.1.10. [Amendment #1:] ~~Exhibit I: Health Insurance Portability Act Business Associate Agreement~~Reserved

3.2.1.11. [Amendment #1:] Exhibit J: ~~Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance~~Vendor Risk Assessment Report (VRAR)

3.2.1.12. [Amendment #1:] Exhibit K: ~~DHHS Information Security Requirements~~ Technical Requirements Workbook

3.2.1.13. Exhibit L: MCO Implementation Plan

3.2.1.14. Exhibit M: MCO Proposal submitted in response to RFP, by reference

3.2.1.15. Exhibit N: Liquidated Damages Matrix

3.2.1.16. Exhibit O: Quality and Oversight Reporting Requirements

3.2.1.17. Exhibit P: MCO Program Oversight Plan

3.2.1.18. [Amendment #1:] Exhibit Q: ~~DoIT Technical Requirements Workbook~~Reserved

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3.3 **Delegation of Authority**

3.3.1 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.

3.4 **Authority of the New Hampshire Insurance Department**

3.4.1 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 MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.4.2 The MCO 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 New Hampshire Insurance Department (NHID); and the NH Comprehensive Health Care Information System (CHIS) Confidential Data reporting submission under NHID rules and/or bulletins.

3.5 **Time of the Essence**

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

3.6 **CMS Approval of Agreement and Any Amendments**

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

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

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

3.6.2.2 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.

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

3.6.4 The Department shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement

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initiatives based on the Department's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.7 **Cooperation with Other Vendors and Prospective Vendors**

3.7.1 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 MCO 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.

3.7.2 The MCO 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 MCO, its subcontractor or a Provider.

3.7.3 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.

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

3.8 **Renegotiation and Re-Procurement Rights**

3.8.1 **Renegotiation of Agreement**

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

3.8.1.2. Upon the MCO's receipt of any Department notice pursuant to this section to renegotiate this Agreement, the MCO 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.

3.8.2 **Re-Procurement of the Services or Procurement of Additional Services**

3.8.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not the Department has accepted or rejected MCO'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 MCO under the Agreement.

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

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3.8.2.3. 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 MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.9 Organization Requirements

3.9.1 General Organization Requirements

3.9.1.1. As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by 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.

3.9.1.2. As a condition to entering into this Agreement, and during the entire Agreement Term, the MCO 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.

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

3.9.1.4. At the Department's discretion and at a Member effective date to be determined, the MCO shall initiate a Centers for Medicare and Medicaid Services defined application process to implement a highly integrated dual eligible special needs plan (HIDE SNP) or an alternate dual-eligible special needs plan (D-SNP) as defined at 42 CFR 422.2.

3.9.2 Articles

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

3.9.3 Ownership and Control Disclosures

3.9.3.1. The MCO 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 MCO that:

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

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

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

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

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

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

3.9.3.2.3 Tax identification number(s) of any corporation;

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

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

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

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

3.9.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.9.3 (Ownership and Control Disclosures) to the Department is accurate to the best of his or her information, knowledge, and belief.

3.9.3.3. The MCO shall disclose the information set forth in this Section 3.9.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to the Department at the following times:

3.9.3.3.1 At the time of Agreement execution;

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

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

3.9.3.3.4 Upon request of the Department during the revalidation of the Provider enrollment; and

3.9.3.3.5 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)]

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

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

3.9.4 Change in Ownership or Proposed Transaction

3.9.4.1. The MCO 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 MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO shall receive prior written approval from the Department and the NHID prior to taking such action.

3.9.5 Prohibited Relationships

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

3.9.5.2. The MCO shall not have an individual:

3.9.5.2.1 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

3.9.5.2.2 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-

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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

3.9.5.2.3 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

3.9.5.2.4 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

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

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

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

3.9.5.4. Within five (5) calendar days of discovery, the MCO shall provide written disclosure to the Department, and Subcontractors shall provide written disclosure to the MCO, 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]

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

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3.9.5.5.1 Terminate the existing Agreement with the MCO;

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

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

3.9.6 **Background Checks**

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

3.9.6.2. The MCO 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 MCO and Subcontractors do not employ or contract with any individual or entity, in accordance with Prohibited Relationship provisions in Section 3.9.5 of this Agreement, on an Exclusion List who are:

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

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

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

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

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

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3.9.6.3.2 The System of Award Management;

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

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

3.9.6.4. The MCO 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 MCO nor its Subcontractors, including contractor employees of MCO Subcontractors, have any employees, directly or indirectly, with:

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

3.9.6.4.2 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;

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

3.9.6.4.4 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

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

3.9.6.5. In the event that the MCO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.9.6 (Background Checks) or Section 3.9.3 (Ownership and Control Disclosures) above, then the MCO 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.

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

3.9.7 Conflict of Interest

3.9.7.1. The MCO 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 MCO shall report transactions between the MCO and parties in interest to the Department

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and any other agency as required, and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.9.7.2. The MCO 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 MCO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

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

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

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

3.9.8 **Compliance with State and Federal Laws**

3.9.8.1. General Requirements

3.9.8.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.9.8 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement.

3.9.8.1.2 The MCO 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)]

3.9.8.1.3 The MCO shall comply, at a minimum, with the following:

3.9.8.1.3.1. 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;

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3.9.8.1.3.2. 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);

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

3.9.8.1.3.4. 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;

3.9.8.1.3.5. State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

3.9.8.1.3.6. State administrative rules and laws pertaining to confidentiality;

3.9.8.1.3.7. American Recovery and Reinvestment Act;

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

3.9.8.1.3.9. The Age Discrimination Act of 1975;

3.9.8.1.3.10. The Rehabilitation Act of 1973;

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

3.9.8.1.3.12. The ADA;

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3.9.8.1.3.13. 42 CFR Part 2; and

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

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

3.9.8.1.5 The MCO shall comply with all aspects of the Department Sentinel Event Reporting and Review Policy PO.1003, and any subsequent versions and/or amendments;

3.9.8.1.6 The MCO shall cooperate with review of any reported sentinel event, and provide any additional reporting information requested by the Department, and participate in a Department sentinel event review, if requested;

3.9.8.1.7 The MCO 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 MCO's responsibility to notify the appropriate authority if the MCO suspects a crime has occurred;

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

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

3.9.9 Non-Discrimination

3.9.9.1. The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.9.8 (Compliance with State and Federal Laws) 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)]

3.9.10 Reporting Discrimination Grievances

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3.9.10.1. The MCO 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 MCO.

3.9.10.2. 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).

3.9.11 Americans with Disabilities Act

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

3.9.11.2. 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.

3.9.11.3. 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.

3.9.11.4. 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.

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

3.9.11.6. The MCO 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 MCO and shall be available for inspection by the Department.

3.9.11.7. [Amendment #1:] The MCO shall, in accordance with Exhibit ~~G~~D (Federal Requirements ~~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 3.9.11 (Americans with Disabilities Act) of the Agreement, and that it

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has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.9.11.8. The MCO 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 MCO to be in compliance with the ADA.

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

3.9.12 **Non-Discrimination in Employment**

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

3.9.12.2. The MCO 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.

3.9.12.3. 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.

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

3.9.12.5. The MCO shall, in all solicitations or advertisements for employees placed by or on behalf of the MCO, 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.

3.9.12.6. The MCO 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 MCO's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.9.12.7. The MCO 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.

3.9.12.8. The MCO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and

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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.

3.9.12.9. The MCO shall include the provisions described in this Section 3.9.12 (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.

3.9.12.10. The MCO 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 MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.9.13 Non-Compliance

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

3.9.14 Changes in Law

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

3.10 Subcontractors

3.10.1 MCO Obligations

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

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

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3.10.1.3. 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.

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

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

3.10.2 **Contracts with Subcontractors**

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

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

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

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

3.10.2.1.4 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);

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

3.10.2.1.6 In accordance with Prohibited Relationship provisions in Section 3.9.5.

3.10.2.1.7 Requirements for the Subcontractor

3.10.2.1.7.1. Provided that the Department makes timely payments to the MCO 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 MCO;

3.10.2.1.7.2. 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.

3.10.2.1.8 Requirements that provide that:

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

3.10.2.1.8.2. 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

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438.230(c)(3)(iii); 42 CFR 438.3(k)]

3.10.2.1.8.3. The MCO, the Department, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit 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)]

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

3.10.2.1.8.5. Require Subcontractor to submit ownership and controlling interest information as required by Section 3.9.3 (Ownership and Control Disclosures);

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

3.10.2.1.8.6.1 A person who has an ownership or control interest in the

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Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)];

3.10.2.1.8.6.2 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)];

3.10.2.1.8.6.3 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

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		day-to-day operation of, the Subcontractor or Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)];
3.10.2.1.8.6.4		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 MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved

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waiver program;

3.10.2.1.8.6.5 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;

3.10.2.1.8.6.6 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;

3.10.2.1.8.6.7 A provision for revoking delegation of activities or obligations, or imposing

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other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the MCO or the Department;

3.10.2.1.8.6.8 Subcontractor's agreement to comply with the ADA, as required by Section 3.9.11 (Americans with Disabilities Act) above;

3.10.2.1.8.6.9 Include provisions of this Section 3.10.2 (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.

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11246 of September 24, 1965;

3.10.2.1.8.6.10 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as 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;

3.10.2.1.8.6.11 Require any Subcontracto

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r 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

3.10.2.1.8.6.12 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]

3.10.2.2. The MCO 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.

3.10.2.3. If any of the MCO's activities or obligations under this Agreement are delegated to a Subcontractor:

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

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3.10.2.3.2 The contract or written arrangement between the MCO 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 MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i)-(iii); 42 CFR 438.3(k)]

3.10.2.4. [Amendment #3:] Any Subcontractor performing utilization review must comply with the licensure or certification requirements set forth in this Agreement. ~~Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire~~.

3.10.3 **Subcontractor Agreement Notification**

3.10.3.1. The MCO shall submit all Subcontractor agreements and Subcontractor Provider agreements to the Department for review at least sixty (60) calendar days prior to the agreement's anticipated implementation date, or change in scope or terms, of the Subcontractor agreement.

3.10.3.2. The MCO remains responsible for ensuring that all Agreement requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.10.3.3. The MCO 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.

3.10.3.4. Review and authorization by the Department of a Subcontractor agreement does not relieve the MCO from any obligation or responsibility regarding the Subcontractor or its Subcontractor oversight, and does not imply any obligation by the Department regarding the Subcontractor or Subcontractor agreement.

3.10.3.5. The Department may grant a written exception to the notice requirements of this Section 3.10.3 (Subcontractor Agreement Notification) if, in the Department's reasonable determination, the MCO has shown good cause for a shorter notice period.

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

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

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

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

3.10.4 **MCO Oversight of Subcontractors**

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

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

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

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

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

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

3.10.4.4. If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the MCO shall notify the Department within seven (7) calendar days and require the Subcontractor to develop a CAP. The MCO 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]

3.11 **Staffing**

3.11.1 **Key Personnel**

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

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

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

3.11.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures.

3.11.1.1.3.1. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the Department's Medical Director.

3.11.1.1.3.2. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).

3.11.1.1.3.3. The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

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

3.11.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with the Department and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.11.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement.

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3.11.1.1.5.1. The Compliance Officer shall report directly to the NH-based CEO or the executive director thereof.

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

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

3.11.1.1.7.1. The Provider Relations Manager shall have prior experience with individual physicians, Provider groups and facilities.

3.11.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities.

3.11.1.1.8.1. The Member Services Manager shall have prior experience with Medicaid populations.

3.11.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities.

3.11.1.1.9.1. [Amendment #3:] The UM Director shall be under the direct supervision of the Medical Director. and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

3.11.1.1.9.2. [Amendment #3:] As soon as possible, but no later than January 1, 2026, the MCO shall ensure any person, including Subcontractors, performing medical necessity determinations must hold an active professional license issued by the applicable board or committee of the New Hampshire Office of Professional Licensure and

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Certification for such person's applicable scope of practice. ~~The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.~~

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

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

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

3.11.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and shall have a minimum of five (5) years pharmacy experience as a practicing pharmacist.

3.11.1.1.13.1. The Pharmacy Manager shall be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.12.24 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

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3.11.1.1.14 Substance Use Disorder Physician: Individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine and participate under the terms of this Agreement.

3.11.1.1.14.1. The SUD Physician's responsibilities shall include, but are not limited to:

3.11.1.1.14.1.1 In-person and in-state presence for greater than .50 FTE to meet with SUD Providers and PCPs to help expand SUD services. Discussion subjects shall include, but are not limited to, appropriate prescribing of medications for the treatment of opioid use disorder (MOUD);

3.11.1.1.14.1.2 In person and in-state to educate SUD Providers regarding appropriate treatment plans, and documentation, and billing practices;

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3.11.1.1.14.1.3 Responsibility for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for Members who visit an ED or are hospitalized for an overdose;

3.11.1.1.14.1.4 Active meeting participation, and at least yearly, meetings with organizations that support persons with a substance use disorder, including OTPs,

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hospitals, harm reduction organizations, The Doorway program sites, CMHCs, sober living homes, and other non-profit and for-profit organizations assisting persons with substance use disorder; and

3.11.1.1.14.1.5 Provide consultative support for the MCM program on a routine basis, including but not limited to, clinical policy related to Substance Use Disorders and individual Member cases, as needed.

3.11.1.2. MCO coordinators, also considered key personnel, shall be responsible for overseeing Care Coordination and Care Management activities, and also serve as liaisons to Department staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis unless otherwise specified:

3.11.1.2.1 Special Needs Coordinator at the Department's option: Individual shall have a minimum of a Master's Degree from a recognized college or university with

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major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.1.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

3.11.1.2.1.2. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.11.1.2.1.3. The Developmental Disability and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.1.3.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the Special Needs and Developmental Disabilities Coordinator positions may be either consolidated or established as individual

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part-time positions.

3.11.1.2.2 [Amendment #1:] Developmental Disability Coordinator at the Department's option: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.2.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

3.11.1.2.2.2. The Developmental Disability Coordinator shall be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.11.1.2.2.3. The Developmental Disability and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.2.3.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the

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Developmental Disabilities and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability.

3.11.1.2.3.1. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.3.2. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services.

3.11.1.2.3.3. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and

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interpretation of clinical policies and procedures; and Health-related social needs Health-related social needs and community-based resources.

3.11.1.2.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues.

3.11.1.2.4.1. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder.

3.11.1.2.4.2. The individual shall have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders.

3.11.1.2.4.3. The individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases.

3.11.1.2.4.4. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management;

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Provider relations; and Health-related social needs health-related social needs and community-based resources.

3.11.1.2.5 Long Term Care Coordinator at the Department's option: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs.

3.11.1.2.5.1. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

3.11.1.2.5.2. [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the Long Term Care Coordinator position is not required.

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

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

3.11.1.2.8 Transportation Coordinator: Individual shall oversee the delivery of NEMT services to Members to ensure that there is a single point of oversight and accountability for all transportation and NEMT services.

3.11.1.2.8.1. The Transportation Coordinator shall be the primary individual responsible for ensuring the MCO's NEMT program is

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operating effectively, and shall be expected to proactively identify and propose operational improvements.

3.11.1.2.8.1.1 The Transportation Coordinator shall be the primary individual responsible for identifying, securing, and maintaining transportation for Members, including but not limited to overseeing the MCO's NEMT Subcontractor and shall have the authority to take any action warranted to resolve an NEMT issue.

3.11.1.2.8.2. The Transportation Coordinator is responsible for ensuring the integration of transportation services into Member Care Plans.

3.11.1.2.8.3. The Transportation Coordinator shall ensure that the NEMT Subcontractor meets all NEMT requirements, including requirements as described in Section 4.1.9 (Non-Emergency Medical Transportation (NEMT)) and Exhibit O: Quality and

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Oversight Reporting Requirements of this Agreement as well as all other requirements in guidance provided by the Department.

3.11.1.2.8.4. The Transportation Coordinator shall be responsible for providing resolution to issues requiring immediate attention, including:

3.11.1.2.8.4.1 Resolution of complaints made by Members and transportation Providers.

3.11.1.2.8.4.2 Service delivery failures, including real-time assistance with rescheduling service appointments and/or transportation

3.11.1.2.8.5. The Transportation Coordinator shall have a minimum of four (4) years' experience relevant to the oversight of transportation services for vulnerable populations.

3.11.1.2.9 Housing Coordinator at the Department's option: The individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options. The Housing Coordinator shall:

3.11.1.2.9.1. Act as the MCO's central housing expert/resource,

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providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues.

3.11.1.2.9.2. Be a dedicated staff person whose primary responsibility is housing-related work.

3.11.1.2.9.3. Be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

3.11.1.2.9.4. At as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building.

3.11.1.2.9.5. Have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing.

3.11.1.2.9.6. [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~, the Housing Coordinator position is not required. ~~Be familiar with the relevant public and private housing resources and stakeholders.~~

3.11.1.2.10 Prior Authorization Coordinator: Individual shall be responsible for all MCO Utilization Management activities and shall work under the direct supervision of the Medical Director.

3.11.1.2.10.1. [Amendment #3:] The Prior Authorization Coordinator shall ensure that all staff performing prior authorization functions meet requirements for Section 3.11.1.1.9.2 and ~~have the necessary clinical backgrounds~~

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needed to apply established coverage criteria to and make appropriate decisions based on Mmedical Necessity. necessary.

3.11.1.2.10.2. The individual shall be licensed by the NH Board of Nursing and have a minimum of eight (8) years of demonstrated experience in both the provision of direct clinical services as well as progressively increasing levels of management responsibilities with a particular focus on performance of a variety of utilization functions including conducting inter-rater reliability quality audits.

3.11.1.2.11 Third Party Liability (TPL) Coordinator: Individual shall be responsible for ensuring the MCO and its subcontractors are performing all required TPL functions when processing claims, that MCOs are properly identifying and recovering on claims not cost avoided, that the MCO has a system in place to manage subrogation cases and comply with contract requirements, and act as liaison between the Department's TPL unit and the MCO. This person shall have claims experience and a financial background.

3.11.2 **Other MCO Required Staff**

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

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

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

3.11.2.2. Behavioral Health Staff: The MCO shall designate one (1) or more staff who have behavioral health specific managed care experience to provide assistance to Members who are homeless and oversee:

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3.11.2.2.1 Behavioral health Care Management;

3.11.2.2.2 Behavioral health Utilization Management;

3.11.2.2.3 Behavioral health network development; and

3.11.2.2.4 The behavioral health Subcontract, as applicable.

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

3.11.3 **On-Site Presence**

3.11.3.1. The MCO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this section of the Agreement means that the MCO's full-time equivalent (1.0 FTE) personnel for each position identified below regularly reports to work in the State of New Hampshire unless otherwise specified:

3.11.3.1.1 CEO/Executive Director;

3.11.3.1.2 Medical Director;

3.11.3.1.3 Network Management Director;

3.11.3.1.4 Provider Relations Manager;

3.11.3.1.5 Pharmacy Manager;

3.11.3.1.6 Substance Use Disorder Physician;

3.11.3.1.7 Special Needs Coordinator (at Department's option);

3.11.3.1.8 Mental Health Coordinator;

3.11.3.1.9 Substance Use Disorder Coordinator

3.11.3.1.10 Developmental Disabilities Coordinator (at Department's option);

3.11.3.1.11 Long Term Care Coordinator (at Department's option);

3.11.3.1.12 Transportation Coordinator;

3.11.3.1.13 Housing Coordinator (at Department's option);

3.11.3.1.14 Grievance Coordinator; and

3.11.3.1.15 Fraud, Waste, and Abuse Coordinator

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

3.11.3.3. The MCO 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.

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

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

3.11.4 **General Staffing Provisions**

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

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

3.11.4.3. 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.

3.11.4.4. 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.

3.11.4.5. The MCO 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.

3.11.4.6. The MCO 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.

3.11.4.7. If a member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform 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.

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

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

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

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3.11.4.8.3 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 MCO shall provide and be responsible for the cost of managed care 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, and as required by newly enacted state and federal laws, rules and regulations including expanded eligibility coverage for the postpartum period, effective October 1, 2023 (RSA 167:68); lawfully residing pregnant women and children, effective January 1, 2024 (RSA 126-A:4-i); and 12 months of continuous eligibility for children, effective January 1, 2024 (section 5112 of the Consolidated Appropriations Act of 2023).

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

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Incarcerated individuals in the State's prison system eligible for participation in the Department's Community Reentry demonstration waiver	X	
Medicaid Children Funded through the Children's Health Insurance Program	X	
Medicaid for Employed Adults with Disabilities Non-Dual	X	
Medicaid for Employed Older Adults with Disabilities	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

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4.1.2.1. The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.12 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management).

4.1.2.2. The MCO 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 MCO shall cover services consistent with 45 CFR 92.207(b).

4.1.2.3. While the MCO 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 MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. The Department reserves the right to alter this list at any time by providing reasonable notice to the MCO. [42 CFR 438.210(a)(1)-(3), (4)(i), (5) (i)-(ii)(A)-(C) and (b).

4.1.2.4. Summary of Covered Services

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
[Amendment #2:] Certified Community Behavioral Health Clinic (CCBHC) Services[3]	X	
Certified Non-Nurse Midwife	X	

[3] [Amendment #2:] Effective January 1, 2025, ARPA compliant mobile crisis services provided by CCBHCs are carved out of the MCM Program. For additional information, refer to https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/nh-ccbhc-demonstration-application-v2.pdf.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT		X
[Amendment #1:] Community Mental Health Services[4]	X	
[Amendment #2:] Community Reentry Services[5]	X	
Crisis Intervention–Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services[6]		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage[7]	X	
Family Planning Services	X	
Freestanding Birth Centers	X	
Furnished Medical Supplies & Durable Medical Equipment	X	
Glencliff Home		X

[4] [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

[5] [Amendment #2:] Effective for dates of service January 1, 2025 through June 30, 2029, in accordance with 1115 Medicaid Demonstration authority for Community Reentry (CRE), the State's "Reentry Demonstration Initiative" approved by CMS on July 16, 2024, as part of the extension for the New Hampshire's Substance Use Disorder Serious Mental Illness (SMI) and Serious Emotional Disturbance (SUD) Treatment Recovery and Access Section 1115 Demonstration Waiver, as specified in separate guidance. Demonstration information is available at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-images/nh-sud-treatment-recovery-access-ext-appvl-06162024_0.pdf.

[6] Certain preventive, restorative, denture and other oral health services are carved-out of the MCM program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages are Covered Services under the MCM program.

[7] [Amendment #2:] Inclusion of anesthesia medical benefit services ancillary to pediatric oral health services covered under Medicaid fee-for-service.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Home Based Therapy–Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	
Hospice	X	
Home and Community-Based In Home Support Services		X
[Amendment #2:] Incarcerated Youth Services[8]	X	
Inpatient Hospital[5a]	X	
Inpatient Hospital Swing Beds, Intermediate Care		X
Inpatient Hospital Swing Beds, Skilled Nursing		X
Inpatient Psychiatric Facility Services Under Age Twenty-One (21)[9]	X	
[Amendment #3:] Inpatient Psychiatric Treatment in State-owned New Hampshire Hospital ~~and Hampstead Hospital,~~ and Other State Determined IMD for Mental Illness[10]	X	
Intensive Home and Community-Based Services–Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities (e.g., Cedarcrest)		X

[8] [Amendment #2:] Effective January 1, 2025, in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) as specified in separate guidance. [SHO #24-004]
As described under "Mandatory Requirements of Section 5121 of the CAA," and detailed in SMDL 21-002, section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old). As mentioned above, the term "eligible juveniles" is not used in the amendments to the CHIP statute effectuated by section 5121 of the CAA, 2023. However, under the section 5121 amendments to section 2102(d) of the Act, the same eligibility policies that apply to "eligible juveniles" in Medicaid also apply to targeted low-income children in CHIP.

[9] Under age 22 if individual admitted prior to age 21.

[10] [Amendment #3:] Medicaid managed care inpatient psychiatric treatment at State-owned New Hampshire Hospital ~~and Hampstead Hospital.~~ and other State determined IMD for mental illness are covered up to sixty (60) days for adults age 21-64 due to a primary diagnosis of mental illness.

[5a] Including coverage for inpatient long-term acute care services in a long-term care hospital.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X
Medical Services Clinic (e.g., Opioid Treatment Program)	X	
Mental health services (e.g., psychology, psychotherapy, psychological and neurological testing)	X	
[Amendment #2:] [Amendment #1:] Mobile Crisis Services	X[11]	X
Non-Emergency Medical Transportation[12]	X	
Occupational Therapy[13]	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital[14]	X	
[Amendment #4:] Psychiatric ~~Pediatric~~ Residential Treatment Facility Services		X
Personal Care Services	X	
Physical Therapy[15]	X	
Physicians Services	X	
Placement Services–Division for Children, Youth & Families		X
Podiatrist Services	X	

[11] [Amendment #2:] Effective January 1, 2025, non-ARPA compliant mobile crisis services are a MCO CCBHC Covered Service only when provided by a State certified CCBHC.
[12] Also includes mileage reimbursement for Medically Necessary travel.
[13] Services are limited to twenty (20) visits per benefit year for each type of therapy including combined habilitation services and outpatient rehabilitation services.
[14] Including facility and ancillary services for dental procedures.
[15] Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Prescribed Drugs	X	
Preventative Services (e.g., nicotine cessation, SBIRT, transitional care management, chronic care management)[16]	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children–Division for Children, Youth & Families		X
Psychology	X	
Qualified Residential Treatment Program Services		X
Rehabilitative Services Post Hospital Discharge	X	
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy[17]	X	
Substance Use Disorder Services (Per He-W 513), including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

[16] See Law of the State of New Hampshire 2023, Chapter79:203 (HB2) (authorizing preventative services which may include, but is not necessarily limited to those listed).
[17]Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

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

4.1.3.2. The MCO 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 MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS.

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

4.1.3.4.1 Covered services shall be consistent with State laws and regulations in effect.

4.1.3.5. In Lieu of Services

4.1.3.5.1 The MCO may provide Members with services or settings that are "In Lieu of" Services or settings with prior approval and in accordance with federal regulations.

4.1.3.5.2 The MCO may cover In Lieu of Services if:

4.1.3.5.2.1. The alternative service or setting is a medically appropriate and cost-effective substitute;

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

4.1.3.5.2.3. The In Lieu of Service has been authorized by the Department and/or CMS, as appropriate; and

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

4.1.3.5.3 For the MCO to obtain approval for In Lieu of Services not previously authorized by the Department, the MCO shall submit an In Lieu of Service request to the Department for each proposed In Lieu of Service not yet authorized.

4.1.3.5.4 [Amendment #1:] The Department has authorized medical nutrition, partial hospitalization for eating

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disorders, alternative therapies for pain management, partial hospitalization for youth with behavioral health diagnoses, critical time intervention (CTI) services, and diabetes self-management, ~~and assistance in finding and keeping housing (not including rent),~~ as In Lieu of Services (subject to CMS approval, as appropriate). This list may be expanded upon or otherwise modified by the Department and with CMS approval, as appropriate, and incorporated into this Agreement.

4.1.3.5.5 The MCO shall monitor the cost-effectiveness of each approved In Lieu of Service in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.3.5.6 [Amendment #1:] The MCO shall utilize a consistent process to ensure that a Provider (either the MCO's clinical staff or network Provider) using their professional judgment determines and documents that the ~~ILOS~~ In Lieu of Service is medically appropriate for the specific enrollee, based on any defined target population eligible for the ~~ILOS~~ In Lieu of Service. The documentation may be included, for example, in a Member's Care Plan or medical record.

4.1.3.6. Telemedicine

4.1.3.6.1 The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Members in certain circumstances.

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

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

4.1.3.7. Non-Participating Indian Health Care Providers

4.1.3.7.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health Care Providers (IHCP)

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from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.7.2 The MCO 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)]

4.1.3.8. Moral and Religious Grounds

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

4.1.3.8.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO 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)]

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

4.1.3.9. [Amendment #2:] Community Reentry Services

4.1.3.9.1 [Amendment #2] For services effective January 1, 2025, MCO shall implement the incarcerated youth community re-entry benefit for Members in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328), CMS guidance, and Department guidance.

4.1.3.9.2 [Amendment #2:] Effective for dates of service January 1, 2025 through June 30, 2029, MCO shall implement the adult community re-entry benefit for Members in accordance with 1115 Medicaid Demonstration authority for Community Reentry

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(CRE), the State's "Reentry Demonstration Initiative" approved by CMS on July 16, 2024, as part of the extension for the New Hampshire's Substance Use Disorder (SUD), Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Treatment Recovery and Access Section 1115 Demonstration Waiver, Department guidance, and applicable CMS guidance.

4.1.3.9.3 [Amendment #2:] Effective for dates of service beginning on or after January 1, 2025, for Members eligible for both the (i) adult community re-entry benefit in accordance with 1115 Medicaid Demonstration authority for Community Reentry (CRE), and (ii) incarcerated youth community re-entry benefit in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328), the MCO shall integrate and make available both adult and youth CRE program Covered Services to such Members.

4.1.4 **Cost Sharing**

4.1.4.1. 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.

4.1.4.2. With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) 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:

4.1.4.2.1 [Amendment #4:] A Copayment of four dollars ($4.00) ~~one dollar ($1.00)~~ shall be required for each preferred prescription drug and each refill of a preferred prescription drug; and

4.1.4.2.2 [Amendment #4:] A Copayment of four dollars ($4.00) ~~two dollars ($2.00)~~ shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug~~, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug shall be one dollar ($1.00)~~;

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4.1.4.2.3 [Amendment #4:] Intentionally left blank. ~~A Copayment of one dollar ($1.00) shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and~~

4.1.4.2.4 [Amendment #4:] [Amendment #3:] ~~Intentionally left blank. A Copayment of one dollar ($1.00) for each preferred prescription drug to two dollars ($2.00) for each non-preferred prescription drug or such other amount(s) as required by state law or the applicable New Hampshire State Plan Amendment.~~

4.1.4.3. The following services are exempt from cost-sharing:

4.1.4.3.1 Emergency services,

4.1.4.3.2 Family planning services,

4.1.4.3.3 Preventive services provided to children,

4.1.4.3.4 Pregnancy-related services,

4.1.4.3.5 Services resulting from potentially preventable events, and,

4.1.4.3.6 Cloraril (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.3.7 [Amendment #4:] Recommended medications, services, and items graded A or B by the U.S. Preventive Services Task Force, including nicotine cessation products and oral and injectable formulations of Pre-Exposure Prophylaxis (PrEP) for persons who are at high risk of HIV acquisition.

4.1.4.4. Members are exempt from Copayments when:

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

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

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

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

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

4.1.4.4.6 [Amendment #4:] The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within twelve (12)

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months ~~sixty (60) calendar days~~ after the month the pregnancy ended;

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

4.1.4.4.6.2. The Member is receiving hospice care; or

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

4.1.4.5. 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]

4.1.5 **Emergency Services**

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

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

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

4.1.5.4. The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the 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]

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

4.1.5.6. The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A-B)].

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

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4.1.5.8. The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or 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)]

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

4.1.5.10. 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)]

4.1.6 **Post-Stabilization Services**

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

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

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

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

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

4.1.6.1.3.2. The MCO cannot be contacted; or

4.1.6.1.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is not available for consultation. In this situation, the MCO shall give the treating

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physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

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

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

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

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

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

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

4.1.7 **Value-Added Services**

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

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

4.1.8 **Early and Periodic Screening, Diagnostic, and Treatment**

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

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4.1.8.2. The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

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

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

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

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

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

4.1.8.5. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria.

4.1.8.6. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

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

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

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

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

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

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

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

4.1.8.11.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.11.4 Comprehensive, unclothed physical examination;

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

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

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

4.1.8.12.1 The benefits of preventive health care;

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

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

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

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4.1.8.13. The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis.

4.1.8.13.1 The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.14. The MCO shall submit its EPSDT plan for the Department's review and approval as part of its Readiness Review and in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.9 **Non-Emergency Medical Transportation (NEMT)**

4.1.9.1. The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO.

4.1.9.1.1 The MCO shall deem NEMT Medically Necessary for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

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

4.1.9.3. The MCO shall ensure that each vehicle providing NEMT Covered Services meets the following requirements:

4.1.9.3.1 Has a valid vehicle registration;

4.1.9.3.2 [Amendment #4:] Has undergone a satisfactory safety inspection in accordance with the mutually agreed comprehensive safety checklist at the time of transportation provider enrollment into the Subcontractor's network, at least annually thereafter, and when a safety issue is reported for the transportation provider vehicle ~~laws of the state of New Hampshire~~; and

4.1.9.3.3 Has no apparent need for maintenance that affects safety including, but not limited to, visible holes in the body of the vehicle, defective brakes, worn or underinflated tires, leaking fluids, or illuminated check engine light.

4.1.9.4. The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family

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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:

4.1.9.4.1 Does not have a valid driver's license;

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

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

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

4.1.9.5. The Family and Friends mileage reimbursement rate shall be 62.5 cents per mile. The MCO shall create incentive programs to encourage the utilization of the Family and Friends Program with a target of fifty percent (50%) utilization.

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

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

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

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

4.1.9.7. Exceptions the above public transportation requirement are:

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

4.1.9.7.2 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

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

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

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

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

4.1.9.7.3.4. Visually impaired;

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4.1.9.7.3.5. Developmentally delayed;

4.1.9.7.3.6. Significant and incapacitating degree of mental illness; or

4.1.9.7.3.7. Other exception by Provider approval only.

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

4.1.9.8.1 For NEMT driver services, excluding public transit drivers, the MCO shall ensure:

4.1.9.8.1.1. Background checks are performed for all NEMT drivers;

4.1.9.8.1.2. 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;

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

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

4.1.9.8.1.5. 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];

4.1.9.8.1.6. Each such individual driver consistently utilizes a Global Positioning System device (GPS) to document the date, time and location for each pick up and drop off to track on-time

performance and ensure that trips take place as scheduled;

4.1.9.8.1.7. All vehicles utilized in the delivery of NEMT services shall be compliant with all federal and state safety requirements during the provision of the NEMT ride; and

4.1.9.8.1.8. Once a ride has been confirmed for a Member, the ride shall be provided unless cancelled by the Member.

4.1.9.8.1.9. [Amendment #4:] Any vehicles used for the purpose of transporting individuals with disabilities must meet the requirements set forth in the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles. [49 CFR 38]

4.1.9.8.2 The Department may require the procurement of an independent evaluator to measure and report on how NEMT services are being provided.

4.1.9.8.3 The Department reserves the right to reject, suspend, or terminate any Transportation Provider and/or individual driver from participation in the NEMT Program.

4.1.9.8.4 The MCO shall submit a weekly issue log for NEMT services as specified in Exhibit O: Quality and Oversight Reporting Requirements, and guidance issued by the Department.

4.1.9.8.4.1. NEMT Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement. In addition the MCO shall submit data on one hundred (100%) percent of the outcomes of scheduled NEMT trips, including, but not limited to trips delivered on-time, delivered late, rescheduled, rescued,

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cancelled, to the Department through NEMT Encounter Data or other means and schedule specified by the Department.

4.1.9.8.5 The Transportation Coordinator shall ensure there are no disruptions to Covered Services due to NEMT issues which shall be subject to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.1.9.8.5.1. The MCO, 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 or shall otherwise be subject to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.1.9.9. The Department reserves the right to require the use of a single transportation Subcontractor.

4.1.9.9.1 The MCO shall subcontract with and provide remuneration to the single transportation Subcontractor designated by the Department for NEMT services. The Department has the sole discretion to establish the subcontract terms.

4.1.9.9.2 The MCO shall not make amendments to the single transportation contract without prior written approval from the Department.

4.1.9.10. Failure of the MCO to meet any of these requirements shall subject the MCO to liquidated damages as specified in Exhibit N: Liquidated Damages Matrix.

4.1.9.11. The MCO 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.

4.1.9.12. [Amendment #1:] The MCO shall perform monitoring and oversight activities of trips provided to Members, including Family and Friends Program reimbursement, to ensure transportation Providers and Members are in compliance with the requirements of the NEMT Medicaid State Plan, including all State and federal regulations.

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4.2 Pharmacy Management

4.2.1 General

4.2.1.1. The Department reserves the right to require the use of a single Pharmacy Benefits Manager (PBM) starting in Year 3 or Year 4 of this Agreement.

4.2.1.1.1 The MCO shall subcontract with and provide remuneration to the Single PBM designated by the Department for pharmacy claims payment and administrative services. The Department has the sole discretion to establish the subcontract terms.

4.2.1.1.2 The MCO shall not make amendments to the Single PBM subcontract without prior written approval from the Department.

4.2.2 MCO and DHHS Covered Prescription Drugs

4.2.2.1. The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which the Department provides coverage as defined in Section 1927(k)(2) of the Social Security Act [42 CFR 438.3(s)(1)]. The MCO shall not include drugs by manufacturers not participating in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) Medicaid rebate program on the MCO formulary without the Department's consent.

4.2.2.2. [Amendment #3:] The Department shall include a High-Cost Pharmacy Risk Pool (HCPRP) for purposes of risk mitigation as described in Section 6.3.4.1.1~~6.3.5.1.1~~ of this Agreement.

4.2.2.3. The MCO shall pay for all prescription drugs, including specialty and office administered drugs consistent with the MCO's formulary, pharmacy edits and Prior Authorization criteria reviewed and approved by the Department, and are consistent with the Department's Preferred Drug List (PDL) as described in Section 4.2.3 (MCO Formulary) below.

4.2.2.4. Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

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

4.2.2.6. The MCO shall ensure Members diagnosed with opioid use disorder, Substance Use Disorder, and behavioral health conditions treated at Community Mental Health Programs, FQHCs, FQHC look-alikes, and Doorway network facilities with integrated on-site pharmacies have immediate access to covered specialty drugs to treat related conditions.

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4.2.3 **MCO Formulary**

4.2.3.1. The Department shall establish the PDL and shall be the sole party responsible for negotiating rebates for drugs on the PDL.

4.2.3.1.1. [Amendment #4:] In addition to the MCO's PDL compliance obligations under this Agreement, the MCO shall achieve Department specified minimum adherence targets for specific Department identified drugs' initial adherence targets measured from January 1, 2026 through June 30, 2026. The Department may update adherence targets annually and shall be maintained by the MCO annually thereafter as described in separate guidance.

4.2.3.1.2. [Amendment #4:] The MCO shall provide quarterly reporting on MCO's adherence targets in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.2.3.1.3. [Amendment #4:] Failure to meet adherence to targets will subject the MCO to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.2.3.2. The MCO shall use the Department's PDL and shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs on the PDL.

4.2.3.3. The Department shall be responsible for invoicing any pharmaceutical manufacturers for federal rebates mandated under federal law and for PDL supplemental rebates negotiated by the Department.

4.2.3.4. The MCO shall develop a formulary that adheres to the Department's PDL for drug classes included in the PDL and is consistent with Section 4.2.2 (MCO and DHHS Covered Prescription Drugs). In the event that the Department makes changes to the PDL, the Department shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.3.5. Negative changes shall apply to new starts within thirty (30) calendar days of notice from the Department. The MCO shall have ninety (90) calendar days to notify Members and prescribers currently utilizing medications that are to be removed from the PDL if current utilization is to be transitioned to a preferred alternative.

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

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

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4.2.3.8. The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary shall be available to Members and Participating Providers electronically, in a machine-readable file and format, and shall, at minimum, contain information related to:

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

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

4.2.3.9. The MCO shall adhere to all relevant State and federal law, including without limitation, with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, laws of 2004, Senate Bill 383-FN, Section IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

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

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

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

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

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

4.2.3.9.6 An age-specific indication;

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

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

4.2.3.10. [Amendment #1:] Through September 30, 20243, the cost of COVID-19 at-home test kits, vaccines, and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

4.2.4 **Pharmacy Clinical Policies and Prior Authorizations**

4.2.4.1. The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and

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complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.8.1.6 (Prior Authorization).

4.2.4.1.1 The MCO's clinical pharmacy team shall periodically review drug Prior Authorization denials issued by any Subcontractor(s) to ensure the denial is appropriate. This does not include Prior Authorization requests denied because the authorization request is incomplete or does not contain enough information to determine Medical Necessity.

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

4.2.4.3. The MCO's pharmacy Prior Authorization criteria shall be no more restrictive than the Prior Authorization criteria of the Fee for Service (FFS) program's medically accepted indication(s) for a covered outpatient drug in accordance with 1927(k)(6).

4.2.4.4. The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.12.34.3 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.4.4.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship.

4.2.4.4.2 The MCO shall conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT.

4.2.4.4.3 The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, Vivitrol®, etc.).

4.2.4.5. The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the Department-approved modification effective date.

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4.2.4.6. Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the Department -approved modification effective date.

4.2.4.7. The MCO shall implement and operate a DUR program that shall be in compliance with Section 1927(g) of the Social Security Act, address Section 1004 provisions of the SUPPORT for Patient and Communities Act, and include:

4.2.4.7.1 Prospective DUR;

4.2.4.7.2 Retrospective DUR;

4.2.4.7.3 An educational program for Participating Providers, including prescribers and dispensers; and

4.2.4.7.4 DUR program features in accordance with Section 1004 provisions of the SUPPORT for Patient and Communities Act, including:

4.2.4.7.4.1. Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.2.4.7.4.2. Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.2.4.7.4.3. A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.2.4.7.4.4. A program to monitor and manage the appropriate use of antipsychotic medications by all

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children including foster children enrolled under the State Plan;

4.2.4.7.4.5. Fraud and abuse identification processes that identifies potential Fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies; and

4.2.4.7.4.6. Operate like the State's Fee-for-Service DUR program. [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)].

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

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

4.2.4.10. The MCO shall develop and/or participate in other State of New Hampshire pharmacy-related quality improvement initiatives, as required by the Department and in alignment with the MCO's QAPI, further described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.2.4.11. For the HEDIS Measure "Use of Opioids from Multiple Providers", the MCO shall achieve performance that is less than or equal to the average rate of New England HMO Medicaid health plans as reported by NCQA Quality Compass for the previous calendar year.

4.2.4.12. The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed by the Department, and complies with requirements included in Section 4.12.34.3 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from the Department, implement Lock-In Programs for other medical services.

4.2.4.13. Members shall not be required to change covered prescription drugs more than once per calendar year, with the following exceptions:

4.2.4.13.1 When a Member is new to Medicaid, or switches from one Medicaid MCO to another Medicaid MCO;

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4.2.4.13.2 When a covered prescription drug change is initiated by the Member's provider;

4.2.4.13.3 When a biosimilar becomes available to the market;

4.2.4.13.4 When FDA boxed warnings or new clinical guidelines are recognized by CMS;

4.2.4.13.5 When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and

4.2.4.13.6 When a covered prescription is not available due to a supply shortage.

4.2.5 **Pharmacy Systems, Data, and Reporting Requirements**

4.2.5.1. Systems Requirements

4.2.5.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to:

4.2.5.1.1.1. Systems maintenance,

4.2.5.1.1.2. Software upgrades, and

4.2.5.1.1.3. National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP).

4.2.5.1.2 Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.5.2. Pharmacy Data and Reporting Requirements

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

4.2.5.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, the Department shall be responsible for collecting OBRA 90 CMS rebates, inclusive of supplemental, from drug manufacturers on MCO pharmacy claims.

4.2.5.2.3 The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the

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Encounter Data file within fourteen (14) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement.

4.2.5.2.4 The drug utilization information reported to the Department shall, at a minimum, include information on:

4.2.5.2.4.1. The total number of units of each dosage form,

4.2.5.2.4.2. Strength, and

4.2.5.2.4.3. Package size by National Drug Code of each covered outpatient drug dispensed, per Department encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.5.2.5 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to the Department. [42 CFR 438.3(s)(3)]

4.2.5.2.6 The MCO shall implement a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program.

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

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

4.2.5.2.9 The MCO shall provide the Department reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.2.5.2.10 [Amendment #1:] The MCO shall provide to the Department a detailed plan describing the exchange of Member pharmacy and medical record information between the PCP, behavioral health Provider, and other appropriate parties for the purpose of medication management. This information shall be provided in a streamlined manner across the MCOs ~~prescribed by the Department~~ as permitted by State and federal law.

4.2.5.2.10.1. All Member medical records and other medication management information exchanged between parties shall be shared with the Member's PCP in an easily identifiable format.

4.2.5.2.10.2. The MCO shall retain oversight and accountability of the medication management program, including data exchanges between parties.

4.2.5.2.10.3. The MCO shall submit its medication management plan for the Department's review and authorization at time of readiness, and prior to implementation when changes to the MCO's medication management program are proposed.

4.2.5.2.10.4. [Amendment #1:] The MCO shall have all processes and systems in place for related information sharing of data between parties no later than December 1, 2024.

4.2.6 **Medication Management**

4.2.6.1. Medication Management for All Members

4.2.6.1.1 Polypharmacy criteria for Members are defined as follows:

4.2.6.1.1.1. Child Members dispensed four (4) or more maintenance drugs based on GPI 10 or an equivalent product identification code (such as HICL) over a rolling sixty (60) day period, each

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drug filled for at least ninety (90) days duration, allowing each drug up to one fifteen (15) day gap between fills;

4.2.6.1.1.2. Adult Members dispensed five (5) or more maintenance drugs based on Generic Product Identifier (GPI) 10 or an equivalent product identification code (such as HICL) over a rolling sixty (60) day period; and

4.2.6.1.1.3. Brand and equivalent generics (or similar relationship such as reference product and biosimilar) within same GPI or equivalent product identification code shall not be counted as separate drugs within the five (5) maintenance drugs.

4.2.6.2. The MCO shall support medication management for Members meeting Polypharmacy criteria, and for other Members requesting medication review to ensure the PCP, pharmacist, or other qualified health care individual pharmacist has the information necessary to conduct Polypharmacy and medication management for child/adolescent and adult Members.

4.2.6.3. Comprehensive Medication Review (CMR) is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. This systematic process shall be used for each CMR.

4.2.6.3.1 [Amendment #1:] The MCO is responsible to ensure that a Member receives at least one Comprehensive Medication Review (CMR) from the PCP, community pharmacist or other qualified individual within six (6) months from the date~~/quarter~~ in which the Member was identified as meeting Polypharmacy criteria and the MCO shall be responsible for providing medication history to the PCP, pharmacist or other qualified individual.

4.2.6.3.2 [Amendment #1:] The PCP, community pharmacist, or other qualified individual shall participate in Polypharmacy and medication management.

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4.2.6.3.3 [Amendment #1:] The PCP, community pharmacist or other qualified individual shall provide counseling with any Member or authorized representative upon request, as described in this section, and in Exhibit O: Quality Oversight Reporting Requirements.

4.2.6.3.4 [Amendment #1:] The MCO shall report to the Department on a quarterly basis the total number of CMRs completed, including total number of counselling interactions with any Member, the Member names, and Provider (PCP, community pharmacist, or other qualified health care provider) who performed the CMR and/or counselling interaction with the Member or authorized representative.

4.2.6.3.5 The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the Member, authorized representative, and the PCP, pharmacist and/or other qualified individual with the intent to improve a Member's knowledge of their prescriptions, over-the-counter medications, herbal therapies, and dietary supplements; identify, and address problems or concerns the patient may have; and empower them to self-manage their medications and health conditions. These items shall be addressed for each Member during each CMR counselling interaction.

4.2.6.3.6 [Amendment #1:] Intentionally left blank. ~~In the event a Member identified for Polypharmacy does not participate in such review offered by a PCP, pharmacist, or other qualified individual at least once annually, the MCO shall offer CMR and counseling at least monthly until the Member actively accepts or denies receipt of CMR services.~~

4.2.6.3.6.1. [Amendment #1:] Intentionally left blank. ~~When the Member does not engage with the PCP, pharmacist, or other qualified individual for the purpose of satisfying medication management requirements of this Agreement, the MCO may subcontract with an appropriately credentialed and licensed professional or entity to support such engagement with~~

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~~prior approval from the Department.~~

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

4.2.6.5. The MCO shall provide to the qualified individual conducting CMR contact information for at least five (5) in-network child/adolescent psychiatrists for the purpose of peer-to-peer consulting whenever a child/adolescent Member is identified for Polypharmacy and is prescribed behavioral health prescriptions.

4.2.6.6. The MCO shall monitor Members who meet criteria for Polypharmacy three (3), six (6), and twelve (12) months after the CMR is completed to see if the member continues to meet criteria for Polypharmacy, or if it has been resolved. The MCO shall report the number of members who continue to meet criteria for Polypharmacy, and the number of members who no longer meet criteria on a quarterly basis.

4.2.7 **Medication Management for Children with Special Health Care Needs**

4.2.7.1. [Amendment #1:] The MCO shall be responsible to ensure~~for~~ active and comprehensive medication management for Children with Special Health Care Needs. In the event the PCP, community pharmacist or other qualified individual has not completed a CMR, t~~T~~he MCO shall offer to Members, their parents, and/or caregivers, comprehensive medication management services for Children with Special Health Care Needs. If comprehensive medication management services are accepted by the Member or authorized representative, the MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that shall include, but not be limited to, the following:

4.2.7.1.1 Performing or obtaining necessary health assessments;

4.2.7.1.2 [Amendment #1:] Formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the Member, parent and/or caregiver with a special focus on safe prescribing of psychotropic medications;

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

4.2.7.1.4 Monitoring, which could include lab assessments and evaluating the Member's response to therapy;

4.2.7.1.5 Consulting with social service agencies on medication management services;

4.2.7.1.6 [Amendment #1:] Initial and on-going CMR to prevent medication-related problems and address drug

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reconciliation, including adverse drug events, followed by targeted medication reviews, including peer-to-peer when requested;

4.2.7.1.7 [Amendment #1:] Requesting medical records, d~~D~~ocumenting and communicating information about care delivered by~~to~~ other appropriate health care Providers;

4.2.7.1.8 [Amendment #1:] Member and/or authorized representative education to enhance understanding and appropriate use of medications; and

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

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

4.2.7.2.1 Pharmacy claims;

4.2.7.2.2 Provider progress reports;

4.2.7.2.3 Comprehensive Assessments and Care Plans;

4.2.7.2.4 Contact with the Member's Providers;

4.2.7.2.5 Current diagnoses;

4.2.7.2.6 Current behavioral health functioning;

4.2.7.2.7 [Amendment #1:] Information from the family, placement p~~P~~rovider, the Department, and residential or other treatment entities or Providers; and

4.2.7.2.8 [Amendment #1:] For infants, children and youth who are involved in the State's protective services and juvenile justice system, and Division for Children Youth and Families (DCYF), including those in foster care who meet red flag criteria[18]: ~~Information shared with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship, to the extent permissible by State and federal law.~~

4.2.7.2.8.1. [Amendment #1:] Information shared with DCYF around oversight, monitoring and managing the use of

[18] [Amendment #1:] SafeRx: Psychotropic Medication Oversight, available on March 27,2023 at https://www.dhhs.nh.gov/programs-services/child-protection-juvenile-justice/foster-care-health-mental-health-programs-0

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psychotropic medications, including activity that occurs after identifying the criteria, how to document the activity, and the action plan that will be initiated and monitored to the extent permissible by State and federal law.

4.2.7.2.8.2. [Amendment #1:] The MCO shall provide to DCYF a written behavioral health CMR for each child and youth meeting red flag criteria in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1. 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 MCM program. The MCO shall comply with eligibility decisions made by the Department.

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

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

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

4.3.1.5. The MCO 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)]

4.3.1.6. In accordance with separate guidance, the MCO shall outreach to Members forty-five (45) calendar days prior to each Member's Medicaid

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eligibility expiration date to assist the Member with completion and submission of required paperwork. The MCO shall submit their outbound call protocols for the Department's review during the Readiness Review process.

4.3.1.6.1 The MCO shall not conduct outreach to address the backlog of pending Medicaid eligibility cases to Members in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits. [CMS State Health Official Letter].

4.3.2 Enrollment

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

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

4.3.2.2.1 [Amendment #1:] The MCO shall accept temporarily auto re-enrolled Members into their managed care plan after the individual's loss of Medicaid coverage for a period of 120 days or less. The temporary auto re-enrollment mechanism shall remain effective until the later of December 31, 2024 or expiration of the State's 1902(e)(14) in accordance with CMS guidance. [Section 1902(e)(14) of the Act]

4.3.2.3. The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not

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select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member.

4.3.2.4. When assigning a PCP, the MCO shall include the following methodology in selecting a PCP for the Member, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.3 Non-Discrimination

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

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

4.3.3.3. The MCO 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)]

4.3.3.4. The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has a discriminatory effect. [42 CFR 438.3(d)(4)] [RSA 354-A]

4.3.4 Auto-Assignment

4.3.4.1. In its sole discretion, the Department shall use the following factors for auto-assignment in an order to be determined by the Department:

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

4.3.4.1.2 Previous MCO enrollment, when applicable;

4.3.4.1.3 Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438 54(d)(7);

4.3.4.1.4 Any members earned through the Performance-Based Auto-Assignment Program; and

4.3.4.1.5 Equitable distribution among the MCOs as determined appropriate solely by the Department.

4.3.4.2. The Performance-Based Auto-Assignment Program determined solely by the Department and communicated to the MCO in guidance issued by the Department, rewards one or more MCOs that demonstrate exceptional performance on one (1) or more key dimensions of performance determined at the Department's sole discretion.

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4.3.4.2.1 High-performing MCO(s) may be rewarded with preferential auto-assigned membership in accordance with separate guidance. Such an award would potentially precede any equitable distribution of Members who do not self-select an MCO across.

4.3.5 Disenrollment

4.3.5.1. Member Disenrollment Request

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

4.3.5.1.1.1. The Member moves out of state;

4.3.5.1.1.2. 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;

4.3.5.1.1.3. 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

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

4.3.5.1.2 For Member disenrollment requests "with cause" as described in in this section of the Agreement, the Member shall first seek redress through the MCO's grievance system.

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

4.3.5.1.3.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into

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the MCO or the date of the Department Member notice of the initial auto-assignment/enrollment, whichever is later;

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

4.3.5.1.3.3. Once every twelve (12) months;

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

4.3.5.1.3.5. 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

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

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

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4.3.5.1.5 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)]

4.3.5.1.6 The MCO 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.

4.3.5.1.7 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.

4.3.5.1.8 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)]

4.3.5.2. MCO Disenrollment Request

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

4.3.5.2.1.1. Member has established out of state residence;

4.3.5.2.1.2. Member death;

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

4.3.5.2.1.4. Fraudulent use of the Member identification card; or

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

4.3.5.2.2 The MCO shall not request disenrollment because of:

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

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4.3.5.2.2.2. The Member's utilization of medical services;

4.3.5.2.2.3. The Member's diminished mental capacity;

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

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

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

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

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

4.3.5.2.3.3. 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 MCO files the request.

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

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4.4 Member Services

4.4.1 Member Information

4.4.1.1. The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members.

4.4.2 PCP Information

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

4.4.3 Member Identification Card

4.4.3.1. The MCO shall issue a hardcopy identification card to all New Members 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.

4.4.3.2. 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:

4.4.3.2.1 The Member's name;

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

4.4.3.2.3 The name of the MCO;

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

4.4.3.2.5 The toll-free telephone number for transportation; and

4.4.3.2.6 How to file an appeal or grievance.

4.4.3.3. The MCO shall reissue a Member identification card if:

4.4.3.3.1 A Member reports a lost card;

4.4.3.3.2 A Member has a name change; or

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

4.4.3.4. [Amendment #2:] Effective July 1, 2026, the MCO shall assign and exclusively use unique Medicaid-specific Bank Identification Number (BIN) and Processor Control Number (PCN) combination, and group number identifiers for all Member identification cards for pharmacy benefits. [42 CFR 438.3(s)(7)]

4.4.4 Member Handbook

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

4.4.4.2. The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other Department initiatives. The MCO 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.

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

4.4.4.3.1 General information;

4.4.4.3.2 A table of contents;

4.4.4.3.3 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)];

4.4.4.3.4 The Department developed definitions, including but not limited to: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

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

4.4.4.3.6 A reminder to report to the Department any change of address, as Members may be liable for premium payments paid during period of ineligibility;

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

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4.4.4.3.8 Appointment procedures;

4.4.4.3.9 How to contact 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;

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

4.4.4.3.11 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;

4.4.4.3.12 The policies and procedures for disenrollment;

4.4.4.3.13 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];

4.4.4.3.14 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];

4.4.4.3.15 A description of utilization review policies and procedures used by the MCO;

4.4.4.3.16 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];

4.4.4.3.17 Information on how to report suspected Fraud or abuse [42 CFR 438.10(g)(2)(xiii-xvi)];

4.4.4.3.18 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];

4.4.4.3.19 Non-Participating Providers and cost-sharing on any benefits carved out and provided by the Department [42 CFR 438.10(g)(2)(i-ii)];

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

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

4.4.4.3.22 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.12.19. (Parity);

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

4.4.4.3.24 Benefits:

4.4.4.3.24.1. How and where to access any benefits provided, including Maternity services, Family Planning Services and NEMT services [42 CFR 438.10(g)(2)(i-ii), (vi-vii)];

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

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

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

4.4.4.3.24.5. 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)];

4.4.4.3.24.6. Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO shall inform Members that the

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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)];

4.4.4.3.24.7. A description of pharmacy policies and pharmacy programs; and

4.4.4.3.24.8. How emergency care is provided, including:

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

4.4.4.3.24.8.2 What constitutes an Emergency Service and an Emergency Medical Condition; The extent to which, and how, after hours and emergency coverage are provided;

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

4.4.4.3.24.8.4 The Member's

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

4.4.4.3.25 Service Limitations:

4.4.4.3.25.1. An explanation of any service limitations or exclusions from coverage;

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

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

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

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

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

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

4.4.4.3.26 Rights and Responsibilities:

4.4.4.3.26.1. Member rights and protections, outlined in Section 4.4.8 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i-vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)]

4.4.4.3.27 Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.4.3.27.1. The right to file grievances and appeals;

4.4.4.3.27.2. The requirements and timeframes for filing grievances or appeals;

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

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

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

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4.4.5 Member Handbook Dissemination

4.4.5.1. The MCO 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)]

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

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

4.4.5.3.1 Information contained in the Member Handbook;

4.4.5.3.2 Information on how to file grievances and appeals;

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

4.4.5.3.3.1. Names and any group affiliations;

4.4.5.3.3.2. Street addresses;

4.4.5.3.3.3. Office hours;

4.4.5.3.3.4. Telephone numbers;

4.4.5.3.3.5. Website (whenever web presence exists);

4.4.5.3.3.6. Specialty (if any),

4.4.5.3.3.7. Description of accommodations offered for people with disabilities;

4.4.5.3.3.8. The cultural and linguistic capabilities of Participating Providers, including languages

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(including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office;

4.4.5.3.3.9. Gender of the Provider;

4.4.5.3.3.10. Identification of Providers that are not accepting new Members; and

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

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

4.4.5.5. The MCO 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 MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. The MCO shall utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.6 Provider Directory

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

4.4.6.2. [Amendment #2:] The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers (including CCBHCs), FQHCs, RHCs):

4.4.6.2.1 Names and any group affiliations;

4.4.6.2.2 Street addresses;

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4.4.6.2.3 Office hours;

4.4.6.2.4 Telephone numbers;

4.4.6.2.5 Website (whenever web presence exists);

4.4.6.2.6 Specialty (if any),

4.4.6.2.7 Gender;

4.4.6.2.8 Description of accommodations offered for people with disabilities;

4.4.6.2.9 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;

4.4.6.2.10 Hospital affiliations (if applicable);

4.4.6.2.11 Board certification (if applicable);

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

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

4.4.6.3. The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from 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 MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request and free of charge.

4.4.6.4. The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2 (Practice Guidelines and Standards). [42 CFR 438.236(c)]

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

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

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

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

4.4.6.9. 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 MCO 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 MCO shall submit the final website Provider Directory.

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

4.4.7 Language and Format of Member Information

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

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

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

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

4.4.7.5. 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.

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

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

4.4.7.8. 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 Members, to explain the availability of written translation or oral interpretation, and include

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

4.4.7.9. 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 MCO 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)]

4.4.7.10. Written Member information shall include at a minimum:

4.4.7.10.1 Provider Directories;

4.4.7.10.2 Member Handbooks;

4.4.7.10.3 Appeal and grievance notices; and

4.4.7.10.4 Denial and termination notices.

4.4.7.11. The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that 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)]

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

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

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

4.4.8 Member Rights

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

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

4.4.8.1.2 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;

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

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

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

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

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

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

4.4.8.1.9 Request and receive a Second Opinion; and

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

4.4.9 Member Communication Supports

4.4.9.1. During the Readiness Review period, the MCO shall provide a blueprint of its website, including Member portal, for review by the Department.

4.4.9.2. [Amendment #1:] The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal.

4.4.10 Member Call Center

4.4.10.1. The MCO shall operate a toll-free Member Call Center Monday through Friday, and be operational on all days the Department Customer Service Center is open.

4.4.10.2. The MCO shall ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.4 (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:

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

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

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

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

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

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

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

4.4.10.4. The MCO shall coordinate its Member Call Center with the Department Customer Service Center, and community-based and statewide crisis lines, and at a minimum, include the development of a warm transfer protocol for Members.

4.4.11 Welcome Call

4.4.11.1. The MCO shall make a welcome call or an interactive voice recognition (IVR) call to each new Member within ninety (90) calendar days of the Member's enrollment in the MCO, and include a means for the Member to request immediate live MCO representative support during the welcome call.

4.4.11.2. In accordance with applicable law, the MCO may communicate with Members by text, email, phone or other digital or electronic communications.

4.4.11.3. The welcome call shall, at a minimum:

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

4.4.11.3.2 [Amendment #1:] ~~Arrange~~ Assist with scheduling ~~for~~ a Wellness Visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs)~~., which shall include:~~

4.4.11.3.2.1. [Amendment #1:] Initial screening ~~Assessments~~ of both physical and behavioral health, including identification of urgent health care needs;

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4.4.11.3.2.2. [Amendment #1:] Initial s~~S~~creening for depression, mood, suicidality, and Substance Use Disorder;

4.4.11.3.2.3. Support development of a Member's plan of care with the PCP;

4.4.11.3.2.4. Arrange for the completion of a HRA Screening in accordance with the terms of this Agreement and Section 4.10.2 (Health Risk Assessment (HRA) Screening).

4.4.11.3.2.5. [Amendment #1:] Initial s~~S~~creening for adverse health needs, special needs, physical and behavioral health, and services of the Member. The MCO shall share the results of screening findings with the Member's PCP to support the Member's plan of care with the Provider;

4.4.11.3.2.6. [Amendment #1:] Answer any ~~other~~ Member questions about the MCO;

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

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

4.4.11.3.3 Regardless of the completion of the welcome call by the MCO, the PCP shall complete HRA Screenings as stipulated in Section 4.10.2 (Health Risk Assessment (HRA) Screening), and documented by a claim encounter.

4.4.12 Member Hotline

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

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4.4.12.2. 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.

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

4.4.12.4. The MCO may substitute a live answering service in place of an automated system.

4.4.13. Program Website

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

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

4.4.13.3. If the MCO chooses to provide required information electronically to Members, it shall:

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

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

4.4.13.3.3 Be consistent with content and language requirements;

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

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

4.4.13.4. The MCO program content included on the website shall be:

4.4.13.4.1 Written in English and Spanish;

4.4.13.4.2 Culturally appropriate;

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

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

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

4.4.13.6. [Amendment #4:] Beginning March 31, 2026 and annually thereafter, the MCO shall report prior authorization data from the prior calendar year in accordance with Exhibit O: Quality and Oversight Reporting Requirements, excluding any and all drugs covered by the MCO. In addition, the MCO shall make this data accessible by posting the information on its website. [42 CFR 210(f)]

4.4.14. Marketing

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

4.4.14.2. 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 MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i-ii), 42 CFR 438.104(b)(1)(iv-v)]

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

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

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

4.4.14.5.1 The recipient shall enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

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

4.4.14.6. The MCO shall distribute Marketing Materials to the entire State. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO 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)]

4.4.15. Member Engagement Strategy

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

4.4.16 Member Advisory Board

4.4.16.1. Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program.

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

4.4.16.3. 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 MCO's QAPI program changes (as further described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.4.16.4. All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.17 Regional Member Meetings

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

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

4.4.18. Cultural and Accessibility Considerations

4.4.18.1. The MCO 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)]

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

4.4.19 Cultural Competency Plan

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

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

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

4.4.20 Communication Access

4.4.20.1. To ensure equitable access to benefits and services for all of the MCO's Members, the MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

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

4.4.20.3. The MCO 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.

4.4.20.4. The MCO shall ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. For any Member who requires interpretation or translation services, the MCO shall not::

4.4.20.4.1 Require a Member with LEP or a disability to provide their own interpreter or translator;

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

4.4.20.4.2.1. In an emergency involving an imminent threat to the safety or welfare of the Member or the public where the MCO has attempted to obtain a Qualified Interpreter for the Member with LEP or Qualified Interpreter for the Member with a Disability, as applicable, and no Qualified

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Interpreter for the Member with LEP or Qualified Interpreter for the Member with a Disability is immediately available. In such cases, the MCO shall continue to make good faith attempts at obtaining a Qualified Interpreter for the Member with a Disability or Qualified Interpreter for the Member with LEP, as applicable, to interpret or facilitate communication for the Member where there is no Qualified Interpreter for the Member with LEP immediately available; or

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

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

4.4.20.5. The MCO shall ensure services provided by Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services, exclusive of inpatient services.

4.4.20.6. The MCO shall recognize that no one interpreter, language, or assistive 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) or assistance will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.4.20.7. Accordingly, the MCO shall provide the most appropriate interpretation or assistive service possible under the circumstances. In all cases, the MCO shall provide interpreter services of Qualified Bilingual/Multilingual Staff, Qualified

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Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators when deemed clinically necessary by the Provider of the encounter service.

4.4.20.8. The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, or Qualified Translators are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.20.8.1 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;

4.4.20.8.2 A sharply delineated image that is large enough to display the Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, or Qualified Translator's face and the participating Member's face regardless of the Member's body position;

4.4.20.8.3 A clear, audible transmission of voices; and

4.4.20.8.4 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)]

4.4.20.9. The MCO shall bear the cost of interpretive services and communication access including SSL, ASL, Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translator interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

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

4.4.20.11. If the Member declines free interpretation services offered by the MCO, the MCO 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.

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

4.4.20.13. The MCO 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 MCO from discriminating on the basis of race, color, or national origin.

4.4.20.14. 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 MCO shall take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

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

4.4.20.16. [Amendment #1:] Digital, video, and phone interpretation services must comply with Exhibit EK: Information Security Requirements and Exhibit KQ: ITTechnical Requirements Workbook.

4.5. Member Grievances and Appeals

4.5.1. General Requirements

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

4.5.1.2. The MCO 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.

4.5.1.3. The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a

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Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement.

4.5.1.4. In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

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

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

4.5.1.5.2 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)];

4.5.1.5.3 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)];

4.5.1.5.4 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)];

4.5.1.5.5 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:

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

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

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

4.5.1.5.6 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]

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

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

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

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

4.5.1.7.3 The availability of assistance with filing;

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

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

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

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

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

4.5.1.10. 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)]

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4.5.1.11. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

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

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

4.5.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.13. The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.1.14. [Amendment #4:] Beginning March 31, 2026, the MCO shall report for the prior calendar year publicly accessible prior authorization data on its plan website, excluding data on any and all drugs covered by the MCO. [42 CFR 438.210].

4.5.2. **Member Grievance Process**

4.5.2.1. The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2. The MCO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3. The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

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4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance 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 MCO 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)]

4.5.2.5. The MCO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.5.2.5.1 If the Member requests the extension; or

4.5.2.5.2 If the MCO 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)]

4.5.2.6. If the MCO extends the timeline for a grievance not at the request of the Member, the MCO shall:

4.5.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.5.2.6.2 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)]

4.5.2.7. If the Member requests disenrollment, then the MCO 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)]

4.5.2.8. The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3. **Member Appeal Process**

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4.5.3.1. The MCO shall develop, implement, and maintain an Member Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2. The MCO shall 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 MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3. The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4. The MCO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)]

4.5.3.5. [Amendment #4:] The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals ~~and confirm those inquires in writing, unless the Member or the authorized Provider requests expedited resolution~~. [42 CFR 438.406(b)(3)]

4.5.3.6. If the Department receives a request to appeal an action of the MCO, the Department shall forward relevant information to the MCO and the MCO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.8. The MCO 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 MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.9. The MCO shall provide the Member and/or the Member's representative an opportunity to receive the Member's case file, free of charge prior to and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b-c)]

4.5.3.10. [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO may offer peer-to-peer review support with a like clinician who is actively licensed by the New Hampshire Office of Professional Licensure and Certification, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

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4.5.3.11. The MCO shall resolve ninety-eight percent (98%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.5.3.12. 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.

4.5.3.13. Members who believe the MCO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.5.3.14. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.5.4. **Member Adverse Actions**

4.5.4.1. The MCO shall permit the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 Denial, in whole or in part, of payment for a service;

4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that the Department has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1) MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5. **Expedited Member Appeal**

4.5.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

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4.5.5.2. The MCO 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)]

4.5.5.3. The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.5.5.4. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. The MCO shall also make reasonable efforts to provide oral notice. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)]

4.5.5.5. 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.

4.5.5.6. If the MCO extends the timeframes not at the request of the Member, it shall:

4.5.5.6.1 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 MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.6.2 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;

4.5.5.6.3 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)]

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

4.5.5.8. The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.9. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

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4.5.5.10. The Member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6. **Content of Member Appeal Notices**

4.5.6.1. The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.1.1 [Amendment #4:] Effective July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), in accordance with the timeframes established in 42 CFR 438.210(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.) as if such requirements applied directly to the MCO according to the decision timeframes in 42 CFR 438.210(d). [42 CFR 438.242(b)(8)]

4.5.6.2. The MCO shall utilize NCQA compliant Department model notices for all adverse actions and appeals. MCO 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:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b-c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request

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that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. [42 CFR 438.404(b)(6)]

4.5.6.3. The MCO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.5.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 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.

4.5.6.4. The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

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4.5.6.4.9 The transfer or discharge from a facility shall occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7. **Timing of Member Notices**

4.5.7.1. For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable Fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2. In accordance with 42 CFR 438.404(c)(2), the MCO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.5.7.3. [Amendment #4:] Beginning July 1, 2026, For standard service authorization decisions ~~denials or partial denials~~, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed seven (7) ~~fourteen (14)~~ calendar days following the date of receipt of 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 from the date of receipt of the request for service is permissible, if:

4.5.7.3.1 The Member, or the Provider, requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4. When the MCO extends the timeframe, the MCO 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 MCO 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)]

4.5.7.5. For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than

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seventy-two (72) hours after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7. The MCO 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)]

4.5.8. **Continuation of Member Benefits**

4.5.8.1. The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2. The intended effective date of the MCO's proposed action;

4.5.8.1.1.3. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.1.4. The services was ordered by an authorized Provider;

4.5.8.1.1.5. The authorization period has not expired;

4.5.8.1.1.6. The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

4.5.8.1.1.7. 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)]

4.5.8.2. If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

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4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1-3); 42 CFR 438.408(d)(2)]

4.5.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4. A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9. **Resolution of Member Appeals**

4.5.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it shall:

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4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2. [Amendment #4:] Under no circumstances may the MCO extend the appeal determination beyond forty-four (44) ~~forty-five (45)~~ calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.5.9.4. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.5.9.5. For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6. For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision

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upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.5.10. **State Fair Hearing for Member Appeals**

4.5.10.1. The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.5.10.2. The parties to the State fair hearing include the MCO as well as the Member and their representative or the representative of a deceased Member's estate.

4.5.10.3. The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.3.1 That Members shall exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with the Department; and

4.5.10.3.2 [Amendment #2:] That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the MCO's notice of the resolution of the appeal. [42 CFR 438.408(f)(2)]

4.5.10.4. If the Member requests a State fair hearing, the MCO shall provide to the Department and the Member, upon request, within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.5. 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:

4.5.10.5.1 The MCO adversely resolved the Member's appeal wholly or partially; or

4.5.10.5.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.6. If the Member requests an expedited State fair hearing, the MCO shall provide to the Department and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but

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not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.7. 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 MCO the case file and any other necessary information. [He-W 506.09(g)]

4.5.10.8. The MCO shall appear and defend its decision before the Department AAU. The MCO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to the Department for the duration of the appeal at no additional cost.

4.5.10.9. The Department AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11. **Effect of Adverse Decisions of Member Appeals and Hearings**

4.5.11.1. If the MCO 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 MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2. If the MCO or 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 MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12. **Survival of Member Appeals and Grievances**

4.5.12.1. The obligations of the MCO 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.

4.6. **Provider Appeals**

4.6.1. **General**

4.6.1.1. The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

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4.6.1.2. The MCO shall provide a complete written description of its Provider Appeals Process, including all policies and procedures, and notices and forms, for the Department's review and approval during the Readiness Review period.

4.6.1.3. Any proposed changes to the Provider Appeals Process shall be approved by the Department at least thirty (30) calendar days in advance of implementation.

4.6.1.4. The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference it in the Provider and Subcontractor agreements.

4.6.1.5. The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.6.1.5.2 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;

4.6.1.5.3 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

4.6.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

4.6.2. **Provider Adverse Actions**

4.6.2.1. [Amendment #1:] The Provider shall have the right to file an appeal with the MCO within sixty (60) calendar days of the date of the MCO's notice of adverse action to the Provider, and may utilize the Provider Appeals Process for any adverse action, ~~in accordance with RSA 126-A:5, VIII~~, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). ~~The Provider shall have the right to file an appeal within sixty (60) calendar days of the date of the MCO's notice of adverse action to the Provider.~~ Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when the Department, MFCU or other government agency has required the MCO to terminate such agreement;

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4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2. The MCO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.6.3. **Provider Appeal Process**

4.6.3.1. The MCO shall provide written notice, and electronic notice if available, 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.

4.6.3.2. Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within sixty (60) calendar days of:

4.6.3.2.1 The date of the MCO's written notice advising the Provider of the adverse action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3. The MCO shall be permitted to extend the decision deadline to issue the Resolution Notice by an additional sixty (60) calendar days to allow the Provider to submit additional evidence or supportive documentation, and for other good cause determined by the MCO.

4.6.3.4. The MCO shall ensure that all Provider Appeal Process decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider appeal.

4.6.3.5. [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO may offer peer-to-peer review support with a like clinician who is actively licensed by the New Hampshire Office of Professional Licensure and Certification, upon request, for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal Process or State fair hearing process.

4.6.3.6. The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

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4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7. If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Provider Appeal Process and may initiate a State fair hearing.

4.6.4. **MCO Resolution of Provider Appeals**

4.6.4.1. The MCO shall provide timely written notice of Provider appeal resolution (Resolution Notice) at a rate of ninety-five percent (95%) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.4.2. The Resolution Notice shall include, without limitation:

4.6.4.2.1 The MCO's decision;

4.6.4.2.2 The reasons for the MCO's decision;

4.6.4.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.4.2.4 For overturned appeals, the MCO shall take all steps to reverse the adverse action within ten (10) calendar days.

4.6.5. **State Fair Hearing for Provider Appeals**

4.6.5.1. The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.6.5.2. The parties to the State fair hearing include the MCO as well as the Provider.

4.6.5.3. The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing.

4.6.5.4. If a Participating Provider requests a State fair hearing, the MCO shall provide to the Department and the Participating Provider, upon request, within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.6.5.5. The MCO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO

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shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.6.5.6. The MCO shall appear and defend its decision before the Department AAU. Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.5.7. [Amendment #2:] ~~The Department AAU shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.~~ The Department AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.6.5.8. The MCO shall:

4.6.5.8.1 Not object to the State intervening in any such appeal;

4.6.5.8.2 Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.5.8.3 Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.6.5.9. Reporting

4.6.5.9.1 The MCO 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)]

4.7. Access

4.7.1. Participating Provider Network

4.7.1.1. The MCO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2. The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its Participating Provider network, the MCO shall consider and address the following factors to ensure network adequacy for each Member:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH Medicaid population;

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4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Participating Providers limiting NH Medicaid patients' access to the Participating Provider or not accepting new or any NH Medicaid patients;

4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, in compliance with Exhibit K: Information Security Requirements and Exhibit Q: IT Requirements Workbook;

4.7.1.2.8 Adequacy of the primary care Participating Provider network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

4.7.1.2.9 Access standards identified in this Agreement; and

4.7.1.2.10 Required access standards set forth by the NHID, including RSA. 420-J; and N.H. Code of Administrative Rules Ins 2700

4.7.1.3. The MCO shall meet the Participating Provider network adequacy standards included in this Agreement in all geographic areas in which the MCO operates for all Provider types covered under this Agreement.

4.7.1.4. The MCO shall ensure that services are as accessible to Members in terms of timeliness, amount, duration and scope as those that are available to Members covered by the Department under FFS Medicaid within the same service area.

4.7.1.5. The MCO shall ensure Participating Providers comply with the accessibility standards of the ADA. Participating Providers 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)]

4.7.1.6. The MCO 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

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services. If Members are permitted by the MCO to access out-of-state IHCPs, or if this circumstance is deemed to be good cause for disenrollment, the MCO shall be considered to have met this requirement. [42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory, as specified in Section 4.4.6 (Provider Directory) of this Agreement.

4.7.2. **Assurances of Adequate Capacity and Services**

4.7.2.1. The MCO's Participating Provider network shall have Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all Covered Services to meet the geographic standards in Section 4.7.3 (Time and Distance Standards), the timely provision of services requirements in Section 4.7.5 (Timely Access to Service Delivery), Equal Access, and reasonable choice by Members to meet their needs [42 CFR 438.207(a)].

4.7.2.2. The MCO shall submit documentation to the Department, in the format and frequency specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, that fulfills the following requirements:

4.7.2.2.1 The MCO 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)]

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with the Department's requirements for availability, accessibility of services, and adequacy of the Participating Provider network including pediatric subspecialists as described in Section 4.7.5.11 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 [Amendment #2:] The MCO is complying with the Department's requirements for Behavioral Health Services, as specified in Section 4.12, including but not limited to Substance Use Disorder treatment services and recovery, Mental Health services,

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Community Mental Health services, CCBHC services, and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3. To permit the Department to determine if access to private duty nursing services is increasing, as indicated by the Department in Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide to the Department the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4. The MCO shall submit documentation to 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 MCO. [42 CFR 438.207(b-c)]

4.7.2.5. For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by the Department.

4.7.3. **Time and Distance Standards**

4.7.3.1. At a minimum, the MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members, subject to alternative CMS requirements. [42 CFR 438.68(b)(1)(i-viii); 42 CFR 438.68(b)(3)]

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Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
[Amendment #2] Certified Community Behavioral Health Clinics (CCBHC)	All certified CCBHCs in New Hampshire
Community Mental Health Programs	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
[Amendment #1:] Intentionally Left Blank~~Mobile Crisis Service Providers~~[19]	~~One (1) within sixty (60) driving minutes or forty-five (45) driving miles~~
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
Tertiary or Specialized Services (e.g., Trauma, Neonatal)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

[19] [Amendment #1:] Intentionally left blank~~Mobile crisis services are provided by CMH Programs but subject to a different Geographic Access Standard requirement pursuant to the Department's selected Mobile Crisis System model~~.

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Geographic Access Standards	
Provider/Service	Requirement
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupation-al Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2. The MCO 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.

4.7.3.3. 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 MCO regarding its Participating Provider network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.4. The MCO shall contract with qualified Substance Use Disorder Providers who request to join its Participating Provider network pending the Substance Use Disorder Provider's agreement to the terms of the MCO's contract.

4.7.3.5. Additional Behavioral Health Provider Standards

Provider/Service	Requirement
MLADCs	The MCO's Participating Provider network shall include seventy percent (70%) of all such Providers licensed and practicing in NH
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH
Buprenorphine Prescribers	The Participating Provider network shall include seventy-five percent (75%) of all such Providers actively prescribing Buprenorphine in their practice and licensed and practicing in NH
Residential Substance Use Disorder Treatment Programs	The MCO's Participating Provider network shall include fifty percent (50%) of all such Providers licensed and practicing in NH
Peer Recovery Programs	The MCO's Participating Provider network shall include one hundred percent (100%) of all such willing Programs in NH
Residential Programs for Serious Mental Illness	The MCO's Participating Provider network shall include 100% of all such Providers, located in NH, if they are operated by or under contract with Community Mental Health Programs, and 100% of all such Providers if they are otherwise under contract with the Department and are appropriately licensed or certified by the Department under He-P 800 or He-M 1000.

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Provider/Service	Requirement
[Amendment #3:] Intentionally left blank ~~Psychiatric Residential [Treatment Facilities~~	[Amendment #3:] Intentionally left blank ~~The MCO's Participating Provider network shall include 100% of all such Providers, located in NH, if they are owned or operated by, under contract with, or are otherwise determined or designated by the Department to provide this service, and are appropriately licensed or certified by the Department or a Department approved alternative certification entity.~~

4.7.4. **Standards for Geographic Accessibility**

4.7.4.1. The MCO may request reasonable exceptions from the Agreement's Participating Provider 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 MCO be unable to contract a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, with the assistance of the Department and after good faith negotiations, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days 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: Liquidated Damages Matrix shall apply.

4.7.4.3. Except within a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with assistance of the Department, continue to be unable to meet geographic and timely access to service delivery standards the Department may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4. At any time the provisions of this section may apply, the MCO shall ensure Members have reasonable access to Covered Services.

4.7.4.5. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6. Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the Participating Provider 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)]

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4.7.4.6.2 The Department may grant the MCO an exception in the event that:

4.7.4.6.2.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the Participating Provider network adequacy standards in this Agreement and as otherwise defined by the NHID and the Department;

4.7.4.6.2.2. The MCO demonstrates, to the satisfaction of the Department, that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.2.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

4.7.4.6.2.4. The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies

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reviewed and approved by the Department, but the MCO shall not use telemedicine to meet the Participating Provider network adequacy standards unless the Department has specifically approved a Request for Exception.

4.7.4.6.3 The MCO shall report on Participating Provider network adequacy and exception requests in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.5. **Timely Access to Service Delivery**

4.7.5.1. The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2. The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3. The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)]

4.7.5.4. The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5. The MCO's Participating Provider network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6. The MCO shall have in its Participating Provider network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., diagnostic, preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

4.7.5.6.2 A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

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4.7.5.6.3 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.4 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.5 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

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

4.7.5.6.7 Obstetrics and gynecological care shall be available within fifteen (15) calendar days from the date of the Member's appointment request.

4.7.5.7. The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards.

4.7.5.8. The MCO shall regularly monitor its Participating Provider 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.

4.7.5.9. The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.10. The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

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4.7.5.11. Access Standards for Children with Special Health Care Needs

4.7.5.11.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

4.7.5.11.2 In addition to the "specialty care" Participating Provider network adequacy requirements, the MCO shall contract with Providers who offer the following specialty services:

4.7.5.11.2.1. Pediatric Critical Care;

4.7.5.11.2.2. Pediatric Child Development;

4.7.5.11.2.3. Pediatric Genetics;

4.7.5.11.2.4. Pediatric Physical Medicine and Rehabilitation;

4.7.5.11.2.5. Pediatric Ambulatory Tertiary Care;

4.7.5.11.2.6. Neonatal-Perinatal Medicine;

4.7.5.11.2.7. Pediatrics-Adolescent Medicine; and

4.7.5.11.2.8. Pediatric Psychiatry.

4.7.5.11.3 The MCO shall have adequate Participating Provider networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.11.4 The MCO shall specify, in their listing of mental health and Substance Use Disorder Provider directories, which Providers specialize in children's services.

4.7.5.11.5 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.11.6 The MCO shall permit a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

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4.7.5.11.7 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.11.8 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.12. Access Standards for Behavioral Health

4.7.5.12.1 The MCO shall have in its Participating Provider network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.12.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its Participating Provider network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.12.2.1. Within six (6) hours for a non-life threatening emergency;

4.7.5.12.2.2. Within forty-eight (48) hours for urgent care; and

4.7.5.12.2.3. Within ten (10) business days for a routine office visit appointment.

4.7.5.12.3 American Society of Addiction Medicine (ASAM) Level of Care

4.7.5.12.3.1. The MCO shall ensure Members timely access to care through a network of Participating Providers in each ASAM Level of Care. During the Readiness

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Review process and in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.7.5.12.3.1.1 The MCO shall submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of Substance Use Disorder service Providers so that services are accessible without unreasonable delays; and

4.7.5.12.3.1.2 The MCO shall have a specified number of Providers able to provide services at each level of care required; if supply precludes compliance, the MCO shall notify the Department and, within

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thirty (30) calendar days, submit an updated plan that identifies the specific steps that shall be taken to increase capacity, including milestones by which to evaluate progress.

4.7.5.12.4 The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.

4.7.5.12.5 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.

4.7.5.12.6 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential

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services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.12.7 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider, and the ordering Provider does not make a referral for the Covered Service within three (3) business days from initial contact, then the MCO is responsible, in collaboration with the Member's care team, for making a closed loop referral for that type of service (for the identified level of care), and to the applicable Doorway Program location within three (3) business days thereafter. The MCO is responsible for ensuring that the Member has access to interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

4.7.5.12.8 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.12.9 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

4.7.5.12.9.1. Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching

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out to identify Providers on the behalf of the Member;

4.7.5.12.10 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

4.7.5.12.11 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6. **Women's Health**

4.7.6.1. The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services provide necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist. [42 CFR 438.206(b)(2)]

4.7.6.2. The MCO shall provide access to Family Planning Services to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3. Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

4.7.6.4. The MCO shall only provide for abortions in the following situations:

4.7.6.4.1 If the pregnancy is the result of an act of rape or incest; or

4.7.6.4.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.5. The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement.

4.7.7. **Access to Special Services**

4.7.7.1. The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the

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equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3. The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8. **Non-Participating Providers**

4.7.8.1. If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2. The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3. The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider,

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the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.3.3 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network. [42 CFR 438.206(b)(5)]

4.7.9. **Access to Providers During Transitions of Care**

4.7.9.1. The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 [Amendment #1:] In the case of a child or youth who qualifies as a target population~~with Special Health Care Needs as~~ defined in Section 4.11.2 (MCO-Delivered Care Management for Required Priority Populations).

4.7.9.2. The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with the Department) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, 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;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her

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Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3. The MCO shall permit that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4. The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing their Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5. The MCO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition plan shall describe how Members shall be identified by the MCO and how Continuity of Care shall be provided.

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4.7.9.6. The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7. The MCO shall make a good faith effort to give written notice of termination of a contracted Provider, as follows:

4.7.9.7.1 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

4.7.9.7.2 Written notice to each Member who received their care from, or was seen on a regular basis by, the terminated Provider, the later of:

4.7.9.7.2.1. Thirty (30) calendar days prior to the effective date of the termination; or

4.7.9.7.2.2. Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated Provider.

4.7.9.8. The MCO shall have a transition plan in place for affected Members described in this section within three (3) calendar days prior to the effective date of the termination.

4.7.9.9. In addition to notification of the Department of Provider terminations, the MCO shall provide reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.9.10. If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.9.11. If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.11.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.11.2 Explain that the Member shall be assigned to an alternative PCP if they do not actively select one; and

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4.7.9.11.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.12. If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.13. The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Management team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant.

4.7.9.14. To minimize disruptions in care, the MCO shall:

4.7.9.14.1 With the exception of Members in their second or third trimester of pregnancy, 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; and

4.7.9.14.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10. **Second Opinion**

4.7.10.1. The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook. [42 CFR 438.206(b)(3)]

4.7.11. **Provider Choice**

4.7.11.1. The MCO shall permit each Member to choose their Provider to the extent possible and appropriate. [42 CFR 438.3(l)]

4.7.12. [Amendment #4:] **Rural Health Care**

4.7.12.1. [Amendment #4:] Beginning as early as January 1, 2026, the MCO shall support the Department's Rural Health Care activities authorized through the 2025 federal budget reconciliation bill as described in separate guidance. [H.R. 1; P.L. 119-21]

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4.8. Utilization Management

4.8.1. Policies and Procedures

4.8.1.1. The MCO'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 MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3. Amount, Duration, and Scope

4.8.1.3.1 The MCO 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)]

4.8.1.3.2 The MCO shall also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services shall be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.3 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.3.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.3.2. Personal Care Attendant (PCA) authorizations shall be issued for no less that one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

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4.8.1.3.3.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

4.8.1.4. Written Utilization Management Policies

4.8.1.4.1 The MCO 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 MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (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

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(including health-related social needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.13.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs;

4.8.1.4.2.2. Pre-hospital admission certification;

4.8.1.4.2.3. Pre-inpatient service eligibility certification;

4.8.1.4.2.4. Concurrent hospital review to determine appropriate length of stay;

4.8.1.4.2.5. The process used by the MCO 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 MCO to the Department for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the MCO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.8.1.4.6 The MCO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The MCO'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 MCO shall provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.66 (c)(7)]

4.8.1.5. Service Limits

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6. Prior Authorization

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4.8.1.6.1 The MCO 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. Any Prior Authorization for Substance Use Disorder shall comply with RSA 420-J:17 and RSA 420-J:18 as described in Section 4.12.34.3 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

4.8.1.6.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including health-related social needs and a subsequent person-centered planning process.

4.8.1.6.3 The MCO's Prior Authorization requirements shall comply with parity in mental health and Substance Use Disorder, as described in Section 4.12.19.4 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.4 The MCO shall use the NH MCM standard Prior Authorization form, as applicable. The MCO shall also 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.

4.8.1.6.5 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

4.8.1.6.7 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely

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because of the diagnosis, type of illness, or condition of the Member.

4.8.1.6.8 The MCO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.8.1. The MCO shall not deny service authorization requests based solely on cost.

4.8.1.6.9 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.1.6.10 The MCO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.1.6.11 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)]

4.8.1.6.12 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.1.6.13 The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.14 Upon receipt of Prior Authorization information from the Department, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.2 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.15 In the event that the Prior Authorization specifies a specific Provider, that MCO shall continue to utilize

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that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network.

4.8.1.6.16 The MCO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.17 [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO shall ensure that medical necessity determinations by Subcontractors or any other party performing utilization review are made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease, and is actively licensed ~~are licensed in NH~~ in accordance with Section 3.10.2.4 (Contracts with Subcontractors) and Section 3.11.1.1.9.2 of this Agreement.

4.8.1.6.18 The MCO shall ensure that Subcontractors or any other party performing utilization reviews applicable to inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:

4.8.1.6.18.1. For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.

4.8.1.6.18.2. Reauthorization of the Member's continuous admission, shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.

4.8.2. **Practice Guidelines and Standards**

4.8.2.1. The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO shall:

4.8.2.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

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4.8.2.1.2 Consider the needs of the MCO's Members,

4.8.2.1.3 Be adopted in consultation with Participating Providers, and

4.8.2.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1-3); 42 CFR 438.236(b)(4)]

4.8.2.2. The MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

4.8.2.3. The MCO 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:

4.8.2.3.1 ASAM, as further described in Section 4.12.27 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.3.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adult, adolescent, and pediatric populations, rated A or B; as well as State specified requirements which include, but are not limited to, pediatric lead testing rates of fifty-five percent (55%) for 12-month olds and forty-four percent (44%) for 24 month olds in the first year of the Agreement, increasing by five percent 5% each year thereafter until the final year of the Agreement when the goals will be seventy-five percent (75%) for 12-month olds and sixty-four percent (64%) for 24-month olds.

4.8.2.3.3 The preventive services recommended by the AAP Bright Futures program; and

4.8.2.3.4 The Zero Suicide Consensus Guide for Emergency Departments.

4.8.2.4. The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is reviewed by the Department prior to implementation.

4.8.2.5. The MCO shall disseminate Practice Guidelines to the Department and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

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4.8.2.6. The MCO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3. **Medical Necessity Determination**

4.8.3.1. The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.3.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2. For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Section 2.1 (Definitions).

4.8.3.3. For Members under twenty-one (21) years of age, per EPSDT, "Medically Necessary" shall be as defined in Section 2.1 (Definitions).

4.8.4. **Notices of Coverage Determinations**

4.8.4.1. The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2. Urgent Determinations and Continued/Extended Services

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4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.4.2.1.2. In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request and shall advise the Member or Member's representative of the specific information necessary to make a coverage determination.

4.8.4.2.1.3. 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.

4.8.4.2.1.4. 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 MCO's receipt of the specified additional information; or the end of the period afforded the

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Member or Member's representative to provide the specified additional information.

4.8.4.2.1.5. 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.

4.8.4.3. All Other Determinations

4.8.4.3.1 [Amendment #4:] Beginning July 1, 2026,t~~T~~he determination of all other authorizations for pre-service benefits (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed seven (7) ~~fourteen (14)~~ calendar days for ninety-five percent (95%) of standard requests after the receipt of a request. [42 CFR 438.210(d)]

4.8.4.3.2 [Amendment #4:] Beginning July 1, 2026, An extension of up to fourteen (14) calendar days after receiving the request is permissible ~~for non-diagnostic radiology determinations~~ if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.3 [Amendment #4:] Intentionally left blank.~~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-~~

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~~five (45) calendar days from receipt of the notice within which to provide the specified information.~~

4.8.4.3.4 [Amendment #4:] Beginning July 1, 2026, Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than seven (7) ~~fourteen (14)~~ calendar days after the earlier of:

4.8.4.3.4.1. The MCO's receipt of the specified additional information; or

4.8.4.3.4.2. The end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.3.4.3. When the MCO extends the timeframe, the MCO 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 MCO 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.

4.8.4.3.5 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 MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.4.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.7 [Amendment #4:] Beginning July 1, 2026, ~~Whenever there is an adverse determination, the MCO shall~~

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~~notify the ordering Provider and the Member. For an adverse standard authorization decision,~~ the MCO shall notify the requesting provider, and give the enrollee written notice of any decision ~~provide written notification~~ as expeditiously as the Member's condition requires, but may not exceed seven (7) ~~within three (3)~~ calendar days after receiving the request for service ~~of the decision~~. [42 CFR 438.10(d)]

4.8.4.3.7.1. [Amendment #4:] Beginning July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), the MCO shall provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request to the MCO. [42 CFR 438.210(d)] Reasons may be communicated via portal (may include existing payer messaging portal), fax, email, mail, or phone. [42 CFR 438.242(b)(8)]

4.8.4.3.8 The MCO shall provide Utilization Management Confidential Data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.8.5. **Advance Directives**

4.8.5.1. The MCO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:20.

4.8.5.2. The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.

4.8.5.3. The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.

4.8.5.4. The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]

4.8.5.5. The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

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4.8.5.6. The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.7. The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.8. The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9. Member Education and Incentives

4.9.1. General Provisions

4.9.1.1. The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by the Department, including the National Diabetes Prevention Program. The MCO shall also participate in other public health initiatives at the direction of the Department.

4.9.1.2. The MCO shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. The MCO shall encourage Members to take an active role in shared decision-making.

4.9.1.3. The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. The Department shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2. Member Health Education

4.9.2.1. The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

4.9.2.2. The MCO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3. Member Cost Transparency

4.9.3.1. The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with

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clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2. The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to permit Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3. The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) of this Agreement.

4.9.4. **Member Incentive Programs**

4.9.4.1. The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this section of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives described in Section 4.15 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.2. For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 [Amendment #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), except as specified in separate guidance.

4.9.4.2.3 The MCO shall submit to the Department for review and approval all Member Incentive Program plan proposals prior to implementation.

4.9.4.3. Within the plan proposal, the MCO shall include adequate assurances, as assessed by the Department, that:

4.9.4.3.1 The program meets the requirements of the Social Security Act; and

4.9.4.3.2 The program meets the criteria determined by the Department as described in Section 4.9.4.5 (Healthy

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Behavior Incentive Programs) and Section 4.9.4.6 (Reference-Based Pricing Incentive Programs) of this Agreement.

4.9.4.4. The MCO 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:

4.9.4.4.1 The number of Members in the program's target population, as determined by the MCO;

4.9.4.4.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.4.4.3 The total value of the incentive payments;

4.9.4.4.4 An analysis of the statistically relevant results of the program; and

4.9.4.4.5 Identification of goals and objectives for the next year informed by the data.

4.9.4.5. Healthy Behavior Incentive Programs

4.9.4.5.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.4.5.1.1. Incorporate incentives for Members who complete a HRA Screening, in compliance with Section 4.10.2 of this Agreement;

4.9.4.5.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.9.4.5.1.3. Address obesity;

4.9.4.5.1.4. Prevent diabetes;

4.9.4.5.1.5. [Amendment #1:] Support nicotine~~smoking~~ cessation;

4.9.4.5.1.6. Increase lead screening rates in one- and two-year old Members; and/or

4.9.4.5.1.7. Other similar types of healthy behavior incentive programs in

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consultation with the collaboration with the Department's Division of Public Health New Hampshire Tobacco Cessation Program, Quitline.

4.9.4.6. Reference-Based Pricing Incentive Programs

4.9.4.6.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO and on its website in compliance with the Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.6.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5. **Collaboration with New Hampshire Tobacco Cessation Programs**

4.9.5.1. [Amendment #1:] The MCO shall enter into a Provider or Subcontractor agreement to cover the cost of nicotine cessation services for youth (13-17 years), and adults without Copayment, Prior Authorization, or annual limits with Department approved nicotine quitline(s). ~~The MCO shall promote and utilize the Department-approved tobacco treatment quitline, 1-800-QUITNOW (1-800-784-8669) to provide:~~

4.9.5.1.1 [Amendment #1:] Intentionally left blank. ~~Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;~~

4.9.5.1.2 [Amendment #1:] Intentionally left blank. ~~Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;~~

4.9.5.1.3 [Amendment #1:] Intentionally left blank. ~~The following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by the Department; and~~

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4.9.5.1.4 [Amendment #1:] Intentionally left blank. ~~Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.~~

4.9.5.2. [Amendment #1:] The MCO shall cover the cost of nicotine cessation, including counseling visits, in addition to the quitline without Copayment, Prior Authorization, or duration/frequency or annual limits. ~~The MCO shall provide tobacco cessation treatment to include, at a minimum~~:

4.9.5.2.1 [Amendment #1:] Intentionally left blank ~~Tobacco cessation coaching/counseling in addition to the quitline~~;

4.9.5.2.2 [Amendment #1:] Intentionally left blank ~~In addition to the quitline, the following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by the Department~~;

4.9.5.2.3 [Amendment #1:] Intentionally left blank ~~In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release; and~~

4.9.5.2.4 [Amendment #1:] Intentionally left blank ~~Covered FDA-approved tobacco cessation prescription medications that qualify for rebates under the Medicaid Prescription Drug Rebate Program, including~~:

4.9.5.2.5 [Amendment #1:] Intentionally left blank ~~Non-nicotine prescription medications; and~~

4.9.5.2.6 [Amendment #1:] Intentionally left blank ~~Inhalers and nasal sprays.~~

4.9.5.3. [Amendment #1:] The MCO shall promote through its website and membership mailings the nicotine cessation quitlines: QuitNow-NH (quitnownh.org and 1-800-QUIT-NOW) for adults, and MYLIFEMYQUIT (nh.mylifemyquit.org and Text 36072) for children 13-17 years old.

4.9.5.3.1 [Amendment #1:] The MCO shall collaborate with the New Hampshire Tobacco Cessation Program (TPCP) within the Department's Division of Public Health

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Services to update and maintain a website presence for QuitNow-NH and resources for nicotine cessation.

4.9.5.3.2 [Amendment #1:] Quarterly, the MCO shall use claims data to identify Members receiving nicotine cessation counseling and mail promotional materials, as indicated by TPCP.

4.9.5.3.3 [Amendment #1:] The MCO shall participate in quitline data sharing with the TPCP by reporting on tobacco cessation activities in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.9.5.4. [Amendment #1:] The MCO shall report on tobacco cessation activities in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10. Primary Care and Prevention Focused Care Model

4.10.1 General Requirements

4.10.1.1. Under the Primary Care and Prevention Focused Care Model of Care, Primary Care services shall be furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant, or nurse practitioner, including alternative provider types as designated by the Department.

4.10.1.2. The MCO shall ensure that the Primary Care and Prevention Care Focused Care Model of Care shall be administered in accordance with this Agreement, including:

4.10.1.2.1 Assurance of comprehensive PCP participation in the Model of Care wholly supported by the MCO;

4.10.1.2.2 Guaranteed access to related services for all Members;

4.10.1.2.3 Delivery of services in a manner that are both clinically and developmentally appropriate, patient-focused, and that consider the Member's, parent's, caregiver's and other networks of support the Member may rely upon, in accordance with this Agreement and all applicable State and federal laws and regulations;

4.10.1.2.4 PCP (and other Providers who share responsibility for primary care of the Member) responsibility for Provider-Delivered Care Coordination as described at Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) of this Agreement consistent with Practice Guidelines and Standards required and stipulated in Section 4.8.2, including a plan for integration of these programs;

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4.10.1.2.5 Member's selection or assignment of a PCP within fifteen (15) calendar days of enrollment with the MCO;

4.10.1.2.6 Completion of the Member welcome call as stipulated at Section 4.4.11 (Welcome Call);

4.10.1.2.7 Member receipt of a Wellness Visit with their PCP, as defined in Section 4.10.3 (Wellness Visits), at least once annually. If the Member is assigned a new PCP, the MCO shall ensure the Member receives a Wellness Visit with the new PCP regardless of when the last Wellness Visit occurred with another Provider;

4.10.1.2.8 Initial and regular reporting to PCPs the names of Members attributed to the PCP's panel within thirty (30) calendar days of PCP assignment or selection, including the date of the attributed Member's last Wellness Visit and HRA Screening, as available, and/or the absence of such visit and screenings if there have been none;

4.10.1.2.9 Demonstration of the authentic engagement between the Member and PCP. At a minimum, as demonstrated through claim encounters initially within ninety (90) days of PCP selection/assignment, and routinely thereafter.

4.10.1.2.10 Provider reimbursement for provision of the following Member services:

4.10.1.2.10.1. Wellness Visits in accordance with Section 4.10.3 (Wellness Visits), including assurance there are no barriers to professional claim billing and payment outside of a Wellness Visit for U.S. Preventive Services Task Force (USPSTF) recommended services that utilize a standardized tool in the screening for obesity, anxiety, depression and suicide risk, unhealthy alcohol use, unhealthy drug use, and falls prevention;

4.10.1.2.10.2. HRA Screening as stipulated in Section 4.10.2 (Health Risk Assessment (HRA) Screening) can occur during a visit for any separate acute service and is not

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solely restricted to a Wellness Visit;

4.10.1.2.10.3. Preventive screenings in accordance with the Practice Guidelines and Standards (Section 4.8.2), including but not limited to the recommendations of the U.S. USPSTF for the provision of primary and secondary care for adult, adolescent, and pediatric populations, rated Level A or B and other preventive screening and services as required by the Department; and

4.10.1.2.10.4. Medically Necessary diagnostic and treatment Covered Services based on the findings or risk factors identified in the annual Wellness Visit, completion of a HRA Screening, or during routine, urgent, or emergent health care visits.

4.10.1.2.10.5. [Amendment #1:] Comprehensive Medication Reviews for Required Priority Population Members, and children and adults meeting Polypharmacy criteria as stipulated in Section 4.2.6.

4.10.1.2.11 Provider and Member incentives for completion of the following:

4.10.1.2.11.1. A Wellness Visit;

4.10.1.2.11.2. A HRA Screening; and

4.10.1.2.11.3. Preventive screenings.

4.10.1.3. Support the PCP to engage Members to complete the HRA Screening in accordance with Section 4.10.2.

4.10.1.4. [Amendment #1:] Intentionally left blankComprehensive Medication Reviews for children and adults meeting Polypharmacy criteria as stipulated in Section 4.2.6.

4.10.1.5. Provider-Delivered Care Coordination utilization of closed-loop referral processes in accordance with Section 4.11.7 (Provider-Delivered Care

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Coordination and Integration with Social Services and Community Care), including:

4.10.1.5.1 PCP initiation and coordination of closed-loop referrals for clinical and non-clinical services the Member needs, including but not limited to Behavioral Health Services and health-related social needs, with the Provider remaining engaged with clinical and non-clinical Provider(s) throughout the course of treatment for the referred service(s);

4.10.1.5.2 PCP adoption and utilization of closed-loop referral processes, and the Department's closed-loop referral system, as it becomes available, to promote efficiency and optimal communication among and between Providers; and

4.10.1.5.3 PCP education and training to ensure that the PCP knows when and how to utilize a closed-loop referral system.

4.10.1.6. The MCO shall ensure the Primary Care and Prevention Focused Model satisfies care and coordination of services as follows: [42.CFR 438.208]

4.10.1.6.1 The MCO shall ensure that each Member has a designated PCP who shall serve as an ongoing source of case appropriate to his or her needs and the Member shall be provided information on how to contact their designated PCP;

4.10.1.6.2 The MCO shall provide Care Management services for times at which a Member does not have an established and designated PCP (e.g., corrections populations, DCYF children and youth);

4.10.1.6.3 The MCO shall also cover Transitions of Care Management (TCM) codes for Participating Providers to perform care transition assistance including coordinating appropriate services between settings of care;

4.10.1.6.4 [Amendment #1:] The MCO shall make best effort to connect each Member to a PCP and to pay network PCPs to review the Member's HRA Screening results with the Member at least once annually or when the Member's circumstances or needs change significantly ~~pay network PCPs to conduct an initial screening of each Member's needs within ninety (90) calendar days of the effective date of enrollment for new Members~~;

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4.10.1.6.5 [Amendment #1:] The MCO shall request documentation from the Participating Provider regarding HRA Screenings ~~and initial screenings~~ of Member needs should the MCO determine that additional entities such as the State, PIHPs and PAHPs are serving the enrollee to prevent duplication of those activities;

4.10.1.6.6 The MCO shall ensure Participating Providers that furnish services to Members maintains and shares, as appropriate, Member health records in accordance with professional standards; and

4.10.1.6.7 The MCO shall ensure that in the process of coordinating care, each Member's privacy is protected in accordance with state and federal privacy requirements in to the extent that they are applicable. [45 CFR parts 160 and 164 subparts A and E]

4.10.1.7. The MCO shall collaborate with the other contracted Medicaid MCOs to offer training for Providers on the Primary Care and Prevention Focused Care Model in an efficient and effective manner that reduces the administrative burden of Providers.

4.10.2 **Health Risk Assessment (HRA) Screening**

4.10.2.1. The HRA Screening process shall identify the need for the Member's Care Coordination and Care Management services and the need for clinical and non-clinical services, including closed-loop referrals to specialists, not limited to Behavioral Health services Providers, and community resources.

4.10.2.2. The MCO shall implement a process to allow professional services billing and payment for Participating Providers who complete and review a Member's HRA Screening, and shall create incentive programs to facilitate the Participating Provider's completion and review of the HRA Screening.

4.10.2.3. [Amendment #1:] The MCO shall support and empower Providers to conduct and review a HRA Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of MCO enrollment and at least annually thereafter for all Members, and when the Member's circumstances or needs change significantly to identify Members who may have unmet health care needs. [42 CFR 438.208(c)(1)]

4.10.2.4. [Amendment #1:] The HRA Screening tool and methodology shall be the same for each MCO~~. The HRA Screening tool~~ and approved ~~shall be developed by the Department and made available for Provider use~~.

4.10.2.4.1 [Amendment #1:] The Provider may utilize an alternate HRA Screening tool that includes the minimum HRA Screening criteria specified by the Department in separate guidance.

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4.10.2.5. [Amendment #2] [Amendment #1:] The MCO shall ~~empower and~~ support and incentivize the PCP to engage Members to complete the HRA screening in an agency office/clinic setting, during a scheduled home visit or medical appointment. The HRA Screening may be conducted in-person or through a HIPAA compliant electronic means, telephonic means, or through completion of the written form by the Member. ~~The MCO shall make best efforts to verify the PCP has made at least three (3) reasonable attempts to contact a Member at the phone number and address most recently reported by the Member.~~ [42 CFR 438.208(b)(3)]

4.10.2.5.1 For Members determined eligible for Community Mental Health services pursuant to He-M 401, the MCO shall encourage the Member's PCP to coordinate completion of the HRA Screening (Section 4.10.2) with the Member's applicable Community Mental Health program (a Community Mental Health Center) or other Community Mental Health Provider, if the Member consents, to enable the Community Mental Health Provider to provide support for effective completion of the Health Risk Assessment Screening by the PCP and the Member.

4.10.2.6. The MCO shall report the number of Members who received a HRA Screening, using claims data, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10.2.7. [Amendment #1:] Intentionally left blankThe MCO shall share with the Department the results of any identification and assessment of Member's needs to prevent duplication of activities as described in separate guidance. [42 CFR 438.208(b)(4)]

4.10.2.7.1 [Amendment #1:] The PCP shall review HRA Screening data and make appropriate referrals to social service agencies or other entities whether the data is collected in-person, digitally or electronically, telephonically, ~~in-person, digitally or electronically, telephonically,~~ or through completion of the written form by the Member.

4.10.2.7.2 The Provider conducting the HRA Screening shall share Member HRA results with the MCO upon request.

4.10.2.8. The MCO shall ensure, through incentives or professional provider reimbursement, that the Participating Provider reviews the HRA Screening results and make appropriate referrals to social service agencies or other entities whether the HRA is collected in person, electronically, telephonically, or through completion of the written form by the Member.

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4.10.2.9. [Amendment #1:] Intentionally left blank.~~The Participating Provider conducting the HRA Screening shall share Member HRA Screening results with the MCO upon request.~~

4.10.2.10. The MCO shall ensure Participating Providers complete and review Member HRA Screenings at least annually as follows:

4.10.2.10.1 By the end of Year 1 (SFY 2025 (June 30, 2025)), the HRA minimum completion rate requirement is twenty percent (20%) of the plan's total membership;

4.10.2.10.2 By the end of Year 2 (SFY 2026 (June 30, 2026)), the HRA minimum completion rate requirement is forty percent (40%) of the plan's total membership;

4.10.2.10.3 By the end of Year 3 (SFY 2027 (June 30, 2027)), the HRA minimum completion rate completion rate requirement is sixty percent (60%) of the plan's total membership; and

4.10.2.10.4 By the end of Year 4 (SFY 2028 (June 30, 2028) and through the end of the contract term, the HRA minimum completion rate requirement is seventy-five percent (75%) of the plan's total membership.

4.10.2.11. [Amendment #1:] The evidence-based HRA Screening tool are described in separate guidance ~~shall identify, at minimum, the following information about Members~~:

4.10.2.11.1 [Amendment #1:] Intentionally left blank ~~Demographics~~;

4.10.2.11.2 [Amendment #1:] Intentionally left blank ~~Chronic and/or acute conditions;~~

4.10.2.11.3 [Amendment #1:] Intentionally left blank ~~Chronic pain;~~

4.10.2.11.4 [Amendment #1:] Intentionally left blank ~~The unique needs of children with developmental delays, Special Health Care Ne eds or involved with the juvenile justice system and child protection agencies (i.e., DCYF);~~

4.10.2.11.5 [Amendment #1:] Intentionally left blank ~~Behavioral Health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.12.10 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.12.20.4 (Comprehensive Assessment and Care Plans), and Section 4.12.26 (Provision of Substance Use Disorder Services);~~

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4.10.2.11.6 [Amendment #1:] Intentionally left blank ~~The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;~~

4.10.2.11.7 [Amendment #1:] Intentionally left blank Nicotine~~Tobacco C~~cessation needs;

4.10.2.11.8 [Amendment #1:] Intentionally left blank ~~Health-related social needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and~~

4.10.3 **[Amendment #1:] Intentionally left blank ~~Other factors or conditions about which the MCO shall need to be aware to arrange available interventions for the Member~~.**

4.10.4 **Wellness Visits**

4.10.4.1. For all Members the MCO shall support the Member to arrange a Wellness Visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs. If the Member changes their PCP, the MCO shall authorize a new Wellness Visit with the new PCP, even if within a calendar year of the last Wellness Visit with the previous PCP.

4.10.4.2. The Wellness Visit conducted by the PCP or other qualified Provider shall include health risk and social determinant of health screening assessments for the purpose of determining a Member's health wellness and development of a plan of care, including evaluations of:

4.10.4.2.1 Both physical and behavioral health, including screening for depression;

4.10.4.2.2 Mood, suicidality; and

4.10.4.2.3 Substance Use Disorder.

4.10.5 **Prior Authorization for Primary Care and Preventive Services**

4.10.5.1. Notwithstanding other provisions of Section 4.8.1.6, Prior Authorizations for any preventive services, as defined in Section 4.8.2.3.2 of this Agreement, and as stipulated to in Practice Guidelines and Standards at Section 4.8.2 shall be prohibited. This prohibition shall include medically appropriate follow-up testing related to the initial test results, as well as any claims or encounters associated with the PCP's coordination and collaboration with Behavioral Health Services to support the Member's participation in preventive services activities.

4.10.6 **Primary Care and Prevention Focused Care Model Implementation Plan**

4.10.6.1. The MCO shall submit a plan for implementing the Primary Care and Prevention Focused Care Model in accordance with Exhibit O: Quality and Oversight Reporting.

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4.11. Care Coordination and Care Management

4.11.1. General Requirements

4.11.1.1. The MCO shall be responsible for ensuring effective management, coordination, and Continuity of Care for all Members, including oversight of Provider-Delivered Care Coordination for the PCPs' attributed Members, and shall develop and maintain policies and procedures to address these responsibilities.

4.11.1.2. The MCO shall submit a plan at time of Readiness Review and implement procedures to facilitate integrated Provider-Delivered Care Coordination and MCO-Delivered Care Management to ensure each Member has an ongoing source of care appropriate to their needs, and includes procedures for confidentiality, consent, or informed consent. [42 CFR 438.208(b)]

4.11.1.3. The MCO shall ensure the services described in this section are provided for all Members who need Care Coordination regardless of their acuity level.

4.11.1.4. The MCO shall implement and monitor Provider-Delivered Care Coordination and MCO-Delivered Care Management, as appropriate, in order to achieve the following goals:

4.11.1.4.1 Improve care of Members;

4.11.1.4.2 Improve health outcomes;

4.11.1.4.3 Increase collaboration among the Member's Providers, including but not limited to Behavioral Health Services Providers;

4.11.1.4.4 Reduce inpatient hospitalizations including readmissions;

4.11.1.4.5 Improve Continuity of Care;

4.11.1.4.6 Improve transition planning;

4.11.1.4.7 Improve medication management;

4.11.1.4.8 Improve U.S. Preventive Services Task Force (USPSTF) recommended Level A and B preventive screenings; as well as State specified screenings

4.11.1.4.9 Reduce utilization of unnecessary Emergency Services;

4.11.1.4.10 Reduce unmet resource needs related to health-related social needs;

4.11.1.4.11 Decrease total costs of care; and

4.11.1.4.12 Increase Member satisfaction with their health care experience.

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4.11.1.5. The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, Behavioral Health Service Providers, and social service resources, and include related documentation in the Member Care Plan.

4.11.1.5.1 The MCO and its Participating Providers shall utilize, leverage and partner with the Department's closed-loop referral system, if available, or 2-1-1 NH if it is not, which is a New Hampshire statewide information and referral service, using closed-loop referral processes to ensure warm transfers are completed and outcomes are reported for all closed-loop referrals.

4.11.1.6. The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from another MCO. [42 CFR 438.208(b)(2)(ii)]

4.11.1.7. The MCO shall also implement procedures to coordinate services the MCO furnishes to the Required Priority Population Member with the services the Member receives in FFS Medicaid, including Medicaid dental services, as applicable. For other Members not included in the Required Priority Population, the PCP shall coordinate these services. [42 CFR 438.208(b)(2)(iii)].

4.11.1.8. The MCO shall provide Care Management support for Required Priority Population Members who utilize services not covered by this Agreement (e.g., Medicaid, commercial, or government health insurance programs). In such cases, the MCO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii-iv). The MCO shall use the Department's closed-loop referral solution, if available, to initiate and support the Required Priority Population Member's access to other services to which the MCO, or its applicable PCP or other Participating Provider is referring the Member.

4.11.2. **MCO-Delivered Care Management for Required Priority Populations**

4.11.2.1. Required Priority Populations are most likely to have Care Management needs that shall be met with the MCO-Delivered Care Management processes described in this Agreement.

4.11.2.2. The following high-risk groups are identified as Required Priority Populations in need of Care Management focus by the MCO:

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Contract Provision	Minimum Care Management Timeframe
[Amendment #1:] 4.11.2.2.1 Individuals who have required an inpatient admission for a behavioral health diagnosis and were discharged within the previous twelve (12) months;	[Amendment #1:] Beginning immediately upon MCO Notice of Discharge, then an additional twelve (12) calendar months after the month of discharge
[Amendment #4:] [Amendment #1:] 4.11.2.2.2 Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care ~~and/or those who have elected voluntary supportive services~~;	[Amendment #1:] Beginning immediately upon DCYF agency engagement, then an additional twelve (12) calendar months after the month of discharge
[Amendment #1:] 4.11.2.2.3 Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS);	[Amendment #1:] Beginning immediately upon MCO identification of low birth weight and/or neonatal abstinence syndrome (NAS) diagnoses, then an additional twelve (12) calendar months after the month of discharge
[Amendment #1:] 4.11.2.2.4 Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval[20]	[Amendment #1:] Beginning immediately upon MCO enrollment for 45 days prior to the scheduled release date, then an additional twelve (12) calendar months after the month of incarceration release
[Amendment #1:] 4.11.2.2.5 Other Required Priority Populations identified by the Department with advance notification to the MCO with an effective date for Care Management services within ninety (90) calendar days of written notice from the Department.	[Amendment #1:] As appropriate for new populations identified by the Department
[Amendment #2:] 4.11.2.2.6 Eligible incarcerated youth as defined by CAA section 5121	[Amendment #2:] Beginning 30-days prior to the scheduled release date, then an additional twelve (12) calendar months after the month of incarceration release

4.11.2.2.1 [Amendment #1:] ~~Individuals who have required an inpatient admission for a behavioral health diagnosis~~

[20] Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver available on July 18, 2023 at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request.pdf.

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and were discharged within the previous twelve (12) months;

4.11.2.2.2 [Amendment #1:] Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services;

4.11.2.2.3 [Amendment #1:] Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS);

4.11.2.2.4 [Amendment #1:] Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval; and

4.11.2.2.5 [Amendment #1:] Other Required Priority Populations identified by the Department with advance notification to the MCO with an effective date for Care Management services within ninety (90) calendar days of written notice from the Department.

4.11.2.3. [Amendment #1:] The MCO may identify other Members who may benefit from the plan's Care Management services as needed for Members in accordance with the clinical care needs of the Member; however, MCO-Delivered Care Management requirements specified in this Agreement apply only to the Required Priority Populations identified by the Department, which may be expanded from time to time with advance notification to the MCO.

4.11.2.4. [Amendment #2:] The MCO shall support reporting for Required Priority Populations as specified by Exhibit O: Quality and Oversight Reporting Requirements of this Agreement.

4.11.3. **Comprehensive Assessment**

4.11.3.1. [Amendment #1:] The MCO shall implement mechanisms to minimally conduct a Comprehensive Assessment for Required Priority Populations to identify whether a Member has Special Health Care Needs and any ongoing special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.208(c)(2)]

4.11.3.1.1 [Amendment #1:] The MCO shall, conduct an initial Comprehensive Assessment screening during a welcome call to assess care needs and to coordinate services for all existing and newly enrolled Members within ninety (90) calendar days of the Member's effective date of MCO enrollment for all new Members,

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including subsequent attempts if the initial attempt to contact the Member is unsuccessful. [42 CFR 438.208(b)(3) and (c)]

4.11.3.2. The Comprehensive Assessment shall identify a Member's health condition that requires a course of treatment that isok either episodic, which is limited in duration or significance to a particular medical episode, or requires ongoing Provider-Delivered Care Coordination or MCO-Delivered Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder).

4.11.3.3. [Amendment #1:] The Comprehensive Assessment shall be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that shall inform whether the Priority Population Member or other Member should receive Care Management, and shall inform the Member's ~~ongoing Care Plan and~~ treatment plan, as well as the Required Priority Population Member's Care Plan managed by the MCO. The MCO shall incorporate into the Comprehensive Assessment information obtained from Providers ~~as a result of Provider referral, or the Wellness Visit~~.

4.11.3.4. [Amendment #1:] ~~In addition to any initial Comprehensive Assessment cited at Section 4.11.3.1.1, t~~The MCO shall complete a Comprehensive Assessment within thirty (30) calendar days of identifying a Priority Population Member at the time of a welcome call or at any time a Member is identified as being part of a one or more Required Priority Population. ~~as being part of one or more Required Priority Population as identified~~ Methods for identifying Required Priority Population Members may include ~~through~~ Medicaid enrollment records, HRA Screening, risk scoring and stratification or other means at the MCO's discretion, or means as determined by the Department.

4.11.3.5. The MCO shall not withhold any Medically Necessary Covered Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.11.3.6. The MCO shall conduct the Comprehensive Assessment in a location of the Member's, parent's or guardian's choosing, as applicable, and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as family members, paid and natural supports as agreed upon and appropriate to the Member/Member's parent, if a minor, or guardian to the maximum extent practicable.

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4.11.3.7. Additionally, participation in the Comprehensive Assessment shall be extended to the Member's Care Team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs, Special Medical Services, and 1915(i) case managers as practicable, with Member consent to the extent required by State and federal law.

4.11.3.8. The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

4.11.3.8.1 Members' immediate care needs;

4.11.3.8.2 Demographics;

4.11.3.8.3 Education;

4.11.3.8.4 Housing;

4.11.3.8.5 Employment and entitlements;

4.11.3.8.6 Legal involvement;

4.11.3.8.7 Risk assessment, including suicide risk;

4.11.3.8.8 Other State or local community and family support services currently used;

4.11.3.8.9 Medical and other health conditions;

4.11.3.8.10 Physical, I/DDs;

4.11.3.8.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living (IADL)) including cognitive functioning;

4.11.3.8.12 Medications;

4.11.3.8.13 Available informal, caregiver, or social supports, including peer supports;

4.11.3.8.14 Current and past mental health and substance use status and/or disorders;

4.11.3.8.15 Health-related social needs; and

4.11.3.8.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).

4.11.3.9. The MCO shall provide to the Department a copy of the Comprehensive Assessment tool and all policies and procedures related to conducting the Comprehensive Assessment for the Department's review as part of Readiness Review and annually thereafter.

4.11.3.10. The MCO shall conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing Care Management:

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4.11.3.10.1 At least annually;

4.11.3.10.2 When the Member's circumstances or needs change significantly;

4.11.3.10.3 At the Member's request; and/or

4.11.3.10.4 Upon the Department's request.

4.11.3.11. The MCO shall share the results of the Comprehensive Assessment in writing with the Member's Care Team within 14 calendar days of completion of the assessment to inform care and treatment planning, with Member consent to the extent required by State and federal law.

4.11.3.12. The MCO shall report to the Department the following in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.11.3.12.1 Assessments conducted as a percentage (%) of total Members and by Required Priority Population category;

4.11.3.12.2 Assessments completed by a Subcontractor entity, such as but not limited to CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.11.3.12.3 Timeliness of assessments;

4.11.3.12.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other members of the local community based care team; and

4.11.3.12.5 Quarterly report of unmet resource needs, aggregated by county, based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.11.4. **Member Care Management Engagement**

4.11.4.1. [Amendment #2:] The MCO shall conduct Care Management in accordance with this Agreement and as specified in separate guidance which shall include assignment a designated Care Manager for every Required Priority Population Member.

4.11.4.2. [Amendment #4:] Intentionally left blank. ~~For any Member identified as part of a Required Priority Population relative to behavioral health, as described in this Agreement, and subsequently identified by the MCO as not needing Care Management, the MCO shall provide documentation to the Member's PCP and behavioral health provider(s), if applicable, of this decision, and to the Department. If, based on Member utilization data or consultation with the behavioral health provider, the Department notifies the MCO that the Member's~~

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~~utilization history is of continuing concern to the Department, such that Care Management is still warranted, the Department will notify the MCO and the MCO shall provide Care Management and designate a Care Manager for the Member.~~

4.11.4.3. Members selected for MCO-Delivered Care Management shall be informed of:

4.11.4.3.1 The nature of the Care Management engagement relationship;

4.11.4.3.2 Circumstances under which information shall be disclosed to third parties, consistent with State and federal law;

4.11.4.3.3 The availability of a grievance and appeals process;

4.11.4.3.4 The rationale for implementing Care Management services; and

4.11.4.3.5 The processes for opting out of and terminating Care Management services.

4.11.4.4. The MCO's Care Management responsibilities shall include, at a minimum:

4.11.4.4.1 Coordination of physical, mental health, Substance Use Disorder and social services using Provider engagement approaches not inconsistent with those described in this Agreement for certain Department identified Required Priority Populations and Behavioral Health Providers, including but not limited to Community Mental Health Programs and Certified Community Behavioral Health Centers, and other Providers providing Behavioral Health Services;

4.11.4.4.2 [Amendment #1:] Comprehensive medication review results and q~~Q~~uarterly medication reconciliation;

4.11.4.4.3 Monthly telephonic contact with the Member;

4.11.4.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the Care Plan for dissemination to care team participants;

4.11.4.4.5 Referral follow-up monthly;

4.11.4.4.6 Peer support;

4.11.4.4.7 Support for unmet resource needs;

4.11.4.4.8 Training on disease self-management, as relevant; and

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4.11.4.4.9 Transitional Care Management as defined in Section 4.11.6 (Transitional Care Management).

4.11.4.5. [Amendment #1:] The MCO shall convene an initial Care Team for each Required Priority Population Member receiving MCO-Delivered Care Management where necessary to improve health outcomes for the Member, dependent on a Member's needs ~~including~~, including but not limited to, the Member, caretaker(s) and guardian(s), PCP, behavioral health Provider(s), specialist(s), targeted case managers, children's behavioral health system coordinators, Critical Time Intervention coaches, Supportive Housing case~~ing~~ managers, transitional case managers, school personnel, nutritionist(s), and/or pharmacist(s) based on applicable need to participate to effectively support achievement of improved health outcomes for the Member.

4.11.4.6. The ongoing Care Team shall be chosen or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.11.4.7. The MCO shall identify the information necessary to support improved health outcomes for the Member to be shared among all Care Team participants concerned with a Member's care to achieve safer, more effective health care delivery and improved health outcomes for the Member, including how the Provider-Delivered Care Coordination and MCO-Delivered Care Management programs interface with the Member's PCP, behavioral health providers for mental illness, SMI, SPMI, SED, I/DD, and Substance Use Disorder, and other applicable specialist Providers and existing community resources and supports. The MCO shall communicate this information, with the Member or their parent(s)' or guardian(s)' consent in compliance with state and federal laws and regulations.

4.11.4.8. [Amendment #1:] The MCO shall maintain a Care Plan for the Required Priority Population Members and shall work in collaboration with the Member's Care Team ~~to identify responsibilities for the Member's Care Plan which is optimally maintained by the PCP, in collaboration with the Care Team participants~~ within thirty (30) calendar days of the completed Comprehensive Assessment to develop a Care Plan in accordance with [42 CFR 438.208].~~, for each Priority Population Member identified through a Comprehensive Assessment or other means as in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)]~~

4.11.4.8.1 The MCO shall ensure that each Provider furnishing services to Members maintains and shares Member health records in accordance with professional standards. [42 CFR 438.208(b)(5)]

4.11.4.8.2 The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with

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confidentiality requirements in 45 CFR 160 and 164, this Agreement, and all other applicable laws and regulations. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164]

4.11.4.8.3 The MCO shall develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.

4.11.4.8.4 The MCO shall contribute to the Member's Care Plan as follows:

4.11.4.8.4.1. At least quarterly;

4.11.4.8.4.2. When a Member's circumstances or needs change significantly;

4.11.4.8.4.3. At the Member's request;

4.11.4.8.4.4. When a re-assessment occurs; and

4.11.4.8.4.5. Upon the Department's request.

4.11.4.8.5 The MCO shall submit coordinating Care Plan processes to the Department for review as part of the Readiness Review process and annually thereafter.

4.11.4.9. The MCO shall track the Member's progress through routine Care Team conferences, the frequency to be determined by the MCO based on the Member's level of need.

4.11.4.10. The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the Care Team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring. Policies and procedures for discharge shall include a Member notification process.

4.11.4.11. For Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.11.5. MCO Care Managers

4.11.5.1. The MCO shall formally designate a Care Manager that is primarily responsible for MCO-Delivered Care Management for each Required Priority Population Member, including regular contact with the Member's PCP who is

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responsible for Provider-Delivered Care Coordination as defined in this Agreement.

4.11.5.2. The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.11.5.3. Care Managers shall have qualifications and competency in the following areas:

4.11.5.3.1 All aspects of person-centered needs assessments and Care Planning;

4.11.5.3.2 Motivational interviewing and self-management;

4.11.5.3.3 Trauma-informed care;

4.11.5.3.4 Cultural and linguistic competency;

4.11.5.3.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and

4.11.5.3.6 Adverse childhood experiences and trauma.

4.11.5.4. Care Managers shall be trained in the following:

4.11.5.4.1 Disease self-management;

4.11.5.4.2 Person-centered needs assessment and Care Planning including coordination of care needs;

4.11.5.4.3 Integrated and coordinated physical and behavioral health, including as they intersect with and are served within the State's Community Mental Health system, Substance Use Disorder system, and Children's Behavioral Health system;

4.11.5.4.4 The State's Behavioral Health Crisis Response system and available resources (for Care Managers with assigned Members with behavioral health needs);

4.11.5.4.5 Cultural and linguistic competency;

4.11.5.4.6 Family support; and

4.11.5.4.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.

4.11.5.5. 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.

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4.11.5.6. The MCO shall provide real-time, high-touch, Care Management for Required Priority Populations and consistent follow up with Providers and Members to assure that Members are making progress with their Care Plans.

4.11.5.7. The MCO shall design an effective Care Management structure for the Required Priority Population Members.

4.11.5.7.1 At a minimum by the measurement period ending June 30, 2026 (SFY 2026), the MCO shall have no less than fifty percent (50%) of each Required Priority Population in MCO-Delivered Care Management.

4.11.5.8. The MCO shall, as described in Section 4.11.6 (Transitional Care Management), demonstrate that it has active access to an Admission, Discharge, Transfer (ADT) data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital or DRF in real-time or near real-time.

4.11.5.8.1 The MCO shall ensure that ADT data from applicable hospitals be made available to the Member's PCP, behavioral health Providers, Care Team, and applicable community-based agencies within twelve (12) hours of the admission, discharge, or transfer.

4.11.6. **Transitional Care Management**

4.11.6.1. For all Members, the MCO shall be responsible, in collaboration with the Member's Care Team, as applicable, which may include the Member's PCP, behavioral health provider(s), specialist(s), targeted case managers, children's behavioral health system service coordinators, Critical Time Intervention coaches, Supportive Housing case managers, and transitional case managers, school personnel as needed, pharmacists, and others as appropriate, for managing transitions of care for all Members moving from one (1) clinical setting to another, including step-up or step-down treatment programs for Members in need of continued mental health and Substance Use Disorder services, to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

4.11.6.2. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management for all Members, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

4.11.6.3. The MCO shall develop policies and procedures for the Department's review, as part of Readiness Review and annually thereafter, which describe how transitions of care between settings shall be effectively managed including data systems that trigger notification that a Member is in transition.

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4.11.6.4. The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(12)]

4.11.6.5. The MCO shall have a documented process to, at a minimum:

4.11.6.5.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.11.6.5.2 Support continuity of care for Members when they move from home to foster care placement; foster care to independent living; return from foster care placement to community; change in legal status from foster care to adoption; or when the Member moves from one level of care to another within the State's behavioral health system for Community Mental Health, Substance Use Disorders, or children's behavioral health;

4.11.6.5.3 [Amendment #1:] Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's Care Plan when a Member of the Required Priority Population is hospitalized;

4.11.6.5.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.12.21 (Agreements for New Hampshire State-Owned Hospital Agreement(s) and Other State Determined IMDs for Mental Illness), and upon discharge from an ED due to a mental illness or substance use disorder; and

4.11.6.5.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.11.6.6. The MCO shall have an established process, inclusive of but not limited to use of the Department's event notification system and closed-loop referral solution, if available, to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs.

4.11.6.6.1 [Amendment #1:] The MCO shall interface with the Department's closed loop referral solution to support Members. The integration shall transfer information and data as necessary to facilitate Member referrals to participating closed loop referral providers.

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4.11.6.7. The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.11.6.8. The MCO shall demonstrate, at a minimum, it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real-time or near real-time.

4.11.6.9. The MCO shall ensure that ADT data from applicable hospitals be made available to PCPs, and behavioral health Providers within twelve (12) hours of the admission, discharge, or transfer.

4.11.6.10. The MCO shall ensure that Transitional Care Management includes, at a minimum:

4.11.6.10.1 Care Management or other services to ensure the Member's Care Plan continues;

4.11.6.10.2 Facilitating clinical hand-offs;

4.11.6.10.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

4.11.6.10.4 Communicating with the Member's PCP about discharge plans and any changes to the Care Plan;

4.11.6.10.5 Conducting medication reconciliation within forty-eight (48) business hours of discharge;

4.11.6.10.6 Ensuring that a Care Manager is assigned to manage the transition, and that the Care Manager collaborates with the Member's applicable Community Mental Health system, Substance Use Disorder system, or Children's Behavioral Health system providers to support the Member's effective transition and continuous access to needed services throughout the transitional period;

4.11.6.10.7 Follow-up by the assigned Care Manager, or otherwise designated member of the Member's care management team, within forty-eight (48) business hours of discharge of the Member;

4.11.6.10.8 Determining when a follow up visit should be conducted in a Member's home;

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4.11.6.10.9 Supporting Members to keep outpatient appointments; and

4.11.6.10.10 [Amendment #1:] A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care within 24 hours of enrollment with the MCO~~who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered~~.

4.11.6.11. The MCO shall assist with coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information.

4.11.6.12. The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.11.6.12.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.11.6.12.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge);

4.11.6.12.3 The hospital's evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.11.6.12.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented.

4.11.7. **Provider-Delivered Care Coordination and Integration with Social Services and Community Care**

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4.11.7.1. The MCO shall implement and provide administrative support of a Provider-Delivered Care Coordination Program that includes reimbursement and other incentives to enable Participating Providers to coordinate health-related and community support services for Members.

4.11.7.2. The MCO shall provide program administrative support that includes, at a minimum:

4.11.7.2.1 Secure transmission of data and other information to Providers about their attributed Members' service utilization and care coordination needs;

4.11.7.2.2 Provider assistance with securing:

4.11.7.2.2.1. Health-related services and community support services, including but not limited to housing, that can improve health and family well-being, including assistance filling out and submitting applications; and

4.11.7.2.2.2. Access to medical-legal partnership for legal issues adversely affecting health, subject to the availability and capacity of a medical-legal assistance Provider.

4.11.7.3. Provider education and training, including:

4.11.7.3.1.1. How to access information about community support services, and housing for Members; and

4.11.7.3.1.2. How to facilitate Member closed-loop referrals utilizing the Department's event notification system and closed-loop referral solution, if available, or another closed-loop referral solution.

4.11.7.3.2 [Amendment #1:] Incentivizing the Provider's use of closed-loop referrals for effective care coordination and reporting on related incentives in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.11.7.4. The MCO shall assist Providers to actively link Members with other State, local, and community programs that may provide or assist Members with health and social services including, but not limited to [42 CFR 438.208(b)(2)(iv)]:

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4.11.7.4.1 Juvenile Justice and Adult Community Corrections;

4.11.7.4.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

4.11.7.4.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.11.7.4.4 Public Health Agencies;

4.11.7.4.5 Schools;

4.11.7.4.6 The court system;

4.11.7.4.7 ServiceLink Resource Network;

4.11.7.4.8 2-1-1 NH;

4.11.7.4.9 Housing; and

4.11.7.4.10 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.11.7.5. The MCO shall report on the number of referrals for social services and community care provided to Required Priority Population Members by Member type, consistent with the format and content requirements in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12. Behavioral Health

4.12.1 General Coordination Requirements

4.12.1.1. This section describes the delivery and coordination of Behavioral Health Services and supports for mental health, Serious Mental Illness, Substance Use Disorders, and Serious Emotional Disturbances, delivered to children, youth and transition-aged youth/young adults, and adults.

4.12.1.2. The MCO shall ensure Behavioral Health Services are delivered in a manner that is both clinically and developmentally appropriate, and that considers the Member, parents, caregivers, and other networks of support the Member may rely upon.

4.12.1.3. The delivery of service shall be Member-centered and align with the principles of system of care, recovery, and resiliency.

4.12.1.4. The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal laws and regulations.

4.12.1.5. The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services, as authorized under the State's Medicaid State Plans and in accordance with the applicable NH Administrative

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Rules identified in this Agreement specific to Behavioral Health Services; ensuring continuity and coordination of care between covered physical health and Behavioral Health Services Providers; and requiring collaboration between physical health and Behavioral Health Providers.

4.12.1.6. The continuum of Behavioral Health Services shall include the following categories of Providers approved by the Department for providing one or more types of services under the State Medicaid Plan, certain Administrative Rules, and under contracts with the Department when necessary to ensure Member access to higher levels of care for Serious Mental Illness, Substance Use Disorder, Serious Emotional Disturbance, and I/DD:

4.12.1.6.1 **Mental Health Services**, including but not limited to psychotherapy, psychological evaluation and testing, authorized in the Medicaid State Plan under Attachment 3.1-A for Medical, Remedial Care and Services. These services shall be provided by appropriately licensed and certified Providers who are not providing the service on behalf of or under agreement with a Community Mental Health Program (also known as Community Mental Health Center) or a Community Mental Health Provider. The MCO shall not authorize payment of these services under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members who are currently eligible for that level of care under He-M 401 and which are only a covered service if provided by Community Mental Health Programs or Community Mental Health Providers.

4.12.1.6.2 **Community Mental Health Services** (CMH Services), authorized in the Medicaid State Plan under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members with current He-M 401 eligibility and which are provided by:

4.12.1.6.2.1. **Community Mental Health Programs** (CMH Programs), also known as Community Mental Health Centers (CMHC) that are currently approved by the Department pursuant to He-M 403; there are ten such programs in NH; or by

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4.12.1.6.2.2. **Community Mental Health Providers** (CMH Providers) that have been previously approved by the Commissioner of the Department of Health and Human Services to provide Community Mental Health Services identified in He-M 426.07-He-M 426.17 for which they have received approval to provide pursuant to He-M 426.04 and remain in compliance with the requirements specified in He-M 426.04.

4.12.1.6.3 **Substance Use Disorder Services** authorized in accordance with the Medicaid State Plan, He-W 513, and where applicable, He-W 300 for Opioid Treatment Programs (OTP).

4.12.2 **Behavioral Health Subcontracts**

4.12.2.1. If the MCO enters into a Subcontractor relationship with a behavioral health (Mental Health, Community Mental Health or Substance Use Disorder Provider) Subcontractor to provide or manage Behavioral Health Services, the MCO shall provide a copy of the agreement between the MCO and the Subcontractor to the Department for review and approval, including but not limited to any agreements with CMH Providers as required in Section 4.12.20 (Community Mental Health Services).

4.12.2.2. Such subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

4.12.2.3. The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to all requirements and guidelines, as outlined in Section 3.10 (Subcontractors).

4.12.3 **Promotion of Integrated Care**

4.12.3.1. The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

4.12.3.2. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall include in its Behavioral Health Strategy Plan

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and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.12.4 **Approach to Behavioral Health Services**

4.12.4.1. The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA[21] and reflect a focus on Recovery and resiliency.[22]

4.12.4.2. The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s).

4.12.4.3. The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

4.12.4.4. In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.12.5 **Behavioral Health Strategy Plan and Report**

4.12.5.1. The MCO shall submit to the Department an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the initial Plan shall address but not be limited to how the MCO shall:

4.12.5.1.1 Assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare;

4.12.5.1.2 Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.12.5.1.3 Assure the promotion of Integrated Care;

4.12.5.1.4 Reduce Psychiatric Boarding described in Section 4.12.20.16 (Psychiatric Boarding);

4.12.5.1.5 Reduce Behavioral Health Readmissions described in Section 4.12.11 (Reduction in Behavioral Health Readmissions and Emergency Department Utilization);

[21] Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at https://www.samhsa.gov/nctic/trauma-interventions.
[22] Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at https://www.samhsa.gov/recovery.

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4.12.5.1.6 Reduce Behavioral Health related emergency department utilization as described in Section 4.12.11 (Reduction in Behavioral Health Readmissions and Emergency Department Utilization);

4.12.5.1.7 Support the NH 10-Year Mental Health Plan23;

4.12.5.1.8 Assure the appropriateness of psychopharmacological medication;

4.12.5.1.9 Assure access to appropriate services;

4.12.5.1.10 Implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and

4.12.5.1.11 Other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.5.2. On an annual basis and in accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which shall include an effectiveness analysis of the initial Plan's program, policies and procedures.

4.12.5.2.1 The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination (i.e., enhanced Care Coordination and Care Management to minimize inpatient readmissions, emergency department utilization, and psychiatric boarding), and collaboration for physical health and Behavioral Health Services.

4.12.6 **Collaboration with the Department**

4.12.6.1. At the discretion of the Department, the MCO shall provide mental health and Substance Use Disorder updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.6.2. To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and the Department at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

[23] New Hampshire Department of Health and Human Services, New Hampshire 10-Year Mental Health Plan (January 2019), available on July 20, 2023 at https://www.dhhs.nh.gov/programs-services/health-care/behavioral-health/10-year-mental-health-plan#:~:text=The%2010-Year%20Mental%20Health%20Plan%20is%20the%20result,health%20needs%20of%20people%20across%20their%20life%20span

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4.12.6.3. Quarterly meetings shall also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O: Quality and Oversight Reporting Requirements. Progress and data reports shall be produced and exchanged between the MCO and the Department two (2) weeks prior to each quarterly meeting.

4.12.6.3.1 At each meeting, the MCO shall update the Department on the following topics:

4.12.6.3.1.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.12.6.3.1.2. Utilization of ACT services and any waitlists for ACT services;

4.12.6.3.1.3. Current EBSE rates;

4.12.6.3.1.4. Current compliance with New Hampshire Hospital discharge performance standards;

4.12.6.3.1.5. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.12.6.3.1.6. Updates regarding services identified in Section 4.12 (Behavioral Health);

4.12.6.3.1.7. Updates on Mental Health and Substance Use Disorder PIPs; and

4.12.6.3.1.8. Other topics requested by the Department.

4.12.6.4. For all Members, the MCO shall work in collaboration with the Department and the NH Suicide Prevention Council to promote suicide prevention awareness programs, including the Zero Suicide program.

4.12.6.5. The MCO shall submit to the Department, as specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, its implementation plan for incorporating the "Zero Suicide" program into its operations; the plan shall include, in addition to any other requirements specified in Exhibit O: Quality and Oversight Reporting Requirements related to the plan, how the MCO shall:

4.12.6.5.1 Incorporate efforts to implement standardized provider screenings and other preventative measures; and

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4.12.6.5.2 Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines and Standards).

4.12.7 **Primary Care Provider Screening for Behavioral Health Needs**

4.12.7.1. The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

4.12.7.2. At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary.

4.12.7.3. The MCO shall encourage PCPs and other Providers to use a screening tool approved by the Department, as well as other mechanisms to facilitate early identification of behavioral health needs.

4.12.7.4. The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

4.12.7.4.1 Demographic,

4.12.7.4.2 Medical,

4.12.7.4.3 Substance Use Disorder,

4.12.7.4.4 Housing,

4.12.7.4.5 Family & support services,

4.12.7.4.6 Education,

4.12.7.4.7 Employment and entitlement,

4.12.7.4.8 Legal, and

4.12.7.4.9 Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.12.7.5. The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

4.12.7.5.1 Depression screening (e.g., PHQ 2 & 9); and

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4.12.7.5.2 Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.12.8 **Referrals**

4.12.8.1. [Amendment #2:] The MCO shall ensure through its initial screening of new Members, Comprehensive Screening for Priority Population Members, ~~HRA Screening (Section 4.10.2) and~~ risk scoring and stratification, or other means at the MCO's discretion that Members with a potential need for Behavioral Health Services, particularly Required Priority Population Members as described in Section 4.11.2 (MCO-Delivered Care Management for Required Priority Populations) are identified by the MCO and appropriately and timely referred to a regionally available CCBHC or other behavioral health Providers if co-located care is not available.

4.12.8.2. [Amendment #2:] This shall include education about Behavioral Health Services, including the availability of CCBHCs, the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s).

4.12.8.3. [Amendment #2:] The MCO shall develop a referral process to be used by Participating Providers, including what information shall be exchanged and when to share this information, as well as notification to the Member's Care Manager. The referral process shall include information about regionally available CCBHCs, including warm hand-off referrals, at the time of a discharge from inpatient, institutional, or substance use disorder residential treatment.

4.12.8.4. The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know when and how to refer Members who need specialty Behavioral Health Services.

4.12.8.5. The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health needs when Integrated Care is not available.

4.12.8.6. The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider.

4.12.8.7. The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.12.9 **Prior Authorization for Behavioral Health Services**

4.12.9.1. As of September 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 517 for behavioral health drugs, including use of the universal online Prior Authorization form provided by the Department for drugs used to treat mental illness.

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4.12.9.2. The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.12.10 **Comprehensive Assessment and Care Plans for Behavioral Health Needs**

4.12.10.1. The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a Care Plan.

4.12.10.2. [Amendment #1:] For Required Priority Population Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by a~~n~~ Care Team~~integrated Provider team~~, the MCO shall maintain a Care Plan and ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and Care Plan development process as well as the ongoing provision of services.

4.12.11 **Reduction in Behavioral Health Readmissions and Emergency Department Utilization**

4.12.11.1. Within the MCO's annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O: Quality and Oversight Reporting Requirements, subject to approval by the Department, the MCO shall develop and detail its plan to reduce readmissions and emergency department utilization attributed to a Member's behavioral health. The plan shall include but is not limited to:

4.12.11.1.1 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs, and other CMH Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day, ninety (90)-day and one hundred and eighty (180)-day readmission.

4.12.11.1.2 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day readmission rates to acute care hospitals attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies

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within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.3 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day repeated ED utilization rates attributed to mental illness, to review Member specific data with each of the CMH Programs, and other CMH Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.4 The MCO's approach to monitoring Members' repeated ED utilization rates within thirty (30)-days and ninety (90)-days attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.5 The MCO's approach to ensuring Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Behavioral Health Services after discharge from inpatient or ED care due to a Behavioral Health reason, with sufficient frequency and amounts, to support the Member's progress on achieving their Behavioral Health goals.

4.12.11.1.6 For Members with readmissions to any inpatient psychiatric setting within thirty (30) days and one hundred and eighty (180) days, the MCO shall report on the CMH and related service utilization that directly proceeded readmission in accordance with Exhibit O: Quality and Oversight Reporting Requirements. This data shall be shared with the Member's CMH Program/CMH Provider, if applicable, and the Department in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.12.12 **Written Consent for Release of Behavioral Health Information**

4.12.12.1. Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider

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request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both, and primary care.

4.12.12.2. The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file.

4.12.12.3. The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.13 **Coordination Among Behavioral Health Providers**

4.12.13.1. The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.12.13.1.1 Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.12.13.1.2 Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.12.13.1.3 Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.12.13.1.4 Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

4.12.13.1.5 Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.12.14 **Member Service Line**

4.12.14.1. As further outlined in Section 4.4.10 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

4.12.14.2. The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a “warm transfer”).

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4.12.14.3. If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.12.15 **Provision of Services Required by Courts**

4.12.15.1. The MCO shall pay for all NH Medicaid State Plan services that are within the Managed Care Program including, but not limited to, assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care only when consistent with Medical Necessity for the service.

4.12.16 **Behavioral Health Member Experience of Care Survey**

4.12.16.1. The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

4.12.16.2. The survey shall be designed by the Department and the MCO's results shall be reported in accordance with Exhibit O: Quality and Oversight Reporting Requirements. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.12.17 **Behavioral Health Emergency Services**

4.12.17.1. The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services.

4.12.17.2. Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program.

4.12.17.2.1 [Amendment #1:] Intentionally left blank. ~~Mobile crisis services may be provided by CMH Programs outside of their designated CMH Region to ensure accessibility to Members in crisis 24 hours a day / 7 days a week and within the Geographic Access Standard requirement. Mobile crisis services provided outside of the applicable CMH region are also included.~~

4.12.17.2.2 CMH Program-delivered emergency services that are not delivered by mobile crisis teams, such as for use in determining whether involuntary emergency admission is required, and applying an existing client's crisis safety plan in an office setting, are also included in the meaning of emergency services, and shall be provided within the CMH Program's applicable CMH region only.

4.12.17.2.3 Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention and who have access to

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a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

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4.12.18 **Behavioral Health Training Plan**

4.12.18.1. [Amendment #2:] In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health service and accessibility capacity for Members within the state and to support the efforts of its Behavioral Health provider network to hire, retain and train qualified staff including, but not limited to, CCBHCs, CMH Programs, other Community Mental Health Providers of services covered under He-M 426, Substance Use Disorder harm reduction, treatment and recovery providers, and other providers of behavioral health services in the MCO's network that provide services under the Medicaid State Plan. The MCO shall ensure that any training provided to employees or Subcontractors of a CCBHC do not violate any specific training restrictions within the SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria, updated March 2023 and any subsequent revisions.[24]

4.12.18.2. The MCO shall coordinate its behavioral health training plan's training offerings with the Department to reduce duplication of training efforts, and shall submit the behavioral health training plan to the Department prior to program start, and annually thereafter, inclusive of the training schedule and target Provider audiences.

4.12.18.3. As part of the behavioral health training plan, the MCO shall also incorporate strategies to engage Providers in accessing the training opportunities, including explaining the benefits of participating in the training, how it may increase or improve provider competence, and how the knowledge gained will lead to improved quality of care. The MCO's approach shall include opportunities for skill-enhancement through its training opportunities and consultation, through either the MCO or other consultants with expertise in the subject of the training.

4.12.18.4. The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.12.18.4.1 Trauma Focused Cognitive Behavioral Therapy;

4.12.18.4.2 Trauma Informed Care;

4.12.18.4.3 Motivational Interviewing;

4.12.18.4.4 Interventions for Nicotine Education and Treatment;

4.12.18.4.5 Dialectical Behavioral Therapy (DBT);

4.12.18.4.6 Cognitive Behavioral Therapy;

4.12.18.4.7 Client Centered Treatment Planning;

4.12.18.4.8 Family Psychoeducation;

[24] [Amendment #2:] SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria available on November 21, 2024 at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

4.12.18.4.9 Crisis Intervention;

4.12.18.4.10 SBIRT for PCPs;

4.12.18.4.11 Depression Screening for PCPs;

4.12.18.4.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.12.18.4.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

4.12.18.5. The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.12.18.5.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

4.12.18.5.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.12.18.5.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.12.18.5.4 Cross training to ensure that Mental Health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive Mental Health training;

4.12.18.5.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.12.18.5.6 Clinical care integration models to Participating Providers; and

4.12.18.5.7 Community-based resources to address health-related social needs.

4.12.18.6. The MCO shall offer a minimum of two (2) hours of training each Agreement year to all contracted CMH Program staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the Department's objective of reducing the number of suicides in NH.

4.12.18.7. The MCO shall provide, on at least an annual basis, training on appropriate billing practices to Participating Providers. The Department reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

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4.12.18.8. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.12.19 **Parity**

4.12.19.1. The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.12.19.2. Semi-Annual Report on Parity

4.12.19.2.1 The MCO shall complete the Department's Parity Compliance Report which shall include, at a minimum:

4.12.19.2.1.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCO pursuant to the Department's criteria;

4.12.19.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.12.19.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.12.19.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.12.19.2.1.5. Any other requirements identified in Exhibit O: Quality

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and Oversight Reporting Requirements. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.12.19.2.2 The MCO shall review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities.

4.12.19.2.3 The MCO shall annually submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

4.12.19.2.4 If the MCO determines that any administrative, clinical, or utilization practices were not in compliance with relevant requirements of the federal Mental Health Parity Law or guidance issued by State and federal entities during the calendar year, the certification shall state that not all practices were in compliance with federal Mental Health Parity Law or any guidance issued by state or federal entities and shall include a list of the practices not in compliance and the steps the MCO has taken to bring these practices into compliance.

4.12.19.2.5 A Member enrolled in any MCO may file a complaint with the Department at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance.

4.12.19.2.6 As described in Section 4.4 (Member Services), the MCO shall describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.12.19.3. Prohibition on Lifetime or Annual Dollar Limits

4.12.19.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

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4.12.19.4. Restrictions on Treatment Limitations

4.12.19.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.12.19.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.12.19.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO shall provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.12.19.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for Community Mental Health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.12.20 **Community Mental Health Services**

4.12.20.1. General Requirements

4.12.20.1.1 The MCO shall be required to enter into a Department approved capitation model of contracting with every CMH Program that is currently approved by the Department pursuant to NH Code of Administrative Rules, Chapter He-M 403, which is essential to

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supporting Member access to the full continuum of Community Mental Health Services under NH Code of Administrative Rules, Chapter He-M 426 in the MCM program. The MCOs shall utilize a Department provided standard contract for this purpose to ensure continuity of services and care across the Community Mental Health Services systems for Members.

4.12.20.1.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by the Department no later than ninety (90) calendar days after the MCM program's Agreement execution.

4.12.20.1.3 For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in September 2024.

4.12.20.1.4 The MCO shall be subject to payment requirements described in Section 4.16 (Provider Payments).

4.12.20.1.5 The MCO shall comply with key administrative functions and processes for CMH Services delivered by CMH Programs (CMHCs), which may include, but are not limited to:

4.12.20.1.5.1. Timely processing of CMH Services Member eligibility lists, which shall be provided to the MCO by the CMH Programs and shall indicate the Member's eligibility for CMH Services pursuant to the eligibility categories under NH Code of Administrative Rules, Chapter He-M 401. The MCO shall validate the eligibility lists through a process developed in collaboration with the CMH Programs and approved by the Department;

4.12.20.1.5.2. Determining whether Members are eligible for the DHHS-required CMH Services Capitation Payments to CMH Programs, or whether the CMH Program should be paid on a

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FFS basis for the service the Member received;

4.12.20.1.5.3. Providing detailed MCO data submissions to DHHS and the CMH Program for purposes of reconciling payments and performance pursuant to the MCO-CMH Program Contract, and for CMH Services provided by a CMH Provider not under subcontract with a CMH Program for the applicable service for purposes of reconciling payments and performance (e.g., 835 file);

4.12.20.1.5.4. Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs by CMH Region, as defined in NH Code of Administrative Rules, Chapter He-M 425, and with CMH Providers not under subcontract with a CMH Program, to ensure Members have access to Substance Use Disorder treatment services they may need from other providers, if not provided by the CMH Program or the CMH Provider under NH Code of Administrative Rules, Chapter He-M 426; and

4.12.20.1.5.5. Monitoring of CMH Program performance through quality metrics and oversight procedures

4.12.20.1.5.6. Ensuring compliance with this Agreement, where applicable, and all applicable State and federal laws, rules and regulations.

4.12.20.1.5.7. Overseeing, enforcing, and remedying contract disputes

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between the MCO and CMH Program.

4.12.20.1.5.8. All additional capabilities set forth by DHHS during the Readiness Review process.

4.12.20.1.6 [Amendment #2:] In the event a CMH Program is designated by the Department as a Certified Community Behavioral Health Clinic, the MCO shall enter into a different contractual relationship and payment model for the payment and delivery of the full continuum of Community Mental Health Services delivered by the agency, Mental Health Services available at lower levels of care, and applicable Substance Use Disorder services as described in Section 4.16 (Provider Payments).

4.12.20.2. MCO Agreements and Payment for Community Mental Health Services – CMH Providers

4.12.20.2.1 Consistent with 4.14, Network Requirements, the MCO shall maintain and monitor a network of CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who are eligible for such services in accordance with He-M 401.

4.12.20.2.2 The MCO shall provide for monitoring of CMH Provider performance through quality metrics and oversight procedures detailed in the MCO's provider or network agreement with each CMH Provider.

4.12.20.2.3 The MCO shall ensure that its agreements with CMH Providers meet the following requirements:

4.12.20.2.3.1. Comply with the requirements of this Agreement and all applicable State and federal laws, rules and regulations;

4.12.20.2.3.2. Define the role of the MCO versus the CMH Provider;

4.12.20.2.3.3. Include procedures for communication and coordination between the MCO and the CMH Provider, other Providers serving the same Member, CMH Programs as may be required by

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He-M 426 for CMH Provider provided services and the need to collaborate with the applicable CMH Program, and the Department;

4.12.20.2.3.4. Include provisions for data sharing on Members;

4.12.20.2.3.5. Include data reporting between the CMH Provider and the MCO and the Department; and

4.12.20.2.3.6. Include provisions for oversight, enforcement, and remedies for contract disputes.

4.12.20.2.4 The MCO shall ensure that Community Mental Health Services provided by CMH Providers are provided in accordance with the Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426.

4.12.20.2.5 This includes, but is not limited to, ensuring that Community Mental Health Services for which the CMH Provider is currently approved by the Department to provide, are appropriately provided to eligible Members.

4.12.20.2.5.1. [Amendment #2:] [Amendment #1:] Upon the termination of a Member's eligibility with the MCO, the MCO shall end date the Member's ~~CMH Program~~ behavioral health certification eligibility span in the next Behavioral Health Certification Data transmission provided to the Department.

4.12.20.2.6 For all Community Mental Health Services provided by a CMH Provider, the CMH Provider shall comply with He-M 426.04, including but not limited to, ensuring that all Members receiving CMH Services from the CMH Provider have been identified as currently eligible Members to receive CMH Services by a CMH Program, pursuant to He-M 401, and that the CMH Provider has a method for collaborative service planning and service delivery with the regional CMH Program, including joint development and approval of an Individual Service Plan for each Member.

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4.12.20.2.7 [Amendment #3:] Beginning January 1, 2026, the MCO shall provide each CMH Program with a monthly electronic 835 file for reconciling CMH program payments and services.

4.12.20.3. Community Mental Health Services Continuum

4.12.20.3.1 Eligible Members shall be offered the provisions of supports for illness self-management and recovery;

4.12.20.3.2 Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.

4.12.20.3.3 The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.12.20.3.4 As described in He-M 400, only Members who are currently eligible for Community Mental Health Services are eligible to receive Community Mental Health Services. Eligibility shall be determined by a CMH Program pursuant to He-M 401, due to a:

4.12.20.3.4.1. Severe or persistent mental illness (SPMI) for an adult;

4.12.20.3.4.2. SMI for an adult;

4.12.20.3.4.3. SPMI or SMI with low service utilization for an adult;

4.12.20.3.4.4. SED for a child; or

4.12.20.3.4.5. SED and interagency involvement for a child.

4.12.20.3.5 Any MCO quality monitoring or audits of the performance of the CMH Programs or of CMH Providers shall be available to the Department upon request.

4.12.20.3.6 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO shall meet with CMH Programs, CMH Providers, and the Department at least quarterly to coordinate data collection and ensure data sharing.

4.12.20.3.7 At a minimum, this shall include sharing of quality assurance activities conducted by the MCO and the Department and a review of quality improvement plans, data reports, Care Coordination activities, and

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outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.12.20.3.8 The MCO shall work in collaboration with the Department, CMH Programs and CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.12.20.4. Comprehensive Assessment and Care Plans

4.12.20.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of the Department administered quality service reviews for adults, that Community Mental Health Services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans.

4.12.20.4.2 [Amendment #1:] The MCO shall ensure that initial and updated Care Plans maintained by CMH Programs are based on a Comprehensive Assessment conducted and completed by a CMH Program using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

4.12.20.4.3 If the MCO, or a CMH Program acting on behalf of the MCO, elects to permit clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO shall notify and receive approval of the specific tool from the Department.

4.12.20.4.4 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by the Department within one hundred and twenty (120) calendar days of implementation by the Department of a web-based training and certification system.

4.12.20.4.5 The MCO shall require that CMH Program's certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by the Department for any newly evaluated Member and for

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an existing Member no later than at the Member's first eligibility renewal determination for CMH Services, following certification.

4.12.20.5. Assertive Community Treatment (ACT)

4.12.20.5.1 The MCO shall work in collaboration with DHHS, CMH Programs, and CMH Providers to ensure that Members identified as needing ACT services are provided ACT services pursuant to He-M 426.16, and in sufficient quantity to ensure applicable Members have appropriate access to these service.

4.12.20.5.2 In collaboration with the Department, the MCO shall support CMH Programs and CMH Providers, if applicable, to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with the Department to achieve full implementation of ACT.

4.12.20.5.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services.

4.12.20.6. Mental Health Performance Improvement Project

4.12.20.6.1 As outlined in Section 4.13.3.8 (Performance Improvement Projects), the MCO shall focus on the Department's objectives outlined in the NH MCM Quality Strategy.

4.12.20.7. Services for the Homeless

4.12.20.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

4.12.20.7.2 In its contract with CMH Programs, the MCO shall describe how it shall provide appropriate oversight of CMH Program responsibilities, including:

4.12.20.7.2.1. Identifying housing options for Members at risk of experiencing homelessness;

4.12.20.7.2.2. Assisting Members in filing applications for housing and

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gathering necessary documentation;

4.12.20.7.2.3. Coordinating the provision of supportive housing; and

4.12.20.7.2.4. Coordinating housing-related services amongst CMH Programs, the MCO and NH's Housing Bridge Subsidy Program.

4.12.20.7.3 The contract with CMH Programs shall require quarterly assessments and documentation of housing status and homelessness for all Members.

4.12.20.7.4 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) within twenty-four (24) hours upon release.

4.12.20.8. Supported Employment

4.12.20.8.1 In coordination with CMH Programs and CMH Providers, if applicable, the MCO shall actively promote an Evidence Based Supported Employment (EBSE) or an Individual Placement and Support Model of Supported Employment (IPS-SE) to eligible Members, whichever is the Department approved model pursuant to He-M 426.

4.12.20.8.2 The MCO shall obtain fidelity review reports from the Department to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program and CMH Provider, if providing supported employment services.

4.12.20.8.3 In collaboration with DHHS, the MCO shall support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the applicable model's Quality Improvement Plan on file with DHHS to achieve full implementation of the model.

4.12.20.8.4 Based on data provided by the Department, the MCO shall support DHHS's goals to ensure that at least nineteen percent (19%) of adult CMH eligible Members are engaged in a Department approved supported employment model of supported employment services and that employment status is

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updated by the CMH Program and CMH Provider, if applicable on a quarterly basis.

4.12.20.8.5 The MCO shall report the Supported Employment participation rate to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements and provide updates as requested by DHHS during regular behavioral health meetings between the MCO and the Department.

4.12.20.9. Illness Management and Recovery (IMR)

4.12.20.9.1 In coordination with CMH Programs and CMH Providers, if applicable, the MCO shall actively promote the delivery of, and increased penetration rates of, Illness Management and Recovery to Members with SMI and SPMI.

4.12.20.9.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and the Department.

4.12.20.10. Dialectical Behavioral Therapy (DBT)

4.12.20.10.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder.

4.12.20.10.2 The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by the Department during regular behavioral health meetings between the MCO and DHHS.

4.12.20.11. Peer Support Services (PSS)

4.12.20.11.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of PSS provided by Peer Support Specialists who are employees of CMH Programs.

4.12.20.11.2 The MCOs, in coordination with CMH Programs, the Department and Peer Support Agencies authorized by the Department under He-M 402, shall actively promote in a variety of settings, such as New Hampshire Hospital, primary care clinics, EDs, CMH Programs, and CMH Provider sites, the delivery of peer support services provided by Peer Support Agencies under He-M 402.

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4.12.20.11.3 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and DHHS on its efforts to promote Peer Support Services delivered in CMH Program and those provided by Peer Support Agencies under He-M 402.

4.12.20.12. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

4.12.20.12.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems25 for children and youth Members experiencing anxiety, depression, trauma and conduct issues.

4.12.20.12.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.13. First Episode Psychosis

4.12.20.13.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis.

4.12.20.13.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.14. Child Parent Psychotherapy

4.12.20.14.1 In coordination with CMH Programs, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children.

4.12.20.14.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.15. Changes in Healthy Behavior

4.12.20.15.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities.

4.12.20.15.2 [Amendment #1:] Efforts can encompass interventions (e.g., ~~tobacco~~nicotine cessation, "InShape") or other efforts designed to improve health.

[25] Available at: http://www.practicewise.com/portals/0/match_public/index.html.

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4.12.20.15.3 The MCO shall gather smoking status data on all Members and report to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.20.15.4 The MCO shall support CMH Programs to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.12.20.16. Psychiatric Boarding

4.12.20.16.1 The MCO shall provide assistance and support to Members, directly or through the Member's care team, to reduce the frequency and duration of the Member's wait for psychiatric services needed on an acute or crisis basis, regardless of the facility type best-suited to meet the Member's immediate care and treatment needs. The MCO's assistance shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or other State determined facility or IMDs for mental illness or Substance Use Disorder services.

4.12.20.16.2 At the request of the Department, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.12.20.16.3 The MCO shall pay no less than the rate paid by NH Medicaid FFS program for all inpatient and outpatient service categories for billable services related to psychiatric boarding.

4.12.20.16.4 The MCO's capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital or other State determined IMDs for mental illness or Substance Use Disorder services.

4.12.20.16.5 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.20.16.6 At minimum, the Plan shall address how:

4.12.20.16.6.1. The MCO identifies when its Members are in the ED awaiting psychiatric placement or in a

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hospital setting awaiting an inpatient psychiatric bed;

4.12.20.16.6.2. Policies for ensuring a prompt crisis team consultation and face-to-face evaluation;

4.12.20.16.6.3. Strategies for identifying placement options or alternatives to hospitalization; and

4.12.20.16.6.4. Coordination with the CMH Programs and CMH Providers, as applicable, serving Members.

4.12.20.16.7 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.12.20.17. Services [Amendment #2:] Certified Community Behavioral Health (CCBHC)

4.12.20.17.1 [Amendment #2:] Effective for dates of services on or after January 1, 2025, New Hampshire has been awarded a SAMHSA demonstration for CCBHCs. CCBHCs are comprehensive centers for behavioral health needs for all populations, and CCBHCs are required to serve anyone who requests care for mental health or substance use. Under the CCBHC model, CCBHCs are reimbursed through a cost based prospective payment methodology for CCBHC services.

4.12.20.17.2 [Amendment #2:] The MCO shall implement the CCBHC model in accordance with SAMHSA demonstration certification criteria and guidance specified by the Department, and shall support the CCBHCs in implementing the CCBHC model of care for Members.

4.12.20.17.3 [Amendment #2:] The MCO shall work with CCBHCs on quality improvement of required and optional CCBHC measures included in New Hampshire's demonstration. The MCO shall submit narrative

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reports describing their plan and activities supporting CCBHC quality improvement in accordance with Exhibit O: Quality and Oversight Reporting Requirements of this Agreement.

4.12.21 **Agreements for New Hampshire State-Owned Hospital Agreement(s) and Other State Determined IMDs for Mental Illness**

4.12.21.1. [Amendment #3:] The MCO shall utilize the Department's model contract for State-owned New Hampshire Hospital and ~~Hampstead Hospital~~ Covered Services.

4.12.21.2. This collaborative agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program and CMH Provider, as applicable, to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and State-Owned Hospitals and other State determined IMDs for mental illness.

4.12.21.3. The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to State-Owned Hospitals and other State determined IMDs for mental illness.

4.12.21.4. Prior to admission to State-Owned Hospitals or other State determined IMDs for mental illness, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist.

4.12.21.5. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to State-Owned Hospitals and determine whether all available less restrictive alternative services and supports are unsuitable.

4.12.22 **Discharge Planning**

4.12.22.1. The MCO shall ensure that upon discharge from a State-Owned Hospital, inpatient psychiatric facility, or other State determined IMDs for mental illness, the Member has immediate access to an appropriate living situation rather than a homeless shelter.

4.12.22.2. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

4.12.22.3. At the Department's option, the MCO shall designate an off-site liaison with privileges to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to State-Owned Hospitals or other State determined IMDs for mental illness.

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4.12.22.4. In the event the Member is attributed to a CMH Program upon their admission or discharge, the MCO's liaison shall assist and collaborate with the applicable CMH Program to expedite discharge and engagement in ongoing CMH Services provided by the CMH Program or CMH Provider, as may be applicable, which may include the Member's participation in Critical Time Intervention, Supportive Housing Services, or other Department approved evidence based practices covered as an In Lieu of Service, a 1915(i) service, or under a Department approved contract for Transitional Housing Services.

4.12.22.5. In the event the Member is not attributed to a CMH Program upon admission or discharge, the MCO's shall actively participate in State-Owned Hospital and other State determined IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

4.12.22.6. The MCO shall actively participate, and assist State-Owned Hospitals and other State determined IMDs for mental illness staff in the development of a written discharge plan within twenty-four (24) hours of admission.

4.12.22.7. [Amendment #2] The MCO shall ensure that the final ~~State-Owned Hospitals or other State determined IMDs for mental illness~~ discharge instruction sheet ~~shall~~ be provided to the Member and the Member's authorized representative prior to discharge, or the next business day after the discharge, for at least ninety-eight percent (98%) of Members discharged from State-Owned Hospitals or other State determined IMDs for mental illness.

4.12.22.8. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.12.22.9. For ACT team service recipients, the MCO shall ensure that the discharge progress note is provided to the CMH Program or CMH Provider, if applicable, within twenty-four (24) hours of Member discharge.

4.12.22.10. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.12.22.11. The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from State-Owned Hospitals and other State determined IMDs for mental illness in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.12.22.12. The performance metric shall be that one hundred percent (100%) of Members discharged shall have been attempted to be contacted within three (3) business days.

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4.12.22.12.1 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member within twenty-four (24) hours.

4.12.22.12.2 The MCO shall ensure an appointment with a CMH Program or CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member.

4.12.22.13. Such appointment shall occur within seven (7) calendar days after discharge.

4.12.22.14. Members receiving ACT team services shall be seen within twenty-four (24) hours of discharge by the applicable CMH Program or CMH Provider.

4.12.22.15. For Members discharged from psychiatric hospitalization who are not currently attributable to a CMH Program, the Member shall have an intake appointment that is scheduled to occur with the CMH Program assigned to the CMH Region in which the Member resides within seven (7) calendar days after discharge.

4.12.22.16. The MCO shall work with DHHS and the applicable CMH Program and CMH Provider to review cases of Members that New Hampshire Hospital and other State determined IMDs for mental illness have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

4.12.23 **Administrative Days and Post Stabilization Care Services**

4.12.23.1. The MCO shall perform Member in-reach activities within State-Owned Hospitals and other State determined IMDs for mental illness and other State determined IMDs for mental illness designed to accomplish transitions to the community in collaboration with the CMH Program applicable to the CMH Region to which the Member's town of residence is attributed. These activities shall include, but not be limited to:

4.12.23.1.1 The MCO's use of the Department's event notification system and closed-loop referral solution, if available, to facilitate sharing of clinical, care, transition to other levels of care, discharge planning, CMH eligibility assessment, and final discharge information;

4.12.23.1.2 The MCO's and CMH Program's meaningful and effective collaboration with applicable members of the IMD's care team assigned to the Member to ensure that the MCO and CMH Program are appropriately informed of the Member's ongoing care needs post-discharge.

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4.12.23.1.3 In the event the Member declines to consent to the CMH Program's involvement in discharge planning and the CMH Program becoming their post-discharge ongoing provider of CMH Services, the MCO shall follow this same approach to in-reach activities utilizing the Member's CMH Provider, if applicable, or other Mental Health Services provider of covered services at levels lower than CMH Services. In such cases, the MCO shall directly, or through the other CMH Provider or Mental Health services, connect, in sufficient frequency and effective duration, with the Member post-discharge to ensure the Member's access to the post-discharge services is sufficient to support the Member's continued progress toward achieving the behavioral health related goals.

4.12.24 **Substance Use Disorder**

4.12.24.1. The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including but not limited to, Chapter 420-J, Section J:15 through Section J:19 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.12.24.2. In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.12.24.3. The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.12.25 **Contracting for Substance Use Disorder**

4.12.25.1. The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.[26]

4.12.25.2. The contract between the MCO and the Substance Use Disorder programs and Participating Providers shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.10.2 (Contracts with Subcontractors).

4.12.25.3. The contract shall, at minimum, address the following:

4.12.25.3.1 The scope of services to be covered;

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

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4.12.25.3.2 Compliance with the requirements of this Agreement and applicable State and federal law;

4.12.25.3.3 The role of the MCO versus the Substance Use Disorder program and/or Provider;

4.12.25.3.4 Procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider;

4.12.25.3.5 Other Providers serving the same Member, and DHHS as applicable;

4.12.25.3.6 The approach to payment, including payment for MAT services;

4.12.25.3.7 Data sharing on Members;

4.12.25.3.8 Data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and

4.12.25.3.9 Oversight, enforcement, and remedies for contract disputes.

4.12.25.4. The contract shall provide for monitoring of Substance Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.12.25.5. When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the State through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract.

4.12.25.6. Intentionally left blank.

4.12.25.7. When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.12.26 **Provision of Substance Use Disorder Services**

4.12.26.1. The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513, this includes but is not limited to all of the MCO's Substance Use Disorder service providers' compliance with the Covered Services provisions in He-W 513.0 applicable to their provider type, to Opioid Treatment Programs, other Substance Use Disorder Treatment, and Recovery Services providers. This includes, but is not limited to:

4.12.26.1.1 Ensuring that the full continuum of care is appropriately provided to eligible Members including, but not limited to the provision of treatment and services that meet the Member's assessed ASAM level of care needs, and subject to the following

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additional conditions associated with certain providers of Substance Use Disorder services:

4.12.26.1.1.1. For those providers for whom the MCO is contracted with under a Department-approved directed payment model, such as Community Mental Health Programs, or a prospective payment system model, such as Certified Community Behavioral Health Clinics, the MCO's obligation to ensure the provision of the continuum of care shall be achieved through the MCO's review of services provided to Members, audits of clinical records no less than annually, and through its collaboration between those providers and the balance of the Member's care team, as appropriate;

4.12.26.1.1.2. Ensuring that eligible Members are provided with recovery support services; and

4.12.26.1.1.3. Ensuring that eligible Members are provided with coordinated care by the current treatment program provider and the provider(s) to whom the Member is being referred for ongoing treatment and services when entering or leaving a treatment program.

4.12.26.1.2 For those providers for whom the MCO is contracted with under a Department-approved directed payment model, such as Community Mental Health Programs, or a prospective payment system model, such as Certified Community Behavioral Health Clinics, the MCO's obligation to ensure the provision of coordinated care shall be achieved through the MCO's direct involvement that facilitates connection between the providers, or at minimum confirms that the connection has been made between the providers.

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4.12.26.1.3 In the event the MCO cannot ensure or otherwise confirm that the Member has been connected to subsequent treatment or other services identified as necessary for the Member, within a time period that is sufficient to support effective continuity of care, including authorization of pharmacotherapy, the MCO shall contact the Member directly to facilitate connection to such services.

4.12.26.2. The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513, through mechanisms including but not limited to claims utilization review, record audits, reauthorizations when applicable, and provider enrollment qualifications and certification audits.

4.12.26.2.1 The MCO shall conduct reviews and audits of clinical records and claims for Members receiving Substance Use Disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP), as described in separate guidance.

4.12.26.2.2 For Providers of Substance Use Disorder services that are delivered through CMH Programs under a Department approved APM, and Certified Community Behavioral Health Clinic under a Department approved PPS, this shall be limited to analysis of utilization patterns, provider and Department released quality reviews, and MCO conducted audits as required by the Department in this Agreement.

4.12.26.3. The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes, including, but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.12.26.4. The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.12.26.5. This includes, but is not limited to:

4.12.26.5.1 Ensuring that Members at-risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and

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4.12.26.5.2 Providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether a Peer Recovery Support Service (PRSS) is an aspect of an additional service provided to the Member.

4.12.26.6. The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.

4.12.26.7. The provision of services to recipients enrolled in an MCO shall not be subject to more stringent service coverage limits than specified under this Agreement or State Medicaid policies.

4.12.27 **Substance Use Disorder Clinical Evaluations and Treatment Plans**

4.12.27.1. The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

4.12.27.2. A clinical evaluation is a biopsychosocial evaluation completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.

4.12.27.3. The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013 or as revised by ASAM.

4.12.27.4. The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission.

4.12.27.5. For a Member being transferred from or otherwise referred by another Provider, the Provider shall use the clinical evaluation completed by a licensed behavioral health professional from the referring agency, which may be amended by the receiving Provider.

4.12.27.6. [Amendment #2:] The Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation (or three (3) sessions, if the Member is meeting with an outpatient treatment provider no more than once per week), that addresses problems in all ASAM ~~2013~~ domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).

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4.12.27.7. The treatment plan shall include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.12.27.8. [Amendment #2:] Treatment plans shall be updated based on any changes in any ASAM domain and at minimal intervals as described by ASAM ~~(2013)~~ for each level of care.

4.12.27.9. Treatment plan updates shall include:

4.12.27.9.1 Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.12.27.9.2 Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives, as appropriate;

4.12.27.9.3 The Provider's assessment of whether or not the Member needs to move to a different level of care based on ASAM continuing care, transfer and discharge criteria; and

4.12.27.9.4 The signature of the Member and the Provider agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.12.28 **Substance Use Disorder Performance Improvement Project**

4.12.28.1. In compliance with the requirements outlined in Section 4.13.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum, conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.12.29 **Reporting**

4.12.29.1. The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O: Quality and Oversight Reporting Requirements including, but not limited to, measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment retention, safety monitoring, and service utilization.

4.12.29.2. The MCO shall provide, in accordance with Exhibit O: Quality and Oversight Reporting Requirements, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns.

4.12.29.3. The MCO shall conduct reviews and audits of clinical records and claims for Members receiving Substance Use Disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).

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4.12.29.4. The MCO shall utilize audit tool(s) provided by or approved by DHHS, collected via one or more mediums made available or approved by DHHS, to assess the activities of Substance Use Disorder Providers and Opioid Treatment Programs (OTPs), to ensure compliance with the He-W 513 rules, He-A 304 rules, and the MCO Contract, and this Agreement. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.12.29.4.1 The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorders conducted by the MCO or on behalf of the MCO.

4.12.29.4.2 The MCO shall report on SUD Provider compliance with service provisions outlined in the SUD audit tool in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.29.5. [Amendment #2:] On a ~~monthly~~quarterly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members.

4.12.29.6. The MCO shall also provide annual training to Participating Providers.

4.12.30 **Services for Members Who are Homeless or At-Risk of Homelessness**

4.12.30.1. In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.12.20.7 (Services for the Homeless).

4.12.31 **Peer Recovery Support Services**

4.12.31.1. In coordination with Peer Recovery Programs and Peer Recovery Coaches, as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.12.32 **Naloxone Availability**

4.12.32.1. The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.12.33 **Prescription Drug Monitoring Program**

4.12.33.1. The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

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4.12.33.2. The Provider agreements shall require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

4.12.33.3. The MCO 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.

4.12.34 **Response After Overdose**

4.12.34.1. Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital.

4.12.34.2. Whenever a Member discharges themselves against medical advice, the MCO shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.12.34.3. Limitations on Prior Authorization Requirements

4.12.34.3.1 To the extent permitted under State and federal law, the MCO shall cover MAT.

4.12.34.3.2 Methadone received at a methadone clinic shall not require Prior Authorization.

4.12.34.3.3 Methadone used to treat pain shall require Prior Authorization.

4.12.34.3.3.1. Any Prior Authorization for office based MAT shall comply with RSA 420-J:17 and RSA 420-J:18.

4.12.34.3.4 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per treated Member.

4.12.34.3.5 In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.12.34.3.6 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.12.34.3.7 The MCO may require prior authorization for SUD treatments, excluding MAT services.

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4.12.34.3.8 The MCO shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

4.12.34.3.9 Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

4.12.34.3.10 [Amendment #2:] The MCO may require prior authorization for covered services only if the MCO has a medical clinician or licensed alcohol and drug counselor available on a 24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care, and the MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than 6 hours of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria, as ~~defined in~~ specified in Section 2.1.9.1 of this Agreement~~RSA 420-J:15, I~~.

4.12.34.3.11 The Department may grant exceptions to this provision in instances where it is necessary to prevent Fraud, Waste or Abuse.

4.12.34.3.12 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.4 (Pharmacy Clinical Policies and Prior Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.12.34.4. Opioid Prescribing Requirements

4.12.34.4.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members.

4.12.34.4.2 As required under the NH Board Administrative Rule MED 502 Opioid Prescribing, the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.12.34.4.2.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

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4.12.34.4.2.2. Random and periodic UDS; and

4.12.34.4.2.3. Utilizing written, informed consent.

4.12.34.4.3 The MCO shall ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED or more per day for longer than ninety (90) calendar days.

4.12.34.4.3.1. If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.12.34.5. Neonatal Abstinence Syndrome

4.12.34.5.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2.

4.12.34.5.2 Substance Use Disorder Care Management features shall include, but not be limited to:

4.12.34.5.2.1. Conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose).

4.12.34.5.2.2. Ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services.

4.12.34.5.2.3. Scheduling Substance Use Disorder treatment appointments and following up to

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ensure appointments are attended.

4.12.34.5.2.4. Coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies.

4.12.34.5.2.5. The MCO shall make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.12.34.5.3 The MCO shall work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed.

4.12.34.5.4 The MCO shall work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care.

4.12.34.5.4.1. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.12.34.5.5 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment protocol for infants at risk of NAS.

4.12.34.5.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.12.34.5.6.1. Opportunities for the primary care giver(s) to room-in;

4.12.34.5.6.2. Transportation and childcare for the primary care giver(s);

4.12.34.5.6.3. Priority given to non-pharmaceutical approaches

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(e.g., quiet environment, swaddling);

4.12.34.5.6.4. Education for primary care giver(s) on caring for newborns;

4.12.34.5.6.5. Coordination with social service agencies proving supports, including coordinated case meetings and appropriate developmental services for the infant;

4.12.34.5.6.6. Information on family planning options; and

4.12.34.5.6.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.12.34.5.7 The MCO shall work with the Department and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network's (NNEPQIN) standards.

4.12.34.6. Discharge Planning After Substance Use Disorder Event

4.12.34.6.1 In all cases where the MCO is notified or otherwise learns that a Member has had an ED visit or is hospitalized for an overdose or Substance Use Disorder, the MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan.

4.12.34.6.2 The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged.

4.12.34.6.3 The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.12.34.6.3.1. If a Member lacks a reasonable means of communicating with a

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plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.12.34.6.4 The MCO shall ensure that any referrals necessary to connect the Member to post-discharge treatment Provider(s) are made as closed-loop referrals prior to the Member's discharge, including those that may be necessary for an ASAM evaluation.

4.12.34.6.5 The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

4.12.34.6.6 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.12.34.6.7 At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.12.34.6.8 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member within twenty-four (24) hours.

4.12.34.6.9 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.12.34.6.10 [Amendment #1:] In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been treated in an ED~~seen~~ for more than three (3) overdose events within a thirty (30) calendar day period or ~~those~~ when the ED discharged Member with a behavioral health diagnosis has~~that have had a~~

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difficulty engaging in treatment services following referral and Care Management~~Coordination~~ provided by the MCO.

4.12.34.6.11 The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.13 Quality Management

4.13.1 General Provisions

4.13.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.13.1.2. The MCO shall work in collaboration with the Department, Members and Providers to actively improve the quality of care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement.

4.13.1.3. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.13.1.4. The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.13.1.5. The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.13.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.13.1.5.2 Foster data-driven decision-making;

4.13.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.13.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.13.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

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4.13.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.13.2 **Health Plan Accreditation**

4.13.2.1. The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module.

4.13.2.2. If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.13.2.3. If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date.

4.13.2.4. To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.13.2.4.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify the Department of the initiation of the process to obtain NCQA Health Plan Accreditation; and

4.13.2.4.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, the MCO shall notify the Department of the date of the scheduled on-site review.

4.13.2.5. The MCO shall inform the Department of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation.

4.13.2.6. The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to the Department, including [42 CFR 438.332(a)]:

4.13.2.6.1 Accreditation status, survey type, and level (as applicable);

4.13.2.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.13.2.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1-3)]

4.13.2.7. 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

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protocols and that the Department shall consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.13.2.8. An MCO going through an NCQA renewal survey shall complete the full Accreditation review of all NCQA Accreditation Standards.

4.13.2.9. During the renewal survey, the MCO shall:

4.13.2.9.1 Request from NCQA the full review of all NCQA Accreditation Standards and cannot participate in the NCQA renewal survey option that allows attestation for certain requirements; and

4.13.2.9.2 Submit to the Department a written confirmation from NCQA stating that the renewal survey for the MCO will be for all NCQA Accreditation Standards without attestation.

4.13.3 **Quality Assessment and Performance Improvement Program**

4.13.3.1. The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.13.3.2. The MCO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to the Department for its review annually.

4.13.3.3. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the QAPI Plan shall contain at a minimum, the following elements:

4.13.3.3.1 A description of the MCO's organization-wide QAPI program structure;

4.13.3.3.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.13.3.3.2.1. Department-required PIPs;

4.13.3.3.2.2. Department-required quality performance data;

4.13.3.3.2.3. Department-required quality reports; and

4.13.3.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.13.3.3.2.5. Mechanisms to detect both underutilization and

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overutilization of services; [42 CFR 438.330(b)(3)]

4.13.3.3.2.6. 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

4.13.3.3.2.7. 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)]

4.13.3.4. The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.13.3.5. The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.13.3.5.1 Is organization-wide, with clear lines of accountability within the organization;

4.13.3.5.2 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;

4.13.3.5.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.13.3.5.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

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4.13.3.6. If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by 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 MCO's QAPI Plan submitted to the Department annually.

4.13.3.7. 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.

4.13.3.8. Performance Improvement Projects

4.13.3.8.1 The MCO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.13.3.8.2 Throughout the contract period, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

4.13.3.8.2.1. At least one (1) clinical PIP shall have a focus on the Department's objectives outlined in the NH MCM Quality Strategy;

4.13.3.8.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.12.24 (Substance Use Disorder);

4.13.3.8.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by the Department;

4.13.3.8.2.4. If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the

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seventy-fifth (75th) percentile; and

4.13.3.8.2.5. Should no quality measure have a lower than seventy-fifth (75th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.13.3.8.3 Throughout the five-year contract term, the MCO shall conduct at least one (1) non-clinical PIP, which shall be related to one (1) of the following topic areas and approved by the Department:

4.13.3.8.3.1. Addressing health-related social needs; and

4.13.3.8.3.2. Integrating physical and behavioral health.

4.13.3.8.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

4.13.3.8.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.13.3.8.5.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.13.3.8.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.13.3.8.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.13.3.8.5.4. Planning and initiation of activities for increasing or

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sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.13.3.8.6 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.

4.13.3.8.7 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO 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 MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.13.3.8.8 At the sole discretion of the Department, the PIPs may be delayed in the event of a public health emergency.

4.13.4 **Member Experience of Care Survey**

4.13.4.1. The MCO shall be responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.13.4.1.1 CAHPS Health Plan Survey 5.1H, Adult Version or later version as specified by the Department;

4.13.4.1.2 CAHPS Health Plan Survey 5.1H, Child Version with Children with Chronic Conditions Supplement or later version as specified by the Department.

4.13.4.2. Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by the Department and indicated in Exhibit O: Quality and Oversight Reporting Requirements. Supplemental questions, including the number, are subject to NCQA approval each October preceding the survey fielding timeframe.

4.13.4.3. The MCO shall obtain the Department approval of instruments prior to fielding the CAHPS surveys.

4.13.5 **Quality and Administrative Reporting Deliverables**

4.13.5.1. Required quality and administrative reporting deliverables appear in this Agreement and/or in Exhibit O: Quality and Oversight Reporting Requirements. For ease of reference, the Department shall list quality deliverables in Exhibit O: Quality and Oversight Reporting Requirements where possible. When a reporting requirement is included in the Agreement, but not Exhibit O, or vice versa, the MCO shall still fulfill the requirement. These deliverables include:

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4.13.5.1.1 Quality measures;

4.13.5.1.2 Narrative Reports;

4.13.5.1.3 Plans; and

4.13.5.1.4 Templates.

4.13.5.2. The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with the submission frequency established in 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)]:

4.13.5.2.1 Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)] to include;

4.13.5.2.1.1. CMS Child Core Set of Health Care Quality deliverables for Medicaid and CHIP, as specified by the Department;

4.13.5.2.1.2. Deliverables included in any future CMS Universal Foundation Measure list;

4.13.5.2.1.3. CMS Adult Core Set of Health Care Quality Measures deliverables for Medicaid, as specified by the Department;

4.13.5.2.1.4. Deliverables indicated by the Department as a requirement for fulfilling CMS waiver requirements; and

4.13.5.2.1.5. Deliverables indicated by the Department as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.13.5.2.2 NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA.

4.13.5.2.2.1. The MCO shall include supplemental Confidential Data in HEDIS measures identified in Exhibit O: Quality and Oversight Reporting Requirements for NCQA Accreditation and

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reporting through the Interactive Confidential Data Submission System.

4.13.5.2.2.2. The MCO shall report Member level Confidential Data for audited HEDIS measures as identified in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.2.3 All available CAHPS measures and sections and additional supplemental questions defined by the Department;

4.13.5.2.4 Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts; and

4.13.5.2.5 Select measures specified by the Department as priority measures for use in assessing and addressing local challenges to high-quality care and access;

4.13.5.3. Where the Department, NCQA, CMS or other key stakeholders require the use of electronic clinical data in deliverable calculation, the MCO shall obtain this data as stipulated in measure specifications and by the measure stewards.

4.13.5.4. If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to the Department.

4.13.5.5. 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 MCO quality measure reporting requirements shall be communicated to MCOs and documented within a format similar to Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.6. The MCO shall report all quality deliverables in accordance with Exhibit O: Quality and Oversight Reporting Requirements, regardless of whether the MCO has achieved accreditation from NCQA.

4.13.5.7. The MCO shall submit all quality deliverables in the formats and schedule in Exhibit O: Quality and Oversight Reporting Requirements or otherwise identified by the Department.

4.13.5.8. The MCO shall work with the Department to ensure their understanding of Department deliverable specifications, deliverable submission processes, and deliverable review processes. This includes, as determined by the Department:

4.13.5.8.1 The MCO shall gain access to and utilize the NH Medicaid Quality Information System, to include participation in any Department-required training deemed necessary;

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4.13.5.8.2 The MCO shall gain access to and utilize the Department SharePoint site utilized for deliverables other than measures, to include any deliverables which contain confidential data;

4.13.5.8.3 The MCO shall attend all meetings with relevant MCO subject matter experts to discuss specifications for deliverables indicated in Exhibit O: Quality and Oversight Reporting Requirements; and

4.13.5.8.4 The MCO shall communicate and distribute all specifications and templates provided by the Department for deliverables in Exhibit O: Quality and Oversight Reporting Requirements, to all MCO subject matter experts involved in the production of deliverables in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.9. The Department shall provide the MCO, with a ninety (90) calendar day notice, any additions or modifications to the deliverables and quality deliverable specifications.

4.13.5.10. At such time as the Department provides access to Medicare Confidential Data sets to the MCO, the MCO 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 MCO shall:

4.13.5.10.1 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;

4.13.5.10.2 Include Medicare Confidential Data in the Department quality reporting; and

4.13.5.10.3 Sign Confidential Data use Agreements and submit Confidential Data management plans, as required by the Department and CMS.

4.13.5.10.4 For failure to submit required reports and quality Confidential Data to the Department, NCQA, the EQRO, and/or other Department-identified entities, the MCO shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

4.13.6 **Evaluation**

4.13.6.1. The Department shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O:

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Quality and Oversight Reporting Requirements, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.13.6.1.1 Performance on required quality measures; and

4.13.6.1.2 The MCO's QAPI Plan.

4.13.6.2. Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.13.6.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.13.6.2.2 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;

4.13.6.2.3 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;

4.13.6.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.13.6.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.13.6.3. The annual evaluation report, developed in accordance with Exhibit O: Quality and Oversight Reporting Requirements, shall be reviewed and approved by the MCO's governing body and submitted to the Department for review [42 CFR 438.330(e)(2)].

4.13.6.4. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as for posting on the web.

4.13.6.5. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of Quality Management activity are documented and reported on a semi-annual basis to the Department and reviewed by the appropriate individuals within the organization.

4.13.7 **Accountability for Quality Improvement**

4.13.7.1. External Quality Review

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4.13.7.1.1 The MCO shall collaborate and cooperate fully with the Department's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.13.7.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

4.13.7.1.3 To facilitate this process, the MCO shall supply information, including but not limited to:

4.13.7.1.3.1. Claims data,

4.13.7.1.3.2. Medical records,

4.13.7.1.3.3. Operational process details, and

4.13.7.1.3.4. Source code used to calculate performance measures to the EQRO as specified by the Department.

4.13.7.2. Auto-Assignment Algorithm

4.13.7.2.1 As indicated in Section 4.3.4 (Auto-Assignment), the auto-assignment algorithm shall, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members.

4.13.7.2.2 The measures used to determine auto-assignment shall not be limited to alignment with the priority measures assigned to the program MCM Withhold and Incentive Program, as determined by the Department.

4.13.7.3. Quality Performance Withhold

4.13.7.3.1 As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by the Department and indicated to the MCO in periodic guidance.

4.14 Network Management

4.14.1 Network Requirements

4.14.1.1. The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.14.1.1.1 Supported by written agreements; and

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4.14.1.1.2 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)]

4.14.1.2. In developing its Participating Provider network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.14.1.3. The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1); 42 CFR 455.101; Section 1932(d)(5) of the Act].

4.14.1.4. The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.14.1.5. The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.14.1.6. 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.

4.14.1.7. The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions. [42 CFR 438.3(q)(1)]

4.14.1.8. The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(3)]

4.14.1.9. The MCO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.14.1.10. The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.14.1.11. When contracting with DME Providers, the MCO shall contract with and have in its network all qualified Willing Providers in the State.

4.14.2 **Provider Enrollment**

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4.14.2.1. The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.14.2.2. The MCO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by the Department for determination of the MCO's network adequacy.

4.14.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.14.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the MCO.

4.14.2.2.3 The MCO 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.

4.14.2.3. The MCO 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.

4.14.2.4. If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.14.2.5. The requirements in 42 CFR 438.12(a) shall not be construed to:

4.14.2.5.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.14.2.5.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.14.2.5.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1-3)]

4.14.2.6. The MCO shall ensure that Participating Providers are enrolled with the Department 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]

4.14.3 Provider Screening, Credentialing and Re-Credentialing

4.14.3.1. The Department shall screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

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4.14.3.2. The MCO 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)]

4.14.3.3. The MCO 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.

4.14.3.4. The MCO 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)]

4.14.3.5. The MCO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)]

4.14.3.6. The MCO 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.

4.14.3.7. For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.14.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with the Department;

4.14.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.14.3.7.3 Concurrently work through MCO and the Department contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.14.3.7.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.14.3.7.4.1. Authorization of out-of-network services;

4.14.3.7.4.2. Single case agreements for an individual Member; and

4.14.3.7.4.3. If agreed upon by the prospective Participating

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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.

4.14.3.8. The MCO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.14.3.8.1 [Amendment #4:] For PCPs (and mental health providers effective January 1, 2026) , within thirty (30) calendar days of receipt of clean and complete credentialing applications; RSA 420-J:4, I(h)

4.14.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications; and

4.14.3.8.3 For any Provider submitting new or missing information for its credentialing application, the MCO shall act upon the new or updated information within ten (10) business days.

4.14.3.9. The start time for the approval process begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.14.3.10. A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.14.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.14.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.14.3.11. In the event the MCO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in this section.

4.14.3.12. For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by the Department or its designee, the MCO shall be fined in accordance with Exhibit N(Liquidated Damages Matrix).

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4.14.3.13. Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.14.4 **Provider Engagement**

4.14.4.1. Provider Support Services

4.14.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

4.14.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.14.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday, and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision, except Department-approved holidays.

4.14.4.1.1.3. Ability for Providers to contact the MCO regarding contracting, billing, and service provisions;

4.14.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, health-related social needs, and quality, privacy and confidentiality of certain conditions;

4.14.4.1.1.5. Training curriculum, to be developed, in coordination with the Department that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for

EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.14.4.1.1.6. Training on billing and required documentation;

4.14.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.14.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as described this Agreement; and

4.14.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

4.14.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.14.4.1.3 As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of Department-approved holidays. The Provider call center shall meet the following minimum standards, which may be modified by the Department as necessary:

4.14.4.1.3.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

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4.14.4.1.3.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds; and

4.14.4.1.3.3. 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).

4.14.4.1.4 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.14.4.1.5 The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.14.4.1.6 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs.

4.14.4.1.7 The Department may provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

4.14.4.1.8 The MCO 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.

4.14.5 Provider Advisory Board

4.14.5.1. The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback

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on the MCM program, and shall include representation from at least one (1) FQHC, and at least one (1) CMH Program.

4.14.5.2. The Provider Advisory Board should meet face-to-face and/or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.14.6 **Provider Contract Requirements**

4.14.6.1. General Provisions

4.14.6.1.1 The MCO's agreement with health care Providers shall:

4.14.6.1.1.1. Be in writing;

4.14.6.1.1.2. Be in compliance with applicable State and federal laws and regulations; and

4.14.6.1.1.3. Include the requirements in this Agreement.

4.14.6.1.2 The MCO shall submit all model Provider contracts to the Department for review before execution of the Provider contracts with NH Medicaid Providers.

4.14.6.1.3 The MCO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.14.6.1.4 The Department retains the right to reject or require changes to any Provider contract.

4.14.6.1.5 In all contracts with Participating Providers, the MCO 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.

4.14.6.1.6 In all contracts with Participating Providers, the MCO 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)]

4.14.6.1.7 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act

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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.

4.14.6.1.8 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.14.6.1.9 The MCO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.14.6.1.10 Within 90 days upon availability or in accordance with applicable law, the MCO shall include in Provider contracts or MCO provider office reference manual a requirement securing cooperation with the QAPI program and shall align the QAPI program to other Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.15 (Alternative Payment Models).

4.14.6.1.11 The MCO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.14.6.1.12 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.15 (Alternative Payment Models).

4.14.6.1.13 The MCO may execute Participating Provider agreements and begin credentialing, 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 the Department that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120)

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day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.14.6.1.14 [Amendment #2:] The MCO shall notify the Department on a Department developed form no later than fourteen (14) calendar days in advance of the one hundred twenty (120) calendar day termination period to request the Department's assistance with NH Medicaid provider enrollment ~~which may be available for~~ pending ~~enrollment~~ applications.

4.14.6.1.15 The MCO shall notify impacted Members upon the MCO's Provider termination at the end of the one hundred twenty (120) day period.

4.14.6.1.16 The MCO shall maintain a Provider relations presence in NH, as approved by the Department.

4.14.6.1.17 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.14.6.1.17.1. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.14.6.1.17.2. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by the Department.

4.14.6.1.17.3. Provider materials shall comply with State and federal laws and the Department and NHID requirements.

4.14.6.1.17.4. The MCO 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.

4.14.6.1.17.5. Any revisions to the Provider Manual(s) and Provider training materials required by the Department shall be provided to

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the MCO within thirty (30) calendar days.

4.14.6.1.18 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and all Participating Providers, including any necessary specialty manuals (e.g., behavioral health).

4.14.6.1.18.1. The Provider Manual shall be available and easily accessible on the web and updated no less than annually.

4.14.6.1.18.2. The Provider Manual shall consist of, at a minimum:

4.14.6.1.18.2.1 A description of the MCO's enrollment and credentialing process;

4.14.6.1.18.2.2 How to access MCO Provider relations assistance;

4.14.6.1.18.2.3 A description of the MCO's medical management and Case Management programs;

4.14.6.1.18.2.4 Detail on the MCO's Prior Authorization processes;

4.14.6.1.18.2.5 A description of the Covered Services and Benefits for Members,

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including EPSDT and pharmacy;

4.14.6.1.18.2.6 A description of Emergency Services coverage;

4.14.6.1.18.2.7 Member parity;

4.14.6.1.18.2.8 The MCO Payment policies and processes; and

4.14.6.1.18.2.9 The MCO Member and Provider Grievance System.

4.14.6.1.19 The MCO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1-2)]

4.14.6.1.19.1. The MCO shall require the Provider 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)]

4.14.6.1.20 In all contracts with Participating Providers, the MCO shall require Participating Providers to remain neutral when assisting potential Members and Members with enrollment decisions.

4.14.6.1.21 The MCO shall not include any provision in a contract with a Provider that incentivizes a Provider not to

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contract, or prohibits or discourages the Provider from contracting, with any other Managed Care Organization to provide services to such other Managed Care Organization's members. [NH RSA 420-I et al]

4.14.6.2. Compliance with MCO Policies and Procedures

The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.14.6.2.1.1. The MCO's DRA policy;

4.14.6.2.1.2. The Provider Manual;

4.14.6.2.1.3. The MCO's Compliance Program;

4.14.6.2.1.4. The MCO's Grievance and Appeal Processes and Provider Appeal Processes;

4.14.6.2.1.5. Clean Claims and Prompt Payment requirements;

4.14.6.2.1.6. ADA requirements;

4.14.6.2.1.7. Clinical Practice Guidelines; and

4.14.6.2.1.8. Prior Authorization requirements.

4.14.6.2.2 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO and periodically thereafter, about the following requirements:

4.14.6.2.2.1. Member grievance and appeal processes as described in Section 4.5 (Member Grievances and Appeals), including:

4.14.6.2.2.1.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.14.6.2.2.1.2 The Member's

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right to file grievances and appeals and the requirements and timeframe for filing;

4.14.6.2.2.1.3 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)];

4.14.6.2.2.1.4 The Member's right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]; and

4.14.6.2.2.1.5 The Member's right to request continuation of benefits

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that the MCO 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)]

4.14.6.3. Requirement to Return Overpayment

4.14.6.3.1 Requirements for the Provider to comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.14.6.3.1.1. 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.

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4.14.6.4. Background Screening

4.14.6.4.1 The MCO shall require the Provider to conduct background screening of its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists.

4.14.6.4.1.1. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the MCO.

4.14.6.5. Books and Records Access

4.14.6.5.1 The selected MCO must maintain the following records during the resulting contract term where appropriate and as prescribed by the Department:

4.14.6.5.1.1. 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).

4.14.6.5.1.2. 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

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time cards, payrolls, and other records requested or required by the Department.

4.14.6.5.1.3. 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.

4.14.6.5.2 Medical records on each patient/recipient of services.

4.14.6.5.3 During the term of the resulting contract(s) and the 10-year period for retention, 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).

4.14.6.5.4 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth in this Agreement and in the MCO's Member Handbook.

4.14.6.6. Continuity of Care

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4.14.6.6.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by the Department and included in the Department's Model Member Handbook.

4.14.6.7. Anti-Gag Clause

4.14.6.7.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient:

4.14.6.7.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.14.6.7.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.14.6.7.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.14.6.7.1.4. 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. [Section 1932(b) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.14.6.7.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Member Appeal). [42 CFR 438.410(b)]

4.14.6.8. Anti-Discrimination

4.14.6.8.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or

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certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment.

4.14.6.8.2 This paragraph shall not be construed to prohibit an organization from:

4.14.6.8.2.1. Including Providers only to the extent necessary to meet the needs of the organization's Members;

4.14.6.8.2.2. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization; or

4.14.6.8.2.3. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.14.6.8.3 If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

4.14.6.8.4 In all contracts with Participating Providers, the MCO'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)]

4.14.6.9. Access and Availability

4.14.6.9.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.5 (Timely Access to Service Delivery).

4.14.6.10. Payment Models

4.14.6.10.1 The MCO shall negotiate rates with Providers in accordance with Section 4.15 (Alternative Payment Models) and Section 4.16 (Provider Payments) of this Agreement, unless otherwise specified by the Department (e.g., minimum Medicaid fee schedule rates, directed payments).

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4.14.6.10.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the PBM.

4.14.6.10.3 The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.14.6.11. Non-Exclusivity

4.14.6.11.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.14.6.12. Proof of Membership

4.14.6.12.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.14.6.13. Other Provisions

4.14.6.13.1 The MCO's Provider contract shall also contain:

4.14.6.13.1.1. All required activities and obligations of the Provider and related reporting responsibilities;

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

4.14.6.13.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.14.7 **Reporting**

4.14.7.1. The MCO 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.

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4.14.7.2. The MCO 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 MCO. [42 CFR 438.608(a)(4)]

4.14.7.3. The MCO shall notify the Department within seven (7) calendar days of any significant changes to the Participating Provider network.

4.14.7.4. As part of the notice, the MCO shall submit a Transition Plan to the Department to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.

4.14.7.5. A significant change is defined as:

4.14.7.5.1 A decrease in the total number of PCPs by more than five percent (5%);

4.14.7.5.2 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

4.14.7.5.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.14.7.5.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

4.14.7.6. The MCO shall provide to the Department and/or the Department's Subcontractors (e.g., the EQRO) 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, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.15 Alternative Payment Models

4.15.1 General

4.15.1.1. The Department is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization. The Department will define a Medicaid APM Strategy that may include supporting

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guidance, worksheets, and templates that will build upon the parameters set forth in this Agreement.

4.15.1.2. The Department will implement 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, with a focus on engaged primary and preventive care model and in a manner that is transparent to the Department, Providers, and the stakeholder community.

4.15.1.3. 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:

4.15.1.3.1 Clearly and effectively communicate the Department requirements through use of the defined categories established by HCP-LAN;

4.15.1.3.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.15.1.3.3 Provide an established framework for monitoring MCO performance on APMs.

4.15.2 Prior to and/or over the course of the Term of this Agreement, the Department shall develop the Department's Medicaid APM Strategy, which shall result in additional guidance, templates, worksheets, required provider contractual provisions and other material that elucidate the requirements to which the MCO is subject under this Agreement.

4.15.3 The MCOs shall develop APMs consistent with guidance in the Department's Medicaid APM Strategy including, but not limited to:

4.15.3.1. Incentivize primary care clinicians to engage attributed Members in Primary and Prevention Focused Model and Provider Delivered Care Coordination.

4.15.4 According to models that incentivize consistent quality outcomes as prescribed by the Department.

4.15.5 Within the guidance parameters established and issued by the Department and subject to Department approval, the MCO shall design Qualifying APMs as defined in Section 4.15.9 (Qualifying Alternative Payment Models) consistent with the Department Medicaid APM strategy and in conformance with CMS guidance.

4.15.6 The MCO shall support the Department in developing the Department's Medicaid APM Strategy through participation in regular stakeholder meetings and planning efforts, implementing required provider contractual provisions, providing all required and otherwise requested information related to APMs, sharing Confidential Data and analysis, and other activities as specified by the Department.

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4.15.7 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and the Department shall ensure that it:

4.15.7.1. 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;

4.15.7.2. Uses a common set of quality performance measures across all similarly situated Providers as directed in the Department's Medicaid APM Strategy;

4.15.7.3. Does not set the amount or frequency of the expenditures; and

4.15.7.4. Does not permit the Department to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.15.8 Required Use of Alternative Payment Models

4.15.8.1. The MCO shall ensure through its APM Implementation Plan as described in Section 4.15.10 (MCO Alternative Payment Model Implementation Plan), and confirmed through Exhibit O: Quality and Oversight Reporting Requirements, reporting that fifty percent (50%) of all Covered Services medical expenditures are in Qualifying APMs, as defined by the Department, subject to the following:

4.15.8.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have twelve (12) months to meet this requirement; and

4.15.8.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.15.8.2. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 12-month period.

4.15.8.3. The MCO shall implement the Qualifying APM models as directed by the Department in the Department's Medicaid APM Strategy including, but not limited to, directed payments with quality incentives for achieving statewide outcomes for Community Mental Health Centers and providers, total cost of care models with large providers including quality metrics incentivizing Provider-Delivered Care Coordination and Primary Care and Prevention Focused care.

4.15.8.4. For failure to meet Section 4.15.8 (Required Use of Alternative Payment Models), the Department reserves the right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N (Liquidated Damages Matrix).

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4.15.8.5. Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined Department, MCO, and Providers to achieve the purpose of the incentives.

4.15.8.6. The MCO shall be subject to incentives, at the Department's sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new Members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.15.9 **Qualifying Alternative Payment Models**

4.15.9.1. A Qualifying APM is a payment approach required and approved by the Department as consistent with the standards specified in this Section 4.15.9 (Qualifying Alternative Payment Models) and the Department's Medicaid APM Strategy.

4.15.9.2. 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.

4.15.9.3. HCP-LAN Categories 3A, 3B, 4A, 4B and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the Department's Medicaid APM Strategy.

4.15.9.4. The Department shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.15.12.3 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to the Department, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.15.9.5. Under no circumstances shall the Department consider as a Qualifying APM a payment methodology that takes cost of care into account without also paying providers for achieving quality outcomes consistent with those set forth in the Department's Medicaid APM Strategy. Providers participating in Qualifying APMs shall have the opportunity to share in cost savings through a formula that is no less than 50/50 split in favor of the participating providers and shall incorporate a opportunity to share up to an additional #% of total payments paid through the APM as provider incentive payments for achieving quality outcomes as part of the Qualifying APM.

4.15.9.6. At the sole discretion of the Department, additional APMs specifically required by and defined as an APM by the Department shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.15.9.7. Standards for Large Providers and Provider Systems

4.15.9.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the Department's Medicaid APM Strategy, including incentives for the Primary Care and

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Prevention Focused Model inclusive of Provider Delivered Care Coordination.

4.15.9.8. Treatment of Payments to Community Mental Health Programs

4.15.9.8.1 The CMH Program payment model prescribed by DHHS in Section 4.12.20 (Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.15.9.9. Alternative Payment Models for Substance Use Disorder Treatment

4.15.9.9.1 The MCO shall include in its APM Implementation Plan:

4.15.9.9.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to birthing parents and infants born affected by exposure to substance use; and

4.15.9.9.1.2. At least one (1) APM that promotes greater use of Medication for treatment of substance use disorders through a bundled payment as set forth in the Department's Medicaid APM Strategy.

4.15.9.10. Accommodations for Other Providers

4.15.9.10.1 The MCO may develop Qualifying APM models appropriate for other primary care Providers, and Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy to incentivize engaged primary and preventive care.

4.15.9.10.2 For example, the MCO 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.

4.15.9.11. Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.15.9.11.1 The MCO shall incentivize Providers participating in the Qualifying APMs by paying incentives for achieving quality outcomes established by the Department in the Department's Medicaid APM Strategy.

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4.15.9.11.2 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden, incentivize primary and preventive care and promote the integration of Behavioral Health.

4.15.9.11.3 The MCO may incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Advanced APM."

4.15.10 **MCO Alternative Payment Model Implementation Plan**

4.15.10.1. The MCO shall submit to the Department for review and approval an APM Implementation Plan in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.15.10.2. 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.

4.15.10.3. Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements and/or through additional guidance.

4.15.10.4. Alternative Payment Model Transparency

4.15.10.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and evaluating Participating Provider performance in the APM, as described in Section 4.15.11 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how the MCO intends to achieve Provider to Member engagement in Primary Care and Prevention model and Provider-Delivered Care Coordination including health and wellness assessments and integrated behavioral health care through the APM.

4.15.10.5. Intentionally Left Blank

4.15.10.6. Provider Engagement and Support

4.15.10.6.1 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

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strategies the MCO shall use to assess and advance such readiness over time.

4.15.10.6.2 The APM Implementation Plan shall outline in detail what strategies the MCO 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. The MCO shall ensure regular and consistent engagement with Providers around APMs on at least a quarterly basis through direct or virtual visits by the MCOs key staff responsible for the MCOs provider relations and APM Implementation Plan.

4.15.10.6.3 The MCO 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.

4.15.10.6.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.15.10.7. Implementation Approach

4.15.10.7.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.15.10.7.1.1. In advance of the Program Start Date;

4.15.10.7.1.2. During the first year of this Agreement; and

4.15.10.7.1.3. Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

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4.15.10.7.2 The APM Implementation Plan shall include the MCO'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 MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.15.10.7.3 The MCO 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.

4.15.10.7.4 For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM and notifies the Providers with clarity throughout the APM period of their progress against incentive payment formulas at least quarterly.

4.15.10.7.5 In addition, the MCO shall provide Member and Provider level Confidential Data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.15.10.7.6 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 MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.15.10.7.7 The information provided shall be consistent with the requirements outlined under Section 4.15.11 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.15.11 Alternative Payment Model Transparency and Reporting Requirements

4.15.12 Transparency

4.15.12.1. In the MCO APM Implementation Plan, the MCO shall provide to the Department for each APM, as applicable, the following information at a minimum:

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4.15.12.1.1 The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.15.12.1.2 The methodology for incentivizing Providers engage Members in Provider-Delivered Care Coordination and Primary Care and Prevention, including, but not limited to, health and wellness screenings;

4.15.12.1.3 The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, and the attachment points for cost targets, and risk adjustment methodology;

4.15.12.1.4 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

4.15.12.1.5 The frequency at which the MCO shall regularly report Confidential Data related to APM performance to Providers on cost, quality, evaluation of progress towards incentive payments and the information that shall be included in each report.

4.15.12.2. 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 MCO requests and receives the Department approval for specified information not to be made available.

4.15.12.3. Standardized Assessment of Alternative Payment Model Usage

4.15.12.3.1 Additional information may be required by the Department's Medicaid APM Strategy and 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 MCO requests and receives the Department approval for specified information not to be made available.

4.15.12.4. Standardized Assessment of Alternative Payment Model Usage

4.15.12.4.1 The MCO 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.

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4.15.12.4.2 Thereafter, the MCO 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.

4.15.12.4.3 If the MCO reaches an agreement with the Department that its implementation of the required APM model(s) may be delayed, the MCO shall comply with all terms set forth by the Department for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.15.12.5. Additional Reporting on Alternative Payment Model Outcomes

4.15.12.5.1 The MCO 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.

4.15.13 Development Period for MCO Implementation

4.15.13.1. Consistent with the requirements for new MCOs, outlined in Section 4.15.9 (Qualifying Alternative Payment Models) above, the Department acknowledges that MCOs may require time to advance their MCO Implementation Plan. The Department shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.15.14 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.15.14.1. The MCO's APM Implementation Plan shall adopt the quantitative, measurable clinical outcomes required by the Department in the Department's Medicaid APM Strategy and additional outcomes the MCO seeks to improve through its APM and QAPI initiative(s).

4.15.14.2. At a minimum, the MCO shall address the priorities identified in this Section 4.15.4 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by the Department in the Department's Medicaid APM Strategy.

4.15.14.3. State Priorities in RSA 126-AA

4.15.14.3.1 The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:

4.15.14.3.1.1. [Amendment #4:] Appropriate use of emergency departments relative to low acuity non-emergent visits Opportunities to

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decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

4.15.14.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.15.14.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of births of infants born affected by exposure to substance use;

4.15.14.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission;

4.15.14.3.1.5. Opportunities to incentivize, through payments to Providers and Member incentives, Provider engagement with attributed Members in primary and preventive care, health needs assessments, Provider-Directed Care Coordination at a frequency and in a manner set forth in the Department's Medicaid APM Strategy;

4.15.14.3.1.6. [Amendment #4:] Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing preferred drug ~~generic~~ prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing Polypharmacy, as described in

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Section 4.2.6 (Medication Management);

4.15.14.3.1.7. Opportunities to enhance access to and the effectiveness of medication to treat Substance Use Disorder treatment; and

4.15.14.3.1.8. Opportunities to address health-related social needs (further addressed in Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.15.14.4. Emerging State Medicaid and Public Health Priorities

4.15.14.4.1 The MCO shall address priorities identified by the Department in the Medicaid APM Strategy or related guidance.

4.15.14.4.2 If the Department adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of it APM Implementation Plan.

4.15.15 **Physician Incentive Plans**

4.15.15.1. The MCO shall submit all Physician Incentive Plans to the Department for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.15.15.2. The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by the Department.

4.15.15.3. [Amendment #2:] Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," "the Department," and "Members," respectively and 42 CFR 438.3(i). These include that:

4.15.15.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or

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indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.15.15.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.15.15.3.3 [Amendment #4:] [Amendment #2:] Effective July 1, 2026, all of MCO's Physician Incentive Plans to a Provider must adhere to the following requirements: (i) have a defined performance period that can be tied to the applicable MLR reporting periods ~~the performance period of the physician incentive contract with the Provider must align with the MLR reporting period;~~ (ii) the Provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCO; (iii) the physician incentive contract with the Provider must include a specific dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including an ~~and~~ expected date of payment for meeting the required metrics; and (iv) the physician incentive contracts with the Provider must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e. defined and linked to an applicable MLR reporting period or periods). [42 438.608(e); 42 CFR 438.3(i)(3) and (4)]

4.15.15.3.4 [Amendment #2:] Effective July 1, 2026, for each of MCO's Physician Incentive Plans with a Provider, MCO must (i) maintain documentation of (a) the methodology used by MCO to determine Member attribution, and sharing information on Member attribution with Provider; (b) the mechanism(s) used to determine cost benchmarks, and Provider's performance against those cost benchmarks, including cost targets and calculations, the attachment point of cost targets, and risk adjustment calculations;

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and (c) MCO's evaluation and assessment of Provider's performance against quality benchmarks; (ii) not rely on Provider attestations as the basis for Provider's meeting performance and quality metrics for incentive amounts included in the MLR calculation; and (iii) provide copies of each Physician Incentive Plan with Providers and supporting documentation upon request of the Department and at a frequency determined by the Department.

4.15.15.4. The MCO 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) Physician Incentive Plans, as described in Exhibit O: Quality and Oversight Reporting Requirements.

4.15.15.5. Annual Physician Incentive Plan reports shall provide assurance satisfactory to the Department that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any Department request to understand the terms of Provider payment arrangements.

4.15.15.6. The MCO shall provide to Members upon request the following information:

4.15.15.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.15.15.6.2 The type of incentive arrangement; and

4.15.15.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.16 Provider Payments

4.16.1 General Requirements

4.16.1.1. The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.16.1.2. The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) under the following circumstances: [Section 1903 of the Social Security Act]:

4.16.1.2.1 When furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

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4.16.1.2.2 When furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX 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);

4.16.1.2.3 When 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 or if the individual or entity has not completed their federally required enrollment revalidation with the Department;

4.16.1.2.4 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; and [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]

4.16.1.2.5 When furnished by a Participating Provider or entity that is not enrolled with NH Medicaid or whose Medicaid participation has been terminated by the Department.

4.16.1.3. No payment shall be made to a Participating Provider other than by the MCO for services covered under the Agreement between the Department and the MCO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR 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]

4.16.1.4. The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by the Department, the MCO shall contact the Department and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.16.1.4.1 [Amendment #1:] For Providers and Covered Services eligible for minimum fee schedule reimbursement as described in Section 4.16.2 (Provider Payment Requirements) of this Agreement or under terms of a Provider's contractual terms with the MCO, u~~U~~pon a

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change to the State's Medicaid FFS fee schedule, the MCO shall implement a code or rate change in the MCO's claims adjudication system to effectuate the updated State's Medicaid FFS fee schedule in the MCO's referenced system. The MCO shall complete implementation of the updated State's Medicaid fee schedule as soon as possible and no later than the latter of:

4.16.1.4.1.1. The effective date of the State's Medicaid FFS fee schedule change; or

4.16.1.4.1.2. Sixty (60) calendar days from the date the Department notifies the MCO of such State Medicaid FFS fee schedule change.

4.16.1.4.2 To the extent the MCO's effective date of implementing a change in the State's Medicaid FFS fee schedule is later than the effective date of the State's Medicaid FFS fee schedule change, the MCO shall retroactively reimburse Provider claims based on the State's effective date of the then current State Medicaid FFS fee schedule.

4.16.1.5. The MCO shall permit Providers up to one hundred and twenty (120) calendar days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.

4.16.1.6. Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.16.1.6.1 A Member providing the wrong Medicaid identification number;

4.16.1.6.2 Natural disasters; or

4.16.1.6.3 Failed information technology systems.

4.16.1.7. The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.16.1.8. Within the first one hundred and eighty (180) calendar days of the Program Start Date, the Department has discretion to direct MCOs to extend the one hundred and twenty (120) calendar days on case by case basis.

4.16.1.9. The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

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4.16.1.10. The MCO 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)]

4.16.1.11. [Amendment #4:] The MCO shall implement and maintain arrangements or procedures for prompt reporting within 30 calendar days of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste or Abuse, to the Department. [42 CFR 438.608(a)(2)]

4.16.1.12. The MCO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider Preventable Conditions.

4.16.1.12.1 The MCO shall not make payments to a Provider for a Provider Preventable Condition that meets the following criteria:

4.16.1.12.1.1. Is identified in the Medicaid State Plan;

4.16.1.12.1.2. 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;

4.16.1.12.1.3. Has a negative consequence for the Member;

4.16.1.12.1.4. Is auditable; and

4.16.1.12.1.5. 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)]

4.16.1.12.2 The MCO 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)]

4.16.1.12.3 Any directed payments proposed to CMS shall be described in the program's actuarial certification for the rating period.

4.16.1.12.3.1. [Amendment #3:] State directed payments payable at minimum fee schedules are excluded for Covered Services in which the Member has active Medicare or other insurance at the time the service was rendered.

4.16.1.12.4 The MCO shall not impose an administrative fee, cost or any other charge upon any form of payment (e.g., electronic or paper checks) to Providers rendering Covered Services to Members.

4.16.1.12.5 The term "minimum fee schedule" in this Section 4.16 (Provider Payments), shall infer the minimum Provider reimbursement amount(s) permissible under the terms of this Agreement.

4.16.2 **Provider Payment Requirements**

4.16.2.1. Ambulance, Stretcher, and Wheelchair Van Providers

4.16.2.1.1 [Amendment #1:] The MCO shall reimburse directed payments to ambulance, stretcher, and wheelchair van Providers for Covered Services, as follows:

4.16.2.1.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), the MCO shall reimburse Participating Providers for all ambulance, stretcher, and wheelchair van Covered Services at no less than NH Medicaid fee schedule rates.

4.16.2.2. Birthing Centers

4.16.2.2.1 [Amendment #1:] The MCO shall reimburse eligible Participating Provider hospital-based and free-

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standing birthing centers directed payments for Covered Services, as follows:~~For the rating period ending August 31, 2024 (subject to future rating period extension(s)), the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.~~

4.16.2.2.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services in accordance with rates that are no less than NH Medicaid FFS rates.

4.16.2.3. [Amendment #1:] Community Mental Health Programs (CMH Programs)~~Centers (CMHCs)~~

4.16.2.3.1 [Amendment #1:] The MCO shall enter into an agreement, defined and approved by the Department, with CMH Programs~~CMHCs Community Mental Health Centers~~ effective September 1, 2024.

4.16.2.3.1.1. [Amendment #3:] [Amendment #2:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s) and reporting required by the Department), the MCO shall reimburse each CMH Program, including CCBHCs that are a CMH Program provider, in accordance with the ~~directed~~ payment minimum monthly directed payment capitated amounts for identified Covered Services provided by a CMH Program~~The agreement shall be defined by the Department and~~

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~~requires a monthly per member rate payment to the Community Mental Health Centers consistent with the directed payment and incentives (subject to CMS approval, as appropriate)~~ for the treatment of Members with Severe/Persistent Mental Illness, Severe Mental Illness, Low Utilizers, Serious Emotionally Disturbed Children (SED and SED-I) in accordance with guidance issued by the Department, and as described in the program's actuarial certification for the rating period. ~~as directed by the Department and detailed in the Department's Medicaid APM Strategy.~~

4.16.2.3.1.1.1 [Amendment #1:] The monthly capitated amount for each CMH Program shall be based on a per Member per month amount, and such per Member per month rate shall be equal to the per Member per month rate determined by the Department for each CMH Program, for each of the following categories (i)

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Severe/Persistent Mental Illness, (ii) Severe Mental Illness, (iii) Low Utilizers, and (iv) Serious Emotionally Disturbed Children (SED and SED-I).

4.16.2.3.1.1.2 [Amendment #1:] The MCO shall determine the aggregate monthly capitated amount to be paid to each CMH Program based on the CMH Program's monthly Member eligibility count in accordance with Department guidance.

4.16.2.3.1.1.3 [Amendment #1:] In the event the MCO is unable to make the monthly capitated payments to

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any CMH Program in accordance with Section 4.16.2.3.2, and in the amount as directed by the Department, the MCO shall make monthly interim payments to the CMH Program in an amount determined by the Department. When such interim payment is invoked, the MCO shall be subject to liquidated damages as specified in Exhibit N (Liquidated Damages Matrix).

4.16.2.3.1.1.4 [Amendment #1:] All such monthly interim payments to a CMH Program shall be reconciled by the MCO against the amount the

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MCO would have reimbursed each CMH Program receiving an interim payment if the MCO reimbursed the CMH Program in accordance with Sections 4.16.2.3.1.1 through 4.16.2.3.1.1.2.

4.16.2.3.1.2. [Amendment #1:] A separate and distinct ~~This~~ directed payment shall include an incentive pool to pay CMHCs for achieving quality outcomes established by the Department consistent with the statewide mental health improvement goals and objectives.

4.16.2.3.1.2.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the

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Department), directed payment amounts determined by the Department shall comprise a fee schedule adjustment or uniform dollar increase for ~~assertive community treatment~~, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, timely access to services following application for CMH Program services, and step down community residence beds for individuals dually diagnosed with serious mental illness

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and developmental disabilities, within the CMH Program class of network providers, as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.3.1.3. The MCO shall not amend, modify, or change the MCO-CMHC agreement effective September 1, 2024 unless MCO obtains prior written approval from the Department.

4.16.2.3.2 [Amendment #1:] The MCO shall reimburse eligible Community Mental Health Programs (CMHPs) directed payments for covered Community Residential Services ~~for Covered Services~~, as follows:

4.16.2.3.2.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30 ~~20~~, 2026 ~~2025~~ ~~ending August 31, 2024~~ (subject to future rating period extension(s) and other changes, and reporting required by the Department), directed payment remittance shall comprise a minimum fee schedule at least at the Medicaid FFS rates established by the Department ~~for Community Residential Services~~.

4.16.2.3.3 [Amendment #3:] [Amendment #2:] ~~Effective January 1, 2025~~ For the rating period July 1, 2025 ~~September~~

~~1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s) and other changes) for the CCBHC's CMH Program eligible population, the MCO shall reimburse each qualifying CCBHC a directed payment at a NH Medicaid center-specific monthly sub-capitation amount, and at least at NH Medicaid fee schedule rates for all other Members who receive CCBHC services in accordance with separate guidance.

4.16.2.3.3.1. [Amendment #3:] [Amendment #2:] ~~Beginning with the January 2025 payment~~, The MCO shall reimburse each CCBHC ~~its January 2025 CCBHC~~ their center specific monthly subcapitation amount as set forth in the program's actuarial certification based on the effective date of each CCBHC's designation. Failure to do so will be grounds for liquidated damages in accordance with Exhibit N (Liquidated Damages Matrix).

4.16.2.4. [Amendment #1:] Qualifying New Hampshire Hospitals ~~Critical Access Hospitals (CAHs)~~

4.16.2.4.1 [Amendment #1:] Critical Access Hospitals (CAHs): The MCO shall remit directed payment(s) to CAHs in accordance with separate guidance, as follows:

4.16.2.4.1.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of MCO's Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services

utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State directed payment preprint approved by CMS. [~~Amendment #1:] For the rating period September 1, 2024 through June 30, 2025current rating period ending August 31, 2024 (subject to future rating period extension(s), and other changes, and reporting required by the Department), directed payment amounts determined by the Department shall comprise a uniform rate increase for all inpatient discharges and outpatient qualified encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.~~

4.16.2.4.1.2. [Amendment #3:] [Amendment #1:] Intentionally left blank ~~For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse qualifying facilities for inpatient services at no less than NH Medicaid fee schedule rates.~~

4.16.2.4.2 [Amendment #3:] [Amendment #1:] Prospective Payment System (PPS) Hospitals: The MCO shall remit directed payment(s) to in-state general acute care PPS hospitals ~~CAHs~~ in accordance with separate guidance, as follows:

4.16.2.4.2.1. [Amendment #3:] [Amendment #2:] [Amendment #1:] For the rating period July 1, 2025

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through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State directed payment preprint approved by CMS. ~~For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse in-state critical access hospitals and prospective payment systems hospitals specified by the Departmentqualifying facilities at uniform price increase directed payment amounts for inpatient discharges and outpatient encounters as determined by the Department, andshall comprise a uniform rate increase for encounters as approved by CMS., including any alternate CMS-approved directed payment methodology. Qualified Such uniform price increase directed payments are tied to actual inpatient and outpatient hospital services reported by in-state critical access hospitals and prospective payment~~

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~~system hospitalsqualifying Providers~~.

4.16.2.4.2.2. [Amendment #3:] [Amendment #2:] [Amendment #1:] Intentionally left blank For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse qualifying facilities in-state and out-of-state hospitals for inpatient services (except for out-of-state hospital services secured with a single case agreement) at no less than NH Medicaid fee schedule rates.

4.16.2.4.3 [Amendment #3:] Non-Profit Academic Medical Centers with Level I Adult Trauma Center and Level II Pediatric Trauma Center Designations: The MCO shall remit uniform price increase directed payments to in-state non-profit academic medical centers with a Level I adult trauma center and a level II pediatric trauma center in accordance with separate guidance, as follows:

4.16.2.4.3.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of MCO's Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State

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directed payment preprint approved by CMS.

4.16.2.4.4 [Amendment #3:] Inpatient Hospital Minimum Fee Schedule:

4.16.2.4.4.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse in-state and out-of-state hospital Providers for inpatient services (except for out-of-state hospital services secured with a single case agreement) at no less than NH Medicaid fee schedule rates.

4.16.2.5. DME Providers

4.16.2.5.1 [Amendment #1:] The MCO shall reimburse DME Providers directed payments for DME and DME related supplies and services, as follows:

4.16.2.5.1.1. [Amendment #3:] [Amendment #1:] For the current rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.6. Hospice Payment Rates

4.16.2.6.1 The Medicaid hospice payment rates shall be calculated based on the annual hospice rates established under Medicare. These rates are authorized by 1814(i)(1)(ii) of the Social Security Act

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which also provides for an annual increase in payment rates for hospice care services.

4.16.2.7. Indian Health Care Providers

4.16.2.7.1 The MCO 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 MCO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i-ii)]

4.16.2.7.2 For contracts involving IHCPs, the MCO 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)]

4.16.2.7.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the MCO shall be paid an amount equal to the amount the MCO 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 MCO pays and what the IIHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.16.2.7.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.16.2.7.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the Department shall make a supplemental payment to

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the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.16.2.8. Private Duty Nursing Services

4.16.2.8.1 [Amendment #1:] The MCO shall remit directed payments for private duty nursing Covered Services, as follows: ~~reimburse private duty nursing agencies for private duty nursing services at least at the FFS rates established by the Department.~~

4.16.2.8.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse covered private duty nursing services in accordance with rates that are no less than NH Medicaid FFS rates.

4.16.2.9. Substance Use Disorder Providers

4.16.2.9.1 [Amendment #1:] The MCO shall reimburse eligible Substance Use Disorder Providers, including Peer Recovery Programs, directed payments for Covered Services, as follows: ~~in accordance with rates that are no less than the equivalent DHHS FFS rates on the applicable Substance Use Disorder Provider fee schedule.~~

4.16.2.9.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s)), other changes, and reporting required by the Department), the MCO shall reimburse Substance Use Disorder Providers, including Peer Recovery Programs, in accordance with rates that are no less than NH Medicaid FFS rates.

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4.16.2.10. Transition Housing Program

4.16.2.10.1 [Amendment #1:] The MCO shall reimburse eligible Transition Housing Programs directed payments for Covered Ssservices, as follows: ~~at least at the FFS rates established by the Department~~.

4.16.2.10.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), directed payment remittance shall comprise a minimum fee schedule at least at the Medicaid FFS rates established by the Department.

4.16.2.11. Designated Receiving Facility (DRF)

4.16.2.11.1 [Amendment #1:] The MCO shall reimburse eligible Medicaid enrolled DRFs as designated by the Commissioner directed payments, as follows:

4.16.2.11.1.1. [Amendment #3:] [Amendment #1:] For the current rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ ~~ending August 31, 2024~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 NH Medicaid State Plan DRG fee schedule payment amounts.

4.16.2.11.2 For administrative days and post stabilization care services delivered under the inpatient and outpatient service categories, the MCO shall pay State-Owned Hospitals and other State determined IMDs for mental illness at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate

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community-based care and services. Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in State-Owned Hospitals and other State determined IMDs for mental illness.

4.16.2.12. Neuropsychological Testing Services

4.16.2.12.1 [Amendment #1:] The MCO shall reimburse eligible Medicaid-enrolled Providers directed payments for covered neuropsychological testing services, as follows:

4.16.2.12.1.1. [Amendment #3:] [Amendment #1:] For the ~~current~~ rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ ~~ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.13. [Amendment #1:] State-Owned Inpatient Psychiatric Hospitals

4.16.2.13.1 [Amendment #3:] [Amendment #1:] The MCO shall reimburse state-owned New Hampshire Hospital ~~and Hampstead Hospital~~ directed payments as described below:

4.16.2.13.1.1. [Amendment #3:] [Amendment #1:] For inpatient psychiatric services, the MCO shall reimburse state-owned New Hampshire Hospital ~~and Hampstead Hospital~~, as follows:

4.16.2.13.1.1.1 [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025

~~September 1,~~ ~~2024~~ through June 30, 2026 ~~2025 current rating period ending August 31, 2024~~ (subject to future rating period extension(s) other changes, and reporting required by the Department), the state-owned facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.16.2.13.2 [Amendment #3:] [Amendment #1:] ~~For psychiatric professional services, t~~The MCO shall reimburse psychiatric—professional services delivered at the state-owned New Hampshire Hospital ~~and Hampstead Hospital~~ directed payments, as follows:

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4.16.2.13.2.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~,~~current rating period ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes~~)~~, and reporting required by the Department), directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for eligible psychiatric professional services delivered in the state-owned facilities established and periodically adjusted by CMS.

4.16.2.14. [Amendment #1:] ~~4.16.3.3~~ Qualifying Children's Hospitals

4.16.2.14.1 The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:

4.16.2.14.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the directed payment amounts determined by the Department shall comprise a uniform rate increase for each eligible inpatient and outpatient hospital service encounter.

4.16.2.15. [Amendment #1:] Certain Primary Care Services

4.16.2.15.1 [Amendment #1:] The MCO shall reimburse eligible primary care Providers directed payments for certain primary care services identified by the Department and specified in separate guidance.

4.16.2.15.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to

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future rating period extension(s) and reporting required by the Department), the MCO shall reimburse eligible Providers, including Federally Qualified Health Centers (FQHC), FQHC Look-Alike clinics, Rural Health Clinics/Hospital-Based/Non-Hospital Based and other eligible providers, for certain services at rates that are no less than NH Medicaid FFS rates.

4.16.2.16. [Amendment #1:] Federally Qualified Health Centers and Rural Health Clinics

4.16.2.16.1 [Amendment #1:] FQHCs and RHCs shall be paid at minimum the encounter rate paid by Department at the time of service and shall also be paid for Department -specified CPT codes outside of the encounter rates.

4.16.2.16.2 [Amendment #1:] The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.16.2.16.3 [Amendment #1:] The MCO shall reimburse Providers for only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

4.16.2.16.3.1. [Amendment #1:] Subsequent to the first encounter, the Member suffers an illness or injury with a different diagnosis; or

4.16.2.16.3.2. [Amendment #1:] Subsequent to the first encounter, the Member received a different treatment at a different time of the same day.

4.16.3 [Amendment #1:] Intentionally left blank~~The MCO shall reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent New Hampshire Medicaid FFS rates~~.

4.17 Readiness Requirements Prior to Operations

4.17.1 General Requirements

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4.17.1.1. Prior to the Program Start Date, the MCO 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).

4.17.1.2. The Readiness Review requirements shall apply to all MCOs regardless of whether they have previously contracted with the Department. [42 CFR 438.66(d)(1)(ii)]

4.17.1.3. The MCO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by the Department.

4.17.1.4. The Readiness Review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.17.1.5. In order to demonstrate its readiness, the MCO shall cooperate in the Readiness Review conducted by the Department.

4.17.1.6. If the MCO 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).

4.17.1.7. The MCO shall participate in all the Department trainings in preparation for implementation of the Agreement.

4.17.2 **Emergency Response Plan/Disaster Recovery Plan**

4.17.2.1. The MCO 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.

4.17.2.2. The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.17.2.2.1 Staff and Provider training;

4.17.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.17.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.17.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.17.2.2.5 Plans to ensure continuity of services to Providers and Members;

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4.17.2.2.6 How the MCO shall coordinate with and support the Department and the other MCOs; and

4.17.2.2.7 How the plan shall be tested, updated and maintained.

4.17.2.3. On an annual basis, or as otherwise specified in Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.18 Managed Care Information System

4.18.1 System Functionality

4.18.1.1. The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.18.1.1.1 Complies with the Exhibit Q: IT Requirements Workbook;

4.18.1.1.2 Collects, analyzes, integrates, and reports Confidential Data; [42 CFR 438.242(a)];

4.18.1.1.3 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.18.1.1.4 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)];

4.18.1.1.5 Is capable of meeting the requirements listed throughout this Agreement; and

4.18.1.1.6 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.

4.18.1.1.7 Demonstrates to the Department's satisfaction prior to Program Start its readiness and ability to meet all State IT and information security standards as further set forth in Exhibit K: DHHS Information Security Requirements.

4.18.1.2. The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

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4.18.1.2.1 Collection and maintenance of sufficient Member Encounter Confidential Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.18.1.2.2 Submission of Member Encounter Confidential Data to the Department at the frequency and level of detail specified by CMS and by the Department;

4.18.1.2.3 Submission of all Member Encounter Confidential Data that NH is required to report to CMS; and

4.18.1.2.4 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]

4.18.1.3. All Subcontractors shall meet the same standards, as described in this Section 4.18 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.18.1.4. The MCO MCIS shall include, but not be limited to:

4.18.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.18.1.4.2 Management of Provider Enrollment and Credentialing;

4.18.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.18.1.4.4 Eligibility Verification;

4.18.1.4.5 Encounter Data;

4.18.1.4.6 Reference File Updates;

4.18.1.4.7 Service Authorization Tracking, Support and Management;

4.18.1.4.8 Third Party Coverage and Cost Avoidance Management;

4.18.1.4.9 Financial Transactions Management and Reporting;

4.18.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);

4.18.1.4.11 Reporting (Ah hoc and Pre-Defined/Scheduled and On-Demand);

4.18.1.4.12 Call Center Management;

4.18.1.4.13 Claims Adjudication;

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4.18.1.4.14 Claims Payments; and

4.18.1.4.15 QOS metrics.

4.18.1.5. Specific functionality related to the above shall include, but is not limited to, the following:

4.18.1.5.1 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;

4.18.1.5.2 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;

4.18.1.5.3 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;

4.18.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;

4.18.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

4.18.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all Department reporting and encounter requirements;

4.18.1.5.7 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;

4.18.1.5.8 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

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4.18.1.5.9 The Encounter Confidential Data system shall have a mechanism in place to receive, process, and store the required data.

4.18.1.6. The MCO 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.

4.18.1.7. The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect 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)]

4.18.1.8. MCIS capability shall include, but not be limited to the following:

4.18.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.18.1.8.2 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;

4.18.1.8.3 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 MCO system(s) and to perform appropriate reporting and operational activities;

4.18.1.8.4 The Department access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals; and

4.18.1.8.5 Documented instructions and user manuals for each component.

4.18.1.9. Managed Care Information System Up-Time

4.18.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by the Department. The maintenance period shall not exceed four (4) consecutive hours without prior the Department approval.

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4.18.1.9.2 MCO 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.

4.18.2 **Information System Confidential Data Transfer**

4.18.2.1. Effective communication between the MCO and the Department requires secure, accurate, complete, and auditable transfer of Confidential Data to/from the MCO and the Department Confidential Data management information systems. Elements of Confidential Data transfer requirements between the MCO and the Department management information systems shall include, but not be limited to:

4.18.2.1.1 Department read access to all MCM 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;

4.18.2.1.2 Exchanges of Confidential Data between the MCO and the Department in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the Confidential Data source and target;

4.18.2.1.3 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;

4.18.2.1.4 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;

4.18.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.18.2.1.6 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,

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automate the ETL processes, and provide for source to target or source to specification mappings;

4.18.2.1.7 Mechanisms to support the electronic reconciliation of all Confidential Data extracts to source tables to validate the integrity of Confidential Data extracts; and

4.18.2.1.8 A given day's Confidential Data transmissions, as specified in this Section 4.19.2 (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.

4.18.2.2. The MCO shall designate a single point of contact to coordinate Confidential Data transfer issues with the Department.

4.18.2.3. The Department shall provide for a Centralized Electronic Repository, providing for secure access to authorized MCO and the Department staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.18.2.4. Confidential Data transmissions from the Department to the MCO shall include, but not be limited to the following:

4.18.2.4.1 Provider Extract (Daily);

4.18.2.4.2 Recipient Eligibility Extract (Daily);

4.18.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.18.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.18.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.18.2.4.6 Claims History (Bi-Weekly); and

4.18.2.4.7 Capitation Payment Confidential Data (Monthly).

4.18.2.5. Confidential Data transmissions from the MCO to the Department shall include, but not be limited to the following:

4.18.2.5.1 Member Demographic changes (Daily);

4.18.2.5.2 Member Primary Care Physician Selection (Daily);

4.18.2.5.3 MCO Provider Network Confidential Data (Daily);

4.18.2.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.18.2.5.5 Member Encounter Confidential Data including paid, denied, adjustment transactions by pay period (Weekly);

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4.18.2.5.6 Financial Transaction Confidential Data (Weekly); and

4.18.2.5.7 Updates to Third Party Coverage Confidential Data (Weekly).

4.18.2.5.8 Behavioral Health Certification Data (Monthly).

4.18.2.6. The MCO shall provide Department staff with access to timely and complete Confidential Data and shall meet the following requirements:

4.18.2.6.1 All exchanges of Confidential Data between the MCO and the Department shall be in a format, file record layout, and scheduled as prescribed by the Department;

4.18.2.6.2 The MCO 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;

4.18.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide the Department with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between the Department and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.18.2.6.4 The MCO shall provide support to the Department and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data; and

4.18.2.6.5 The MCO shall be responsible for correcting Confidential Data extract errors in a timeline set forth by the Department as outlined within this Agreement.

4.18.3 **Systems Operation and Support**

4.18.3.1. Systems operations and support shall include, but not be limited to:

4.18.3.1.1 On-call procedures and contacts;

4.18.3.1.2 Job scheduling and failure notification documentation;

4.18.3.1.3 Secure (encrypted) Confidential Data transmission and storage methodology;

4.18.3.1.4 Interface acknowledgements and error reporting;

4.18.3.1.5 Technical issue escalation procedures;

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4.18.3.1.6 Business and Member notification;

4.18.3.1.7 Change control management;

4.18.3.1.8 Assistance with UAT and implementation coordination;

4.18.3.1.9 Documented Confidential Data interface specifications – Confidential Data imported and extracts exported including database mapping specifications;

4.18.3.1.10 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.18.3.1.11 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.

4.18.3.2. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.18.3.2.1 Network diagram that fully defines the topology of the MCO's network;

4.18.3.2.2 DHHS/MCO connectivity;

4.18.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and

4.18.3.2.4 Web access for the Department staff, Providers and recipients.

4.18.3.3. The MCO shall utilize either its own or the State's open model Electronic Visit (EVV) system as prescribed by the Department in separate guidance for all Medicaid personal care services and home health Covered Services that require an in-home visit by a Provider in accordance with Section 12006(a) of the 21st Century Cures Act. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver, as applicable.

4.18.4 **Ownership and Access to Systems and Data**

4.18.4.1. The MCO shall make available to the Department and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.18.4.2. Confidential Data accumulated, as part of the MCM program shall remain the property of the State.

4.18.4.3. The MCO shall provide the Department with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports,

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as well as the ability to respond promptly to ad-hoc requests to support the Department Confidential Data and information needs.

4.18.4.4. The Department acknowledges the MCO'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 MCO's systems.

4.18.5 **Records Retention**

4.18.5.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.18.5.2. 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.

4.18.5.3. 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.

4.18.5.4. 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.

4.18.5.5. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

4.18.6 **Web Access and Use by Providers and Members**

4.18.6.1. The MCIS shall include web access for use by and support to Participating Providers and Members.

4.18.6.2. The services shall be provided at no cost to the Participating Provider or Members.

4.18.6.3. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.18.6.4. The MCO 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:

4.18.6.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.18.6.4.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

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4.18.6.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

4.18.6.4.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.18.6.5. Providers shall have access to drug information;

4.18.6.5.1 The website shall provide an encrypted e-mail link to the MCO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.18.6.5.2 The website shall provide a link to the State's Medicaid website;

4.18.6.5.3 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.18.6.5.4 Access shall be limited to verified users.

4.18.6.6. The MCO 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.

4.18.6.7. System Support Performance Standards shall include:

4.18.6.7.1 Email inquiries–one (1) business day response;

4.18.6.7.2 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;

4.18.6.7.3 Routine maintenance;

4.18.6.7.4 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

4.18.6.7.5 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, MCO shall redirect user to site to install appropriate browser.

4.18.7 Contingency Plans and Quality Assurance

4.18.7.1. Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

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4.18.7.2. The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.18.7.3. 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 MCO and the Department.

4.18.7.4. 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 MCO.

4.18.7.5. [Amendment #1:] Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with Exhibit KG: ~~IT~~ Technical Requirements Workbook and security and access rights granted to users.

4.18.7.6. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall submit the following documents and corresponding checklists for the Departments Information Security review:

4.18.7.6.1 Disaster Recovery Plan;

4.18.7.6.2 Business Continuity Plan;

4.18.7.6.3 Security Plan;

4.18.7.6.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for Department review:

4.18.7.6.4.1. Risk Management Plan;

4.18.7.6.4.2. Systems Quality Assurance Plan; and

4.18.7.6.4.3. Confirmation of 5010 compliance and Companion Guides.

4.18.7.7. 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 MCO's change management process:

4.18.7.7.1 The complete system shall have proper configuration management/change management in place (to be reviewed by the Department).

4.18.7.7.2 The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

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4.18.7.7.3 The MCO 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 MCO and the Department and/or the fiscal agent.

4.18.7.7.4 The Department retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.18.7.7.5 The MCO 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.

4.18.7.7.6 The MCO shall provide the Department with official points of contact for MCIS issues on an ongoing basis.

4.18.7.7.7 The MCO shall ensure appropriate testing is done for all system changes. MCO 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.

4.18.7.7.8 The MCO 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.

4.18.7.8. The Department, or its agent, may conduct a Systems readiness review to validate the MCO's ability to meet the MCIS requirements.

4.18.7.9. 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 MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from the Department.

4.18.7.10. 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.

4.18.7.11. If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by the Department, either correct such deficiency or

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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.

4.18.7.12. QOS metrics shall include:

4.18.7.12.1 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:

4.18.7.12.1.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring;

4.18.7.12.1.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system; and

4.18.7.12.1.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.18.7.12.2 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.

4.18.7.12.3 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.

4.18.8 Interoperability and Patient Access

4.18.8.1. The MCO 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.

4.18.8.1.1. The MCO 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:

4.18.8.1.2 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)];

4.18.8.1.2.1. [Amendment #4:] Effective July 1, 2026, implement and maintain a Patient Access Application Programming Interface (API) required in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the MCO, and:

4.18.8.1.2.1.1 [Amendment #4:] Include all encounter data, including encounter data from any network providers compensated by the MCO based on capitation payments and adjudicated claims and encounter data from any Subcontractors

4.18.8.1.2.1.2 [Amendment #4:]

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Exclude covered outpatient drugs as defined in section 1927(k)(2) of the Act.

4.18.8.1.2.1.3 [Amendment #4:] Report metrics specified in 42 CFR 431.60(f) (total members whose data are transferred to an API and total members whose data were transferred more than once). [42 CFR 438.242(b)(5)]

4.18.8.1.3 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

4.18.8.1.4 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)].

4.18.8.2. The MCO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60, and include(s):

4.18.8.2.1 Confidential Data concerning adjudicated claims, including claims Confidential Data for payment decisions that may be appealed, were appealed, or

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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;

4.18.8.2.2 Encounter data, including encounter Confidential Data from any network providers the MCO 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

4.18.8.2.3 Clinical data, including laboratory results, if the MCO maintains any such data, no later than one (1) business day after the Confidential Data is received by the State.

4.18.8.2.4 Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)]

4.18.8.3. [Amendment #2:] The MCO shall implement and maintain a publicly accessible standards-based API 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), as well as Section 5123(c) of the Consolidated Appropriations Act, 2023, amended section 2107(e)(1)(G) of the Act to apply section 1902(a)(83) of the Act to States for CHIP in effect no later than July 1, 2025. [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)~~]~~; SMD 18-007]

4.19 Claims Quality Assurance Standards

4.19.1 Claims Payment Standards

4.19.1.1. For purposes of this Section 4.20 (Claims Quality Assurance Standards), the Department has adopted the claims definitions established by CMS. [42 CFR 447.25(b)]

4.19.1.1.1 “Clean Claim” as defined in Section 2.1 (Definitions); and

4.19.1.1.2 “Incomplete Claim” means a claim that is rejected for the purpose of obtaining additional information from the Provider.

4.19.1.1.3 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is

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received in the MCO's mailroom by its date stamp or the date an electronic claim is submitted.

4.19.1.2. 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]

4.19.1.3. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.19.1.4. The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt, or receipt of additional information.

4.19.1.5. The MCO 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].

4.19.1.6. The MCO 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. Upon request, the MCO shall make available Provider support staff to review Incomplete Claims, and support and educate Providers in the submission of Clean Claims.

4.19.2 **Claims Quality Assurance Program**

4.19.2.1. The MCO shall verify the accuracy and timeliness of Confidential Data reported by Providers, including Confidential Data from Participating Providers the MCO is compensating through a capitated payment arrangement.

4.19.2.2. The MCO shall screen the Confidential Data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

4.19.2.3. The MCO 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.

4.19.2.4. As indicated in Exhibit O: 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.

4.19.2.5. The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to the Department.

4.19.3 **Claims Financial Accuracy**

4.19.3.1. 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.

4.19.3.2. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

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4.19.4 Claims Payment Accuracy

4.19.4.1. 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.

4.19.4.2. The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.19.5 Claims Processing Accuracy

4.19.5.1. 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.

4.19.5.2. The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

5.1.1.1. As indicated throughout this Agreement, the Department shall document ongoing MCO reporting requirements through Exhibit O: Quality and Oversight Reporting Requirements and additional specifications provided by the Department.

5.1.1.2. The MCO shall provide data, reports, and plans in accordance with Exhibit O: Quality and Oversight Reporting Requirements, this Agreement, and any additional specifications provided by the Department.

5.1.1.3. The MCO shall comply with all NHID rules for Confidential Data reporting, including those related to the NH CHIS, NH code of Administrative Rule, Chapter Ins 4000. Failure to submit timely, accurate, and/or complete files to the NH CHIS shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.1.4. For all historical files submitted under NH Code of Administrative Rule, Chapter Ins 4000 after the submission start date, if DHHS or NHID notifies the MCO of not meeting compliance, the MCO shall remediate all related files within forty-five (45) calendar days after such notice.

5.1.1.5. If the MCO fails to comply with either error resolution timeline, DHHS shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.1.6. The MCO shall make all collected Confidential Data available to the Department upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.7. The MCO shall collect Confidential Data on Member and Provider characteristics as specified by the Department and on services furnished to

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Members through a MCIS system or other methods as may be specified by the Department. [42 CFR 438.242(b)(2)]

5.1.1.8. The MCO shall ensure that Confidential Data received from Providers are accurate and complete by:

5.1.1.8.1 Verifying the accuracy and timeliness of reported data;

5.1.1.8.2 Screening the Confidential Data for completeness, logic, and consistency; and

5.1.1.8.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.9. The Department shall at a minimum collect, and the MCO shall provide, 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 MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.9.1 Enrollment and disenrollment data;

5.1.1.9.2 Member grievance and appeal logs;

5.1.1.9.3 Medical management committee reports and minutes;

5.1.1.9.4 Audited financial and encounter data;

5.1.1.9.5 The MLR summary reports;

5.1.1.9.6 Customer service performance data;

5.1.1.9.7 Performance on required quality measures; and

5.1.1.9.8 The MCO's QAPI Plan.

5.1.1.10. The MCO 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:

5.1.1.10.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.10.2 A description of the innovative programs the MCO has developed and the outcomes associated with those programs;

5.1.1.10.3 A description of how the MCO is addressing health-related social needs and the outcomes associated with MCO-implemented interventions;

5.1.1.10.4 A description of how the MCO is improving health outcomes in the State; and

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5.1.1.10.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.11. 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 MCO policies and procedures and/or other administrative documentation.

5.1.1.11.1 The Department shall deem materials as pass or fail following the Department review.

5.1.1.11.2 The MCO shall complete and submit a Department-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.11.3 The Department may require modifications to MCO policies and procedures or other documentation at any time as determined by the Department.

5.1.1.12. The MCO shall submit all required data to meet CMS standards for submission to the Transformed Medicaid Statistical Information System.

5.1.2 **Requirements for Waiver Programs**

5.1.2.1. The MCO 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 MCO. These include but are not limited to:

5.1.2.1.1 Substance Use Disorder and Severe Mental Illness Institute for Mental Disease 1115 waiver;

5.1.2.1.2 Mandatory managed care 1915b waiver; and

5.1.2.1.3 Granite Advantage 1115 waiver.

5.1.3 **Encounter Data**

5.1.3.1. The MCO 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 MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO meets all Department reporting requirements.

5.1.3.3. The MCO shall submit to the Department for review, during the Readiness Review process, its policies and procedures that detail the MCO's encounter

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process. The MCO-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 MCO's encounter process;

5.1.3.3.2 Encounter specific source to target mapping detail that traces the inbound provider claim, in the applicable format, to the MCO's encounter system data storage location. The MCO shall provide the level of detail for each transmission of the source data that is used to create the encounter files that are submitted to DHHS;

5.1.3.3.3 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.4 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4. The MCO shall, as requested by the Department, submit updates to and revise upon request its policies and procedures that detail the MCO'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 MCO shall submit Encounter Confidential Data to the EQRO and the Department or its designated vendor upon the Department's request 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 MCO'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 MCO shall ensure that encounter records are consistent with the Department requirements and all applicable State and federal laws.

5.1.3.9. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.9.1 The MCO shall submit claim and claim line denial reason codes in the level of detail and format as specified by the Department.

5.1.3.10. The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

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5.1.3.11. The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12. The MCO shall have a computer and 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 MCO 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 MCO 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 MCO'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 Health Care Common Procedure Coding System (HCPCS);

5.1.3.16.2 CPT codes;

5.1.3.16.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.16.4 National Drug Codes which is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.16.5 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);

5.1.3.16.6 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;

5.1.3.16.7 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC

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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

5.1.3.16.8 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 MCO 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 (P – Professional and I - Institutional) or at the discretion of the Department the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NH file format, and other proprietary file layouts as defined by the Department.

5.1.3.18. All MCO encounters shall be submitted with MCO 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. [Amendment #3:] The paid amount (or FFS equivalent) submitted with Encounter Confidential Data shall be the final net amount paid to Providers by the MCO or any Subcontractor and, not limited to the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities.

5.1.3.19.1 [Amendment #3:] For example, the MCO paid amount submitted with pharmacy claim Encounter Confidential Data shall be the amount ultimately paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The submission of only the amount paid to the MCO's PBM is not acceptable

5.1.3.20. [Amendment #3:] Intentionally left blank ~~This requirement means that, for example for pharmacy claims, the MCO paid amount shall include the amount paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The amount paid to the MCO's PBM is not acceptable.~~

5.1.3.21. The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.22. The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.23. The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Confidential Data for all Covered Services.

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5.1.3.24. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.25. The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.25.1 Batch and Online Transaction Types are as follows:

5.1.3.25.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.25.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.25.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction;

5.1.3.25.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction;

5.1.3.25.1.5. ASC X12N 837P Professional Claim/Encounter Transaction;

5.1.3.25.1.6. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.25.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.25.2 Online transaction types are as follows:

5.1.3.25.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

5.1.3.25.2.2. ASC X12N 276 Claims Status Inquiry;

5.1.3.25.2.3. ASC X12N 277 Claims Status Response;

5.1.3.25.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and

5.1.3.25.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.26. 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.

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5.1.3.27. The MCO shall submit summary reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements, to be used to validate Encounter submissions.

5.1.3.28. The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by the Department for reporting Encounters and fee- for-service claims.

5.1.3.29. Any exceptions shall be considered on a code-by-code basis after the Department receives written notice from the MCO requesting an exception.

5.1.3.30. The MCO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.31. The MCO 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.

5.1.3.32. The MCO 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).

5.1.3.33. The MCO shall assign staff to participate in encounter technical work group meetings as directed by the Department.

5.1.3.34. The MCO shall provide complete and accurate encounters to the Department.

5.1.3.35. The MCO shall implement review procedures to validate Encounter Confidential Data submitted by Providers. The MCO shall meet the following standards:

5.1.3.35.1 Completeness

5.1.3.35.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.35.2 Accuracy

5.1.3.35.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions of

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each individual batch and online transaction type.

5.1.3.35.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.35.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.35.2.4. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.35.2.5. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.35.2.6. The MCO 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.

5.1.3.35.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Confidential Data quality.

5.1.3.35.2.8. The end to end test shall include a review of the Provider claim to what Confidential Data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.35.2.9. The MCO shall report a pass or fail to the Department. If the

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result is a fail, the MCO shall also submit a root cause analysis that includes plans for remediation.

5.1.3.35.2.10. If the Department or the MCO identifies a Confidential Data defect, the MCO 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.

5.1.3.35.2.11. If two (2) or more Encounter Confidential Data defects are identified within a rolling twelve (12) month period, the Department may require the MCO to contract with an external vendor to independently assess the MCO Encounter Confidential Data process. The external vendor shall produce a report that shall be shared with the Department.

5.1.3.35.3 Timeliness

5.1.3.35.3.1. Encounter Confidential Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.35.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.35.3.3. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.35.4 Error Resolution

5.1.3.35.4.1. For all historical encounters submitted after the submission

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start date, if the Department or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.35.4.2. For all ongoing claim encounters, if the Department or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

5.1.3.35.4.3. If the MCO 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).

5.1.3.35.4.4. The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by the Department.

5.1.3.35.5 Survival

5.1.3.35.5.1. All Encounter Confidential Data accumulated as part of the MCM 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

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Section 7.2 (Termination for Other Reasons).

5.1.3.35.6 Reporting

5.1.3.35.6.1. The MCO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to the MCO, including base Confidential Data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

5.1.3.35.6.2. When requested by the Department, the MCO 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.

5.1.3.35.6.3. The MCO'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 MCO shall be certified by one (1) of the following:

5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CFO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

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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 MCO 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 MCO shall submit the MCO 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 MCO shall have a Confidential Data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.14.3 (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 MCO 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 MCO 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 MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1. Section 3.10 (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 MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board

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of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The MCO 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 MCO 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 MCO 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 MCO 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 MCO 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 MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2. Within thirty (30) calendar days from the date of contract signing and annually thereafter, the MCO shall submit all updates and modifications to the Department for approval at least thirty (30) calendar days in advance of the effective date. The MCO 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 MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and re-credentialing processes.

5.3.1.4. The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 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 MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of Fraud, Waste and Abuse, and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to the Department.

5.3.1.6. The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against Fraud, waste and abuse.

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 MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9. The MCO 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 MCO program integrity meetings with the Department following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

5.3.1.9.1.1. The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.2 Discussion at these meetings shall include, but not be limited to, case development and monitoring, implementation of Fraud, Waste, and Abuse Annual Plans, plan use of data analytic Fraud detection algorithms required in Section 5.3.2.2.4.4, quality control and review of Encounter Confidential Data submitted to the Department, and corrective actions from the Department Program Integrity audits.

5.3.1.9.3 The MCO shall ensure Subcontractors attend monthly meetings based on relevant agenda items and ensure

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agenda items are removed if essential MCO or Subcontractor staff are unavailable;

5.3.1.9.4 Participation in any MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned; and

5.3.1.9.5 Participation in meetings with MFCU, as determined by MFCU and the Department.

5.3.2 **Fraud, Waste and Abuse**

5.3.2.1. The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste and Abuse. [42 CFR 438.608(a)]

5.3.2.2. The arrangements or procedures 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:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

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5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i-vii)]

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such as inducements;

5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or Fraud, Waste and Abuse to the Department within thirty (30) business days;

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5.3.2.2.4 The MCO shall maintain and report as requested specific controls to detect and prevent potential Fraud, Waste and Abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.4.4. 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 MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change based on outcomes of the algorithms and Department approval;

5.3.2.2.4.5. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.6. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or

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inappropriate use of Medicaid services and a description demonstrating the results of such protocols when requested by the Department;

5.3.2.2.4.7. 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 MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.8. Provider and Member materials identifying the MCO's Fraud and Abuse reporting hotline number;

5.3.2.2.4.9. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.10. The Department reserves the right to require at least ten (10) specific on-site investigations based on the MCO's request to open an investigation;

5.3.2.2.4.11. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency

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of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.12. 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

5.3.2.2.4.13. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and/or abusive, incorrect billing trends with a particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.5 [Amendment #4:] A provision for the prompt reporting within 30 calendar days of all Overpayments identified and recovered, specifying the Overpayments due to potential Fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider Fraud, Waste and Abuse that the MCO or Subcontractor identifies to the Department Program Integrity and any potential Fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO'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

5.3.2.2.8 A provision for notification to the Department when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O: Quality and Oversight Reporting Requirements.

5.3.2.3. The MCO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide

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detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4. The MCO, and if required by the MCO's Subcontractors, shall post and maintain 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.

5.3.2.5. [Amendment #3:] By October, 1, 2025, the MCO shall establish protocols to identify and report any NH Medicaid Member concurrently enrolled in the corporate entity's other state Medicaid plan(s) (as applicable), and also report Members discovered to be enrolled in any other State Medicaid program in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

5.3.3 **Identification and Recoveries of Overpayments**

5.3.3.1. The MCO shall maintain an effective Fraud, Waste and Abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2. The MCO 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.

5.3.3.4. The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to Fraud, Waste and Abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5. The MCO 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. [Amendment #4:] The Department may recover Overpayments that are not recovered by or returned to the MCO within ninety (90) ~~sixty (60)~~ calendar days

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of the end of the appeal timeframe ~~notification by final findings letter to the Provider by the MCO~~ unless the MCO has a recovery agreement with the Provider,or is actively recovering through claims recoupment. The Department will notify MCO if the Department has plans to pursue recovery.

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.

5.3.3.8. Any settlement reached by the MCO 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 MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.10. If the MCO does not meet the required metrics related to expected Fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O: Quality and Oversight Reporting Requirements, the Department shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

5.3.4 **Referrals of Credible Allegations of Fraud, Waste or Abuse and Provider and Payment Suspensions**

5.3.4.1. General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to 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 MCO 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. The Department’s Program Integrity Unit shall have fifteen (15) business days to respond to the MCO’s “Request to Open” form.

5.3.4.1.3 When the MCO or its Subcontractor has concluded that a credible allegation of Fraud or abuse exists, the MCO shall make a referral to the Department’s 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 MCO 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 [Amendment #2:] The MCO shall employ pre-payment review when directed or approved by the Department.

5.3.4.1.6 [Amendment #2:] The MCO may employ pre-payment review with approval from the Department when requirements specified in separate guidance are met.~~In addition, the MCO may employ pre-payment review in the following circumstances without approval:~~

5.3.4.1.6.1. [Amendment #2:] Intentionally left blank~~Upon new Participating Provider enrollment;~~

5.3.4.1.6.2. [Amendment #2:] Intentionally left blank~~For delayed payment during Provider education;~~

5.3.4.1.6.3. [Amendment #2:] Intentionally left blank~~For existing Providers with billing inaccuracies; or~~

5.3.4.1.6.4. [Amendment #2:] Intentionally left blank.~~Fraud 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 MCO's Compliance Officer

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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 an exception to suspension does not apply, as determined by the Department under 42 CFR 455.23.

5.3.4.1.8 The Department shall notify the MCO 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, Waste or Abuse referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this section of the Agreement.

5.3.4.1.10 Upon receipt of notification from the Department, the MCO 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

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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 MCO.

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 MCO is notified by the Department that there is insufficient evidence of Fraud, Waste or Abuse by the Provider; or

5.3.4.1.12.2. The MCO is notified by the Department that the legal proceedings related to the Provider's alleged Fraud, Waste or Abuse are completed.

5.3.4.1.13 The MCO 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 as set forth in 42 CFR 455.23.

5.3.4.1.15 Every thirty (30) calendar days that a payment suspension exists, the Department shall direct the

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MCO to continue, reduce, or remove the payment suspension.

5.3.4.1.16 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.1.16.1. Details of payment suspensions that were imposed in whole or in part; and

5.3.4.1.16.2. Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.1.17 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of Fraud, Waste or Abuse without good cause, and the Department directed the MCO to suspend payments, the Department may impose liquidated damages.

5.3.4.1.18 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 MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.1.19 Furthermore, the MCO 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 MCO 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.

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5.3.4.1.20 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 MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate Fraud, Waste and Abuse.

5.3.5.2. The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3. The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, the Department, OIG, and CMS).

5.3.5.4. The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5. The MCO 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 MCO 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 MCO 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 MCO 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.

5.3.5.9. These refunds shall be reported to the Department as Overpayments.

5.3.5.10. The Department shall conduct investigations related to suspected Provider Fraud, Waste or Abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO has not submitted a request to open or for which the MCO has not continued to pursue the case. The State shall notify the MCO of any investigation it intends to open prior to contacting the Provider.

5.3.5.11. Investigations should be concluded within nine (9) months of the approval of the request to open. The MCO must submit a justification for the investigation remaining open if it exceeds nine (9) months with an expected date for the conclusion of the investigation and receive approval from the Department to continue the investigation. The MCO may be penalized if the justification is not approved in accordance with Exhibit N: Liquidated Damages

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Matrix. A case shall be considered completed when a final conclusion letter is sent to the provider or a referral has been made to MFCU.

5.3.5.11.1 The MCO shall submit a final letter to the Department's Program Integrity Unit for each investigation, which explains the outcome of the case and actions taken by the MCO.

5.3.5.12. The MCO shall conduct a follow up investigation twelve (12) months after the final recovery letter date to ensure the same issue is not repeated.

5.3.6 **Reporting**

5.3.6.1. Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

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:

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.

5.3.6.1.3 As part of this report, the MCO shall submit to the Department the Overpayments it recovered, certified by its CFO that this information is accurate to the best

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of their information, knowledge, and belief, as required by Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.606]

5.3.6.2. Reporting Member Fraud

5.3.6.2.1 The MCO shall notify the Department of any cases in which the MCO believes there is a serious likelihood of Member Fraud, Waste and Abuse by sending a secure email to the Department Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member Fraud, Waste and Abuse and referring Member Fraud, Waste or Abuse to the Department. The MCO shall provide initial allegations, investigations and resolutions of Member Fraud, Waste and Abuse to the Department.

5.3.6.3. Termination Report

5.3.6.3.1 The MCO 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 MCO shall submit to the Department demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 [Amendment #4:] The MCO shall report at least annually to the Department, and as otherwise required by this Agreement, on all ~~their recoveries of~~ Overpayments identified and recovered. [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 MCO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the MCO shall provide the Department program integrity staff (or its designee), real time access to all of the MCO electronic encounter and claims Confidential Data (including the

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Department third-party liability) from the MCO's current claims reporting system.

5.3.7.2. The MCO shall provide the Department with the capability to access accurate, timely, and complete Confidential Data as specified in Section 4.20.2 Claims Quality Assurance Program).

5.3.7.3. The MCO and the MCO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.

5.3.7.4. The MCO 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 Medical 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 an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

5.3.7.6. Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate the Department, MFCU or other State or federal agencies.

5.3.7.7. The MCO and the MCO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours. [42 CFR 438.3(h)]

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5.3.7.8. The MCO 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 MCO or its Subcontractors at the MCO's expense.

5.3.7.10. The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.11. The Department shall conduct, or contract for the conducting of, periodic audits of the MCO 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 MCO. [42 CFR 438.602(e)]

5.3.7.12. This shall include, but not be limited to, any records relevant to the MCO'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 MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 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 MCO resulting from the State's periodic audit; and

5.3.8.1.4 Performance metrics and outcomes.

5.4 **MCM Withhold and Incentive Program**

5.4.1 [Amendment #3:] Beginning September 1, 2024, t~~T~~he Department shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted Capitation Payment will be recouped from the MCO and be available for distribution ~~in future years~~ upon meeting specific criteria set forth in program guidance issued by the Department.

5.4.2 The Department shall issue Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by the Department.

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5.4.3 [Amendment #3:] Beginning September 1, 2024, t~~T~~he Department shall institute a Withhold and Incentive Program which directs an annual actuarially sound two percent (2%) retention of the MCO'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.

5.4.4 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall:

5.4.4.1. 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;

5.4.4.2. Not be renewed automatically;

5.4.4.3. Be made available to both public and private contractors under the same terms of performance;

5.4.4.4. Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements; and

5.4.4.5. Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.5 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.5.1. Pursuant to 42 CFR 438.6(b)(2), this incentive arrangement shall:

5.4.5.1.1 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;

5.4.5.1.2 Not be renewed automatically;

5.4.5.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.5.1.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.5.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.6 Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

5.4.7 [Amendment #1:] Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the

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Withhold and Incentive Program is to maintain withhold funds in the program for actuarial soundness, should there be a remaining amount in withheld funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract closeout period~~term~~ in accordance with separate guidance.

5.4.8 [Amendment #4:] In accordance with RSA 126-A:3, the Department will seek to implement an outpatient procedure incentive program beginning as early as January 1, 2026, subject to review and approval from the fiscal committee of the general court.

5.5 Remedies

5.5.1 Reservation of Rights and Remedies

5.5.1.1. The MCO 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 MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State 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 MCO'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

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non-compliance, and update Exhibit N: Liquidated Damages Matrix as needed via contract amendment.

5.5.2.2. DHHS and the MCO agree that it shall be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event the MCO 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: Liquidated Damages Matrix, 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 MCO 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.

5.5.2.8. At its sole discretion, the Department may temporarily provide the MCO 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 MCO 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 MCO in

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excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 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 MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide 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 $25,000 for each failure to provide medically necessary services, and may also:

5.5.4.2.2.1. Appoint temporary management for the MCO,

5.5.4.2.2.2. In the event of multiple MCOs, 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 MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.2.5. Suspend payments for new enrollments to the MCO 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

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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 $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 MCO;

5.5.4.2.3.2. Grant Members the right to disenroll without cause;

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or 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 one hundred thousand dollars ($100,000) for each determination by the Department of discrimination. The Department may impose a civil monetary penalty of up to fifteen thousand dollars ($15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar ($100,000) maximum. The Department may also:

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5.5.4.2.4.1. Appoint temporary management to the MCO;

5.5.4.2.4.2. Grant Members the right to disenroll without cause;

5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or 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 $25,000 for each instance of misrepresentation. The Department may also:

5.5.4.2.5.1. Appoint temporary management to the MCO;

5.5.4.2.5.2. Grant Members the right to disenroll without case;

5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

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5.5.4.2.5.4. Suspend payments for new enrollments to the MCO 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 one hundred thousand dollars ($100,000) for each instance of misrepresentation. The Department may also:

5.5.4.2.6.1. Appoint temporary management to the MCO;

5.5.4.2.6.2. Grant Members the right to disenroll without cause;

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or 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);

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1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.7 Fails to comply with the Medicare Physician Incentive Plan requirements, in which case, DHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply. DHHS may also:

5.5.4.2.7.1. Appoint temporary management to the MCO;

5.5.4.2.7.2. Grant Members the right to disenroll without cause;

5.5.4.2.7.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.7.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3. The Department shall have the right to impose civil monetary penalty of up to $25,000 for each distribution if the Department determines that the MCO 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 MCO's Members in other MCOs if the Department determines that the MCO 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

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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 MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b-d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6. The Department shall only have the right to impose the following intermediate sanctions when the Department determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of 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 MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or 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.

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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 MCO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.1.4. The Department shall impose mandatory temporary management when the MCO 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 MCO 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**

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5.5.6.1. If requested by the Department, the MCO 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) business days of receipt.

5.5.6.3. The MCO 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 MCO 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 MCOs 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. MCOs 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 MCO;

5.5.8.1.5 Whether a CAP is being requested; and

5.5.8.1.6 The timeframe and procedure for the MCO to dispute the Department's determination.

5.5.8.2. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.3. 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 MCO'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 to allow for adjustments to start-up operations; thereafter,

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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 The Department, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right to audit the records and/or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.2 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 MCO or its Subcontractors pertaining to:

5.6.2.1. The ability of the MCO to bear the risk of financial losses; and

5.6.2.2. Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, no later than forty (40) business days after the end of the State Fiscal Year, the MCO shall provide the Department a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.4 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.

5.6.5 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:

5.6.5.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

5.6.5.2. Written assertion by the MCO's management about whether:

5.6.5.2.1 The aforementioned description fairly presents the system in all material respects;

5.6.5.2.2 The controls were suitably designed to achieve the control objectives stated in that description; and

5.6.5.2.3 The controls operated effectively throughout the specified period to achieve those control objectives.

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5.6.5.3. Report of the MCO's auditor, which:

5.6.5.3.1 Expresses an opinion on the matters covered in management's written assertion; and

5.6.5.3.2 Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

5.6.6 The MCO shall notify the Department if there are significant or material changes to the internal controls of the MCO.

5.6.7 If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

5.6.8 The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

5.6.9 The Department may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing CAPs and review MCO compliance with requirements and standards as specified in this Agreement.

5.6.10 The MCO shall use reasonable efforts to respond to the Department oral and written correspondence within one (1) business day of receipt.

5.6.11 The MCO shall file annual and interim financial statements in accordance with the standards set forth below.

5.6.12 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 MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]

5.6.13 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.

5.6.14 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.

5.6.15 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

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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 MCO may protest such action or decision by the delivery of a written notice of protest to the Department and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director").

5.7.1.2. The MCO 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 MCO 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 MCO 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 MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of the Department under RSA chapter 541-A, if applicable, or any applicable

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provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from 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 MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO 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 MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

6.1.6 The MCO shall submit Confidential Data on the basis of which the Department has the ability to determine that the MCO has made adequate provisions against the risk of insolvency.

6.1.7 The MCO 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 MCO to perform under this Agreement.

6.1.8 [Amendment #3:] The MCO shall not participate in and shall prohibit clawback business arrangements, network access fees, transaction fees, and all other similar types of arrangements with its Pharmacy Benefit Managers (PBM) or any other Subcontractor for Covered Services whereby such PBM or Subcontractor reimburses network pharmacies or other Providers an initial reimbursement amount and subsequently the PBM or

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other Subcontractor receives remuneration for a portion of that fee. Such clawback or similar arrangements include, but are not limited to, both rate guarantee agreements between the PBM and MCO and the PBM and the network pharmacy. Rate guarantee agreement solely between the MCO and PBM shall not be considered a prohibited clawback business arrangement under this Agreement, but must be reported in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

6.2 **Capitation Payments**

6.2.1 Capitation payments made by the Department and retained by the MCO 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 MCO 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 Capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.

6.2.3.1. The risk adjustment process shall use the most recent version of the CDPS+Rx model to assign scored individuals to a demographic category and disease categories based on their medical claims and drug utilization during the study period. The methodology shall also incorporate a custom risk weight related to the cost of opioid addiction services, as deemed necessary by the Department and its actuary. Scored individuals are those with at least six months of eligibility and claims experience in the base data. The methodology shall exclude diagnosis codes related to radiology and laboratory services to avoid including false positive diagnostic indicators for tests run on an individual. Additionally, each scored member with less than 12 months of experience in the base data period shall also be assigned a durational adjustment to compensate for missing diagnoses due to shorter enrollment durations, similar to a missing data adjustment.

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6.2.3.2. Each unscored member shall be assigned a demographic-only risk weight instead of receiving the average risk score for each MCO's scored members in the same rate cell. The risk adjustment methodology shall also incorporate a specific adjustment to address cost and acuity differences between the scored and unscored populations, which shall be documented by a thorough review of historical data for those populations based on generally accepted actuarial techniques.

6.2.3.3. Members shall be assigned to MCOs and rate cells using the actual enrollment by MCO in each quarter to calculate risk scores in order to capture actual membership growth for each MCO.

6.2.3.4. The Department and its actuary reserve the right to modify the risk adjustment methodology.

6.2.4 The MCO 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)]

6.2.5 The MCO and the Department agree the Capitation Rates 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.

6.2.6 The MCO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, including base Confidential Data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.7 When requested by the Department, the MCO shall submit Encounter Data, financial data, and other Confidential Data to the Department to ensure actuarial soundness in development of the capitation rates, or any other actuarial analysis required by the Department or State or federal law.

6.2.8 The MCO'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 capitation rates, is complete and accurate. [42 CFR 438.606]

6.2.9 The MCO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The MCO may retain such recoveries, subject to the parameters in the Agreement, since the capitation rates are calculated net of expected MCO recoveries.

6.2.10 The Department shall make a monthly payment to the MCO for each Member enrolled in the MCO's plan as the Department currently structures its capitation payments.

6.2.10.1. Capitation Payments for all standard Medicaid Members shall be made retrospectively with a one month plus five (5) business day lag.

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6.2.10.2. Capitation Payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.11 The capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.12 [Amendment #1:] The Department may adjust the capitation rate based on Member enrollment span changes (e.g., category of eligibility, enrollment termination, age) that occurred during the month that are not otherwise recognized in capitation adjustments. ~~The 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~~.

6.2.13 Capitation adjustments are processed systematically each month by the Department's MMIS.

6.2.14 The Department shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.15 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.

6.2.16 **Capitation Settlement**

6.2.16.1. The Department has sole discretion over the capitation settlement process.

6.2.16.2. The MCO shall follow policies and procedures for the settlement process as developed by the Department.

6.2.16.3. Based on the provisions herein, the Department shall not make any further retroactive adjustments other than those described herein or elsewhere in this Agreement.

6.2.16.4. The Department and the MCO agree there is a nine (9) month limitation from the date of the Capitation Payment and is applicable only to retroactive Capitation Payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO.

6.2.16.5. 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.

6.2.16.6. For each live birth, the Department shall:

6.2.16.6.1 Make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.16.6.2 This payment is a global fee to cover all delivery care.

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6.2.16.6.3 In the event of a multiple birth DHHS shall make only one (1) maternity kick payment.

6.2.16.6.4 A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.16.7. Make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.16.7.1 This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services.

6.2.16.7.2 Enrolled babies shall be covered under the MCO capitated rates thereafter.

6.2.16.7.3 Different rates of newborn kick payments may be employed by the Department, in its sole discretion, to increase actuarial soundness.

6.2.16.7.4 Two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns.

6.2.16.7.5 Each type of payment is distinct and only one payment is made per newborn.

6.2.16.7.6 The MCO shall submit information on maternity and newborn events to DHHS, and shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.16.8. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025 ending August 31, 2024~~ (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.17.3 below.

6.2.16.8.1 The kick payment shall be specific to the corresponding Peer Groups established by DHHS. Separate kick payments exist for Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09.

6.2.16.8.2 Psychiatric admissions for dually eligible Members are not subject to the kick payment and shall be paid out of the capitation rates.

6.2.16.8.3 [Amendment #3:] Psychiatric admissions for Members at New Hampshire Hospital ~~and Hampstead Hospital~~

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are not subject to the kick payment and shall be paid out of the MCO's capitation rates.

6.2.16.9. [Amenment #4:][Amendment #2:] Beginning f~~F~~or services effective January 1, 2025, for the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each of three (3) new kick payments to cover juveniles and adults who are incarcerated to comply with new service requirements as part of the implementation of the expansion of its Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance Treatment and Recovery Access 1115 Demonstration Waiver~~Intentionally left blank~~.

6.2.16.10. Intentionally left blank.

6.2.16.11. Intentionally left blank.

6.2.16.12. Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to the Department's MMIS by the MCO.

6.2.16.13. [Amendment #1:] Eligibility for a capitation payment from the MCO to the CMH Program is based on a valid behavioral health certification and the Member having had an encounter in the last three (3) months. ~~The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months.~~

6.2.16.14. [Amendment #1:] Changes to a Member's behavioral health certification enrollment span are reflected in Capitation Payments as described in Section 6.2.12 of this Agreement. ~~Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.~~

6.2.17 **Capitation Adjustments**

6.2.17.1. After the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted Capitation Payment net of directed payments to the MCO shall be calculated as having been withheld by the Department. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance.

6.2.17.1.1 Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by the Department as indicated in Section 5.4 (Withhold and Incentive Payment Program).

6.2.17.1.2 The Department shall inform the MCO of any required program revisions or additions in a timely manner.

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6.2.17.1.3 The Department may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.17.2. The Department shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.17.3. In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member.

6.2.17.4. The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.17.5. 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 MCO must do no work on that part after the effective date of the loss of program authority.

6.2.17.6. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.17.7. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work.

6.2.17.8. If the State paid the MCO 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.

6.2.17.9. However, if the MCO 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 MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6.2.18 Other Reimbursement Considerations

6.2.18.1. Unless MCOs 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 MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

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6.3 Medical Loss Ratio (MLR) Reporting and Settlement

6.3.1 Minimum MLR Performance and Rebate Requirements

6.3.1.1. The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2. [Amendment #1:] In the event the MCO's MLR for any single reporting year is below the minimum ~~of the~~eighty-five percent (85%) requirement as reported by the MCO in accordance with Section 6.3.2 of this Agreement, or determined by the State's actuary or the State's contracted MLR examiner required under CMS rule, the MCO 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 MCO from the Department multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR.

6.3.1.3. If the MCO 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 MCO 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 MLR

6.3.2.1. The MCO 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)]

6.3.2.2.1 The calculation of the MLR will be updated to consider new provisions added or amended by CMS through published rules and guidance.

6.3.2.3. Each MCO 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.

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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 MLR report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims, expenditures for activities that improve health care quality or licensing and regulatory fees or federal and state taxes.

6.3.2.5.1 Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue-based assessments.

6.3.2.5.2 Expenses for administrative services may include amounts that exceed a third party's costs (profit margin), but these amounts must be justified and consistent with prudent management and fiscal soundness requirements to be includable when these transactions are between related parties. [42 C.F.R. § 422.516(b)].

6.3.2.6. Health Care Quality Improvement (HCQI) expenses are limited to the portion of salaries and benefits for employees directly performing administrative functions for inclusion in the MLR calculation. Expenses for items such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, equipment, computer and telephone usage, travel and entertainment, company parties and retreats, information technology infrastructure and systems, and software licenses do not qualify as direct HCQI expenses.

6.3.2.7. The MCO may add a credibility adjustment in accordance with 42 CFR 438.8(h) to a calculated MLR if the MLR reporting year experience is partially credible.

6.3.2.7.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.7.2 The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

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6.3.2.7.3 If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 **MLR Reporting**

6.3.3.1. The MCO shall submit MLR summary reports quarterly to the Department in accordance with Exhibit O: 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 MCO 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)]

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6.3.3.5. The MCO 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 MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying Confidential Data associated with MLR reporting to the MCO 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 MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.6.1 [Amendment #2:] Effective July 1, 2026, the MCO shall require its Subcontractors responsible for the delivery or administration of the covered outpatient drug benefit to report separately to the MCO the amounts related to:

6.3.3.6.1.1. [Amendment #2:] The incurred claims described in 42 CFR 438.8(e)(2) such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to Providers or pharmacies for dispensing or administering a covered outpatient drug; and

6.3.3.6.1.2. [Amendment #2:] Administrative costs, fees and expenses of the Subcontractor. [42 CFR 438.3(s)(8)]

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 MCO 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)]

6.3.3.8. The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.4 **Risk Mitigation**

6.3.4.1. Risk Pool Protections

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6.3.4.1.1 [Amendment #3:] [Amendment #1:] High-Cost Pharmacy Risk Pool. The Department will provide an actuarially sound High-Cost Pharmacy Risk Pool (HCPRP) funded though the MCO capitation rates that will allocate HCPRP funding to each MCO based on the qualifying pharmacy claim payments for Members with annual pharmacy claim payments over a specified threshold. The HCPRP will offer the Department and the MCOs protection for Members with total pharmacy spend exceeding a predetermined threshold. Any pharmacy costs above the threshold are included in the HCPRP pool amount (excluding medications typically included as part of the NH Medicaid DRG grouper reimbursement methodology; gene therapies and other high-cost medications should be billed separate from the DRG grouper for inclusion in the HCPRP), and first subject to an at-risk coinsurance amount that is the responsibility of the MCOs. The remaining HCPRP amount will be redistributed across MCOs based on actual experience of the remaining pharmacy expenses (i.e., in excess of the threshold after coinsurance is applied). All associated pharmacy funding, including the HCPRP amounts, will be prospectively included in the capitation rates by rate cell. The HCPRP amount will be subject to a separate HCPRP risk corridor to provide further protection from under or over funding of the HCPRP amount~~provide MCO protection for Members with pharmacy claims in access of the attachment point. Detailed program features and parameters will be established on an annual basis in guidance~~.

6.3.4.1.1.1. [Amendment #1:] During the contract year, the MCO will be required to pay pharmacy claims as normal.

6.3.4.1.1.2. [Amendment #1:] Reconciliation and reallocation of HCPRP amounts will be based on actual HCPRP expenditures as described in separate guidance.

6.3.4.1.1.3. [Amendment #1:] The HCPRP includes threshold, coinsurance, and risk corridor features, as follows:

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6.3.4.1.1.3.1 [Amendment #3:] [Amendment #1:] For the July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ rating period and annually thereafter, the threshold is set at $250,000 total drug spend per Member.

6.3.4.1.1.3.2 [Amendment #3:] [Amendment #1:] For the July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ rating period, the MCO is at-risk for coinsurance across all eligible rate cells, as follows:

6.3.4.1.1.3.2.1 [Amendment #1:] 30% coinsurance for members with a total drug spend of $250,000 - $750,000;

6.3.4.1.1.3.2.2 [Amendment #1:] 20% coinsurance for members with a total drug spend of $750,000 - $1,250,000; and

6.3.4.1.1.3.3.2.3 [Amendment #1:] 10% coinsurance for

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members with a total drug spend greater than $1,250,000.

6.3.4.1.1.4. [Amendment #3:] [Amendment #1:] For the ~~September~~July 1, 2025 ~~2024~~ through June 30, 2026 ~~2025~~ rating period, the Department shall implement a risk corridor for pharmacy costs as described in Section 6.3.4.1.1 of this Agreement ~~for all pharmacy costs (excluding inpatient pharmacy services) around the HCPRP to offer additional protection against under/over funding of the HCPRP~~, as follows:

Under/Overfunding	DHHS Share	MCO Share
Less than Pool Fund -10%	100%	0%
Pool Fund -10% to -5%	50%	50%
Pool Fund -5% to +5%	0%	100%
Pool Fund +5% to +10%	50%	50%
Greater than Pool Fund +10%	100%	0%

6.3.4.1.2 The Department shall implement a budget neutral-risk pool for services provided at Boston Children's Hospital in order to better allocate funds based on MCO-specific spending for these services. Inpatient and outpatient facility services provided at Boston Children's Hospital qualify for risk pool calculation.

6.3.4.2. Minimum and Maximum MLR

6.3.4.2.1 The Department reserves the right to modify its risk mitigation strategies in accordance with actuarially sound practices.

6.3.4.2.2 For each year under this Agreement, the Department and its actuary will determine if a minimum and maximum MLR should be implemented due to unforeseen events that could materially impact the level of uncertainty associated with the financial soundness of the MCM program. The MCM program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such

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as enrollment projections, emerging utilization experience, and retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period based on the target MLRs determined by the Department.

6.3.4.2.2.1. [Amendment #2] [Amendment #1] For the September 1, 2024 through June 30~~August 31~~, 2025 rating period, the Department is committed to reviewing more mature emerging experience to evaluate the need for additional modifications to the acuity adjustment factors that could be required due to a potential deterioration of the aggregate program MLR. As part of the Amendment #2 capitation rate development process, the Department will request additional information from the MCO and conduct a review of recent MLR results. If these results show a material deterioration of the program MLR in aggregate, the Department and its actuaries may implement corrective adjustments to address this deterioration in financial performance retroactive to September 1, 2024.

6.3.4.2.3 Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation (i.e., High-Cost Drug Risk Pool, Boston Children's Hospital risk pool, prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.2.4 Minimum MLR settlement operational requirements include:

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6.3.4.2.4.1. 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 not include costs related to quality improvement activities or Fraud, Waste and Abuse prevention.

6.3.4.2.5 The denominator for the actual MLR shall equal the risk adjusted capitation revenue including risk mitigation settlement amounts as described in Section 6.3.4 (Risk Mitigation).

6.3.4.2.6 Payments and revenue related to directed payments and premium taxes shall be excluded from the numerator and denominator for the actual MLR.

6.3.4.2.7 Any incentive payments made to higher-performing MCOs as part of the Withhold Program shall not impact the minimum or maximum MLR provision of the Agreement.

6.3.4.2.8 The timing of the minimum and maximum MLR settlement shall occur after the contract year is closed and substantial paid claims runout is available.

6.3.4.2.9 Payments or recoupments related to the Withhold and Incentive Program shall be excluded from the MLR settlement. The Withhold and Incentive Program settlement shall occur after the MLR settlement is complete.

6.3.4.2.10 [Amendment #4:] The MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available. At the Department's discretion, a final revised MLR settlement calculation may occur upon completion of an MLR audit for the period, if applicable, to consider any adjustments identified during the MLR audit impacting the final MLR settlement calculation.

6.3.4.2.11 [Amendment #1:] The projected overall MCO MLR for at-risk services excludes the impact of the separate payment term directed payments and the 2.0% premium tax allowance in both the numerator and denominator of the MLR calculation. The following

overall MCO MLRs are projected under this Agreement:

6.3.4.2.11.1. [Amendment #1:] For the September 1, 2024 through June 30, 2025 rating period, at-risk services are projected as follows:

6.3.4.2.11.1.1 [Amendment #2:][Amendment #1:] For September 1, 2024 through December 31, 2024, at-risk services are projected as 91.2% ~~90.9%~~ for the Standard Medicaid population and 90.3% ~~89.9%~~ for the GAHCP population which includes an overall 7.3%~~7.6%~~ administrative cost allowance for the Standard Medicaid population, and 8.2% ~~8.6%~~ for the GAHCP population; and 1.5% risk margin applied as a percentage of revenue prior to the

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directed payments and the premium tax allowance; and

6.3.4.2.11.1.1.1 [Amendment #2:] For January 1, 2025 through June 30, 2025, at-risk services are projected as 91.2% for the Standard Medicaid population and 90.4% for the GAHCP population which includes an overall 7.3% administrative cost allowance for the Standard Medicaid population, and 8.1% for the GAHCP population; and 1.5% risk margin applied as a percentage of revenue prior to the directed payments and the premium tax allowance; and

6.3.4.2.11.1.2 [Amendment #2:] [Amendment #1:] For the September 1, 2024 through June 30, 2025 rating period, the minimum MLR is set on a program-wide basis for each major population,

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such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target, the minimum MLR will be 88.7% for the Standard Medicaid population and 87.9% for the GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above The minimum e target MLR, such that MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR will be 94.7% for the

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Standard Medicaid population and 93.9% for the GAHCP population.

6.3.4.2.11.1.3 [Amendment #4:] [Amendment #3:] For the July 1, 2025 through June 30, 2026 rating period, the capitation rates reflect an average target MLR, which measures the projected medical service costs as a percentage of the total at-risk capitation rates. The minimum MLR will limit MCO gains if the actual MLR is lower than the minimum MLR. The maximum MLR will limit MCO losses if the actual MLR is higher than the maximum MLR. The average

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target MLR for at-risk services is 91.2%~~90.9%~~ for Standard Medicaid and 90.3%~~90.0%~~ for GAHCP based on the SFY 2026 projected enrollment distribution. The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs for the rating period, the minimum MLR will be 88.7%~~88.4%~~ for the Standard Medicaid population and 87.8%~~87.5%~~ for the

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GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCO will have a maximum loss of 2%. Based on the target MLRs for the rating period, the average maximum MLR will be 94.7%~~94.4%~~ for the Standard Medicaid population and 93.8%~~93.5%~~ for the GAHCP population.

6.3.4.2.12 [Amendment #1:] Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation (i.e., High-Cost Drug Risk Pool, Boston Children's Hospital risk pool, prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.3. [Amendment #3:] [Amendment #2] [Amendment #1:] CMH Programs: For the July 1, 2025 ~~September 1, 2024~~ through June 30~~August 31, 2026~~ ~~2025~~ rating period, the Department shall mitigate the MCO and Department gains and losses due to significant changes under the new CMH Program payment

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model when experience is above or below the actuarial estimate of a 12.0% ~~14.0%~~ adjustment for the three-month lookback. Specifically, the Department shall review whether the CMH Program outreach efforts targeted at serving more members within the three-month lookback period are higher or lower than the estimate included in the rating period's capitation rates. To compensate for higher or lower utilization estimates, a risk corridor around the 12.0% ~~14.0%~~ adjustment for the three-month lookback shall be included in the development of the CMH Program specific capitation rates for the period. The risk corridor shall reduce or increase overall MCO capitation payment funding for the CMH Programs if actual experience is outside a plus or minus 2% range for the three-month lookback adjustment factor of 12.0% ~~14.0%.~~

6.4 **[Amendment #1:] Financial Responsibility for ~~Dual-Eligible~~ Members with Other Insurance**

6.4.1 For Medicare Part A crossover claims and Medicare Part B crossover claims billed on the UB-04, the MCO shall pay the patient responsibility amount (deductible and coinsurance) for Covered Services.

6.4.1.1. [Amendment #4:] For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment.

6.4.2 For Part B crossover claims billed on the CMS-1500, the MCO shall pay the lesser of:

6.4.2.1. The patient responsibility amount (deductible and coinsurance) for Covered Services, or

6.4.2.2. The difference between the amount paid by the primary payer and the Medicaid allowed amount.

6.4.2.3. [Amendment #4:] Intentionally left blank ~~For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment~~.

6.4.3 [Amendment #1:] For all medical and pharmacy claims with other insurance payment (e.g., commercial, Medicare Advantage), excluding Medicare Part A, Part B, and Part D, the MCO shall use the lessor logic described below unless otherwise stipulated in this Agreement:

6.4.3.1. [Amendment #1:] The patient responsibility amount (deductible, Co-payment, or coinsurance), or

6.4.3.2. [Amendment #1:] The difference between the amount paid by the primary payer and the Medicaid allowed amount, if less than the patient responsibility amount, or

6.4.3.3. [Amendment #1:] If the Member responsibility amount is "0" then the MCO shall make no payment.

6.4.4 [Amendment #4:] [Amendment #1:] For all claims (medical and pharmacy) with other insurance or Medicare Advantage plans, the MCO shall follow

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coordination of benefit processes described in entirety of this Section 6.4, ~~the primary insurance claim process in paying as secondary~~ unless otherwise stipulated in this Agreement.

6.4.4.1. [Amendment #2] For CMHCs and State certified CCBHCs, for (1) Covered Services statutorily excluded from Medicare (excluding Medicare Advantage plans), the MCO shall institute a claims edit approving payment for such Covered Service and shall not require the CMHC or CCBHC to first bill Medicare (excluding Medicare Advantage plans); and (2) Members also enrolled in a Medicare Advantage plan or private commercial plan, the MCO shall only require CMHCs and CCBHCs to receive one denial per year, from the Member's Medicare Advantage plan or private commercial plan, for functional support services or targeted case management Covered Services provided by the CMHC or CCBHC, and MCO shall institute a claims edit approving functional support services or targeted case management Covered Services provided by the CMHC or CCBHC when CMHC or CCBHC has received the required one denial per year from the Member's Medicare Advantage plan or private commercial plan.

6.4.4.2. [Amendment #4:] [Amendment #3:] Beginning March 1, 2026, t~~T~~he MCO shall pay ~~claims~~ as primary payer ~~when a provider~~ for Medicare Part A and Part B claims when the provider is not enrolled with Medicare on the date of service ~~as a participating provider~~.

6.4.4.3. [Amendment #4:] Beginning March 1, 2026, the MCO is responsible for Member Cost Sharing, (e.g., Copayment, deductible) (excluding Medicare Part D medications), as applicable, when other insurance, Medicare Part A or Part B, or Medicare Advantage pays as primary for a Covered Service via an automated crosswalk table or other methodology to effectuate payment regardless of whether the primary payer uses a different billing code for the same Covered Service.

6.4.5 [Amendment #4] The MCO shall not pay Member Cost Sharing for Medicare Part D covered medications regardless of whether the Member has one or both Medicare Part A and/or Medicare Part B.

6.5 Medical Cost Accruals

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The MCO shall permit the Department or its designee(s) and/or the NHID to inspect and audit any of the financial records of the MCO 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,

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appropriateness or timeliness of services and reasonableness of their costs. [SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The MCO 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 MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant.

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 MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.7 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 **Member Liability**

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1. The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2. The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3. The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4. Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c); section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly

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[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 MCO 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 MCO 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 MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 **Federal Matching Funds**

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the MCO by the Department.

6.10 **Third Party Liability**

6.10.1 NH Medicaid shall be the payer of last resort for all Covered Services in accordance with federal regulations.

6.10.2 The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.3 The Department and the MCO shall cooperate in implementing cost avoidance and cost recovery activities.

6.10.4 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.10.5 The Department shall conduct, at times solely determined by the Department, policy and procedure audits of the MCO and its Subcontractors.

6.10.5.1. Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

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6.10.6 The MCO shall have one (1) dedicated contact person for the Department for TPL.

6.10.7 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.

6.10.8 [Amendment #2] All cost recovery amounts shall be retained by the MCO, except overpayments by other insurance. For recoveries over the Provider paid amount see Section 6.10.1112.5.3. of this Agreement.

6.10.9 The MCO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.10.9.1. 42 CFR 433.138;

6.10.9.2. 42 CFR 433.139; and

6.10.9.3. RSA 167:14-a.

6.10.10 **Cost Avoidance**

6.10.10.1. The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, Medicare Advantage plans, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 42 U.S.C. 1396a(a)(25) plans and workers compensation.

6.10.10.2. The MCO shall establish claims edits and deny payment of claims when active Medicare, Medicare Advantage Plans, or active private insurance exist at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.10.10.3. The MCO shall deny payment on a claim that has been denied by Medicare Advantage Plan 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.

6.10.10.4. The MCO shall establish claim edits to ensure claims with Medicare, Medicare Advantage plan, or private insurance denials are properly adjudicated based on the denial reason. The MCO is required to determine which specific Medicare, Medicare Advantage plan, and private insurance denials should be processed for payment or denial by the MCO.

6.10.10.5. The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance, Medicare, or Medicare Advantage plans if either:

6.10.10.5.1 The primary payer does not cover the services and the MCO does; or

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6.10.10.5.2 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.

6.10.10.6. If a claim is denied by the MCO based on active Medicare, Medicare Advantage Plan, or private insurance, the MCO shall provide the Medicare, Medicare Advantage Plan, or private insurance information to the Provider.

6.10.10.7. To ensure the MCO is cost avoiding, the MCO shall implement a file transfer protocol between the Department MMIS and the MCO's MCIS to send new, terminated, and changed Medicare or private insurance information and other information as required pursuant to 42 CFR 433.138.

6.10.10.8. The MCO 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.

6.10.10.9. The MCO shall perform monthly electronic confidential data matches with private insurance companies (medical and pharmacy) unless the Department performs these functions.

6.10.10.9.1 Should the Department establish data matching and provide to the MCO individual member private insurance data, then the MCO will not be required to perform direct data matching.

6.10.10.9.2 The date of the Department transmission of the data will be considered the date of discovery for the plan regarding member private insurance. The MCO will be required to meet cost avoidance requirements outlined in this section of this Agreement within two (2) business days of the date of discovery and four (4) business days for any subcontractors.

6.10.10.9.3 The Department shall provide the MCO with the Member name, Medicaid ID, private insurance company name, the Department's private insurance ID, private insurance policy number, type of coverage, policy begin date, policy end date (if open, end date will be 12/31/9999), and policy holder information, if available.

6.10.10.10. If the Department is not performing the data matching with other insurances, then it will be the responsibility of the MCO to establish, and shall ensure the MCO and its Subcontractors utilize, monthly electronic Confidential Data matches with private insurance companies (Medical and pharmacy), and Medicare Advantage plans that sell insurance in the State to obtain current and accurate private insurance information for their Members in accordance with

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this Agreement. This provision may be satisfied by a contract with a third-party vendor to the MCO or its Subcontractors.

6.10.10.11. Upon audit, the MCO 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 MCO. All communication with the insurer relating to and including the Confidential data matching agreements shall be in writing and in accordance with this Agreement.

6.10.10.12. The MCO 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:

6.10.10.12.1 Member's first and last name;

6.10.10.12.2 Member's policy number;

6.10.10.12.3 Member's group number, if available;

6.10.10.12.4 Policyholder's first and last name, if available;

6.10.10.12.5 Policy coverage type to include at a minimum:

6.10.10.12.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.10.10.12.5.2. Hospital coverage;

6.10.10.12.5.3. Pharmacy coverage;

6.10.10.12.5.4. Dental coverage; and

6.10.10.12.5.5. Vision Coverage.

6.10.10.12.6 Begin date of insurance; and

6.10.10.12.7 End date of insurance (when terminated).

6.10.10.13. The MCO shall submit any new, changed, or terminated private insurance Confidential Data to the Department through file transfer on a monthly basis.

6.10.10.14. [Amendment #2:] The MCO shall not cost avoid claims for preventive pediatric services, including screening, diagnosis, and treatment services covered under the ~~(including~~ EPSDT~~)~~ benefit, as well as related medical benefit services ancillary to pediatric services covered under Medicaid fee-for-service (e.g., anesthesia for oral health services), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3).

6.10.10.15. [Amendment #2:] The MCO shall pay all preventive pediatric services, including screening, diagnosis, and treatment services covered under

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the EPSDT benefit, as well as related medical benefit services ancillary to pediatric services covered under Medicaid fee-for-service (e.g., anesthesia for oral health services), and collect reimbursement from private insurance after the Medicaid managed care claim adjudicates.

6.10.10.16. The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable or any other agreement to payment in the MCO/Provider contract.

6.10.10.17. [Amendment #3:] [Amendment #2:] Intentionally left blank. ~~The MCO shall disregard the TPL lesser of logic payment methodology for claims that require provider reimbursement at rates no less than Medicaid or Medicare minimum fee schedule rates under this Agreement as described in Section 4.16 (Provider Payments).~~

6.10.10.17.1 [Amendment #3] [Amendment #2:] Intentionally left blank. ~~The MCO shall pay the difference between the TPL amount and the minimum Medicaid or Medicare fee schedule amount required in accordance with separate guidance.~~

6.10.10.17.2 [Amendment #3:] Intentionally left blank. ~~If the TPL payment is more than the Medicaid or Medicare minimum fee schedule amount requirement, then the MCO pays nothing.~~

6.10.10.18. On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O: Quality and Oversight Reporting Requirements.

6.10.10.19. This report shall reflect the number of claims and billed dollar amount avoided by private insurance, including Medicare and Medicare Advantage plans for all types of coverage as follows:

6.10.10.19.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.10.10.19.2 Hospital coverage;

6.10.10.19.3 Pharmacy coverage;

6.10.10.19.4 Dental coverage; and

6.10.10.19.5 Vision coverage.

6.10.11 **Pay and Chase Private Insurance**

6.10.11.1. If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company, including Medicare Advantage plans.

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6.10.11.2. The MCO shall submit quarterly TPL billed and recovery reports, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

6.10.11.3. These reports shall reflect detail and summary information of the MCO's billing, collection efforts, and recovery from Standards Medicare, Medicare Advantage Plans, and private insurance for all types of coverage as follows:

6.10.11.3.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

6.10.11.3.2 Hospital coverage;

6.10.11.3.3 Pharmacy coverage;

6.10.11.3.4 Dental coverage; and

6.10.11.3.5 Vision Coverage.

6.10.11.4. [Amendment #4:] The MCO shall have five (5) months ~~one-hundred-twenty (120) calendar days~~ from the original paid date to bill ~~initiate recovery of funds from~~ private insurance. The MCO shall have six (6) years to recover funds with the following exceptions:

6.10.11.4.1 The Department may, beginning one year from the date the MCO paid the claim, directly bill and recover the private insurance amount paid by the MCO but not collected. The Department shall inform the MCO in writing any claims in which the Department plans to pursue Pay and Chase recovery, and the Department shall retain any recovered funds.

6.10.11.4.2 If a recovery is closed on the Exhibit O: 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 closure, and retain any funds recovered.

6.10.11.4.3 [Amendment #4] The Department may directly bill and recover the private insurance amount paid by the MCO if the MCO has not billed the private insurance within five (5) months from the MCO original paid date. The Department shall inform the MCO in writing of any claims in which the Department plans to pursue Pay and Case recovery and retain any recovered funds.

6.10.11.5. The MCO shall treat funds recovered from private insurance and Medicare Advantage plans as offsets to claims payments by posting within the claim system.

6.10.11.5.1 The MCO shall post all payments to claim level detail by Member.

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6.10.11.5.2 Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.10.11.5.3 [Amendment #2:] The MCO shall submit amounts beyond a Member's outstanding MCO payment to the Department semi-annually to determine if the Department has any claims to apply the funds. If there are no claims in which to apply the funds, the MCO must return any remaining over payments to the Member annually.

6.10.11.6. The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.10.11.7. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.11.8. The MCO or its Subcontractor shall follow up on any billed TPL that is not collected or properly denied by the other insurance once a $1,500 cumulative minimum threshold for medical claims is reached per member or single claim of fifty dollars ($50) and one hundred dollars ($100) per cumulative prescription is reached per member.

6.10.11.9. Subrogation Recoveries

6.10.11.9.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.10.11.9.2 The MCO is responsible for class action lawsuits when the member is enrolled in an MCO on the date of injury and only includes MCO claims related to the class action. If the class action has fee for service and MCO claims, the Department is responsible for the case and will settle for both MCO and fee for service claims and will retain all funds.

6.10.11.9.3 The MCO shall act upon any information from insurance carriers or attorneys regarding potential subrogation cases. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.10.11.9.4 The MCO shall establish detailed policies and procedures for determining, processing, and

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recovering funds based on accident and trauma Subrogation cases.

6.10.11.9.5 The MCO shall submit its policies and procedures, including those related to their case tracking system as described in Section 6.10.11.9.7 of this Agreement, to the Department for approval during the Readiness Review process. The MCO shall have in its policies and procedures, at a minimum, the following:

6.10.11.9.5.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party.

6.10.11.9.5.2. The claims required to be identified, at a minimum, should include ICD-10 diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y".

6.10.11.9.5.3. The MCO shall present a list of ICD-10 diagnostic codes to the Department for approval in identifying claims for review.

6.10.11.9.5.4. The Department reserves the right to require specific codes be reviewed by MCO.

6.10.11.9.5.5. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members.

6.10.11.9.5.6. The MCO shall submit a report of questionnaires generated and sent as described in Exhibit O: Quality and Oversight Reporting Requirements.

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6.10.11.9.5.7. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indictors.

6.10.11.9.5.8. The MCO shall respond to accident referrals and lien request within twenty-one (21) calendar days of the notice per RSA 167:14-a.

6.10.11.9.6 The MCO shall establish a case tracking system to monitor and manage Subrogation cases.

6.10.11.9.7 This system shall allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

6.10.11.9.7.1. Date inquiry letter sent to Member, if applicable;

6.10.11.9.7.2. Date inquiry letter received back from Member, if applicable;

6.10.11.9.7.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;

6.10.11.9.7.4. Date case is established;

6.10.11.9.7.5. Date of incident;

6.10.11.9.7.6. Reason for incident;

6.10.11.9.7.7. Claims associated with incident;

6.10.11.9.7.8. All correspondence and dates;

6.10.11.9.7.9. Case comments by date;

6.10.11.9.7.10. Lien amount and date updated;

6.10.11.9.7.11. Settlement amount;

6.10.11.9.7.12. Date settlement funds received; and

6.10.11.9.7.13. Date case closed.

6.10.11.9.8 The MCO shall submit Subrogation reports in accordance with Exhibit O: Quality and Oversight

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Reporting Requirements. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.11.9.9 DHHS shall inform the MCO of any claims related to an MCO Subrogation cases. The MCO shall pursue the Department's claim recovery as part of their case.

6.10.11.9.10 The MCO shall submit to the Department any and all information regarding the case upon request if the Department also has a Subrogation lien.

6.10.11.9.11 The MCO shall coordinate with the Department on any dual Subrogation settlement recoveries identified in writing by the Department.

6.10.11.9.11.1. The MCO shall pay the Department claims first in the event of any settlement less than the combined total MCO and Department lien amount.

6.10.11.9.11.2. The MCO shall be liable for repayment to the Department for the total Department lien amount in situations when the Department informed the MCO of the State's lien in advance of the settlement, regardless of whether the Department lien amount exceeds the total settlement amount recovered when the MCO settles a subrogation case and accepts a settlement amount without written authorization from the Department.

6.10.11.9.12 If the MCO notifies the Department that they have closed a case prior to the case settling, the Department reserves the right to pursue and retain payment of any remaining paid MCO and FFS claims related to the case.

6.10.11.9.13 The MCO shall submit to the Department for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement.

6.10.11.9.14 The Department shall have twenty (20) business days to review the case once the MCO provides all relevant

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information as determined by the Department to approve the settlement from date received from the MCO.

6.10.11.9.15 If the Department does not respond within twenty (20) business days, the MCO may proceed with settlement.

6.10.11.9.16 If the Department does not approve of the settlement agreement, then the Department may work with the MCO and other parties on the settlement.

6.10.11.9.17 The MCO must notify the Department TPL unit within ten (10) calendar days of a Subrogation case in which the Member was not eligible under the MCO for the date of incident. The MCO cannot close these cases with no lien letter until the Department responds to the notification.

6.10.11.9.18 The Department shall have exclusive rights to pursue subrogations in which the MCO does not have an active subrogation case within ninety (90) calendar days of receiving a referral, of sending the first questionnaire as referenced in 6.10.11.9.5.5 of this Agreement, or of claim paid date if no action was taken since claims paid date, or if the MCO closes the case, as noted on the MCO Subrogation.01 report which indicates the MCO is no longer pursuing the case.

6.10.11.9.18.1. The Department shall retain and manage any restitution cases.

6.10.11.9.18.2. The MCO shall notify the Department's TPL Unit within ten (10) calendar days of any new class action lawsuit.

6.10.11.9.19 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign the Department all rights to such cases to complete and collect on those Subrogation settlements.

6.10.11.9.20 The Department shall retain all recoveries after Agreement termination.

6.10.11.9.21 The MCOs shall report on all subrogation recoveries in a manner prescribed by the Department.

6.10.11.10. Medicare

6.10.11.10.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable.

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6.10.11.10.2 The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process. [42 CFR 438.3(t)]

6.10.11.10.3 A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.10.11.10.4 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.10.11.10.4.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

6.10.11.10.4.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.10.11.10.4.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and shall establish claims edits and deny part D for those part C Members.

6.10.11.10.4.4. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.10.11.10.5 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the Medicare timely filing requirements.

6.10.11.10.5.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.10.11.10.6 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.10.11.10.7 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4

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(Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment. The MCO shall not pay any member liability for Medicare Part D claims.

6.10.11.11. The MCO shall pay any wrap around services not covered by Medicare that are Covered Services under the Medicaid State Plan Amendment and this Agreement.

6.10.12 **Estate Recoveries**

6.10.12.1. 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 MCO:

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.

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7.2 Termination for Other Reasons

7.2.1 The MCO 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 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 MCO prompt written notice of such termination.

7.2.3 Notwithstanding the above, the MCO shall not be relieved of liability to the Department or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.4 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to the Department immediately on demand.

7.2.5 The Department may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if the Department determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.6 In such event, Section 4.7.9 (Access to Providers During Transitions of Care) shall apply.

7.3 Claims Responsibilities

7.3.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.5.2 (Service Authorization/Continuity of Care) of this Agreement, 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 MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the MCO's outstanding final financial obligations.

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7.4.2 If all financial obligations of the MCO have been satisfied, amounts due to the MCO for unpaid premiums, risk settlement, High-Cost Drug Risk Pool, and other risk mitigation initiatives identified in this Agreement by the Department shall be paid to the MCO 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 MCO 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 MCO shall work cooperatively with the Department and/or its designee to process service authorization requests received.

7.5.2.1.1 Disputes between the MCO 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 MCO shall give written notice to the Department of all service authorizations that are not decided upon by the MCO 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 4.7.9 (Access to Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.5.2.4. The Member shall be referred to appropriate Participating Providers.

7.5.2.5. The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization Confidential Data from the new MCO 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.

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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 MCO must;

7.6.1.9.1 Only use a State email address assigned to them with a "@ affiliate.DHHS.NH.Gov".

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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 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 Agreement, said End User may face removal from the Agreement, 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 Agreement. The solicitation or disclosure of PHI, PII, or other Confidential Information shall be

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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 this Agreement 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.

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EXHIBIT C – Payment Terms – Amendment #4

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit B. 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 of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

Eligibility Category **Medicaid Care Management**	**July-December 2025**
Foster Care / Adoption	$521.56
Severely Disabled Children	3,711.62
Low Income Children - Age 0-11 Months	516.60
Low Income Children - Age 1-18 Years	298.49
Low Income Adults	884.52
Elderly and Disabled Adults - Age 19-64	2,266.18
Dual Eligibles	331.69
Elderly and Disabled Adults - Age 65+	1,774.17
CHIP	256.42
Behavioral Health Population Rates	
Severe/Persistent Mental Illness - Dual	$1,850.85
Severe/Persistent Mental Illness - Non-Dual	3,253.46
Severe Mental Illness - Dual	1,240.34
Severe Mental Illness - Non-Dual	2,690.32
Low Utilizer - Dual	797.69
Low Utilizer - Non-Dual	2,488.18
Serious Emotionally Disturbed Child	1,368.33
Medicaid Expansion	
Granite Advantage - Medically Frail	$1,974.97
Granite Advantage - Non-Medically Frail	873.24
Maternity /Newborn Kick Payments	
Maternity Kick Payment	$7,114.07
Newborn Kick Payment	11,789.92
Neonatal Abstinence Syndrome Kick Payment	36,970.20

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EXHIBIT C – Payment Terms – Amendment #4

Eligibility Category **Medicaid Care Management**	**January-June 2026**
Foster Care / Adoption	$522.21
Severely Disabled Children	$3,715.47
Low Income Children - Age 0-11 Months	$517.18
Low Income Children - Age 1-18 Years	$298.84
Low Income Adults	$853.55
Elderly and Disabled Adults - Age 18-64	$2,245.97
Dual Eligibles	$330.34
Elderly and Disabled Adults - Age 65+	$1,772.69
CHIP	$256.72
Behavioral Health Population Rates	
Severe/Persistent Mental Illness - Dual	$1,849.22
Severe/Persistent Mental Illness - Non-Dual	$3,217.89
Severe Mental Illness - Dual	$1,240.45
Severe Mental Illness - Non-Dual	$2,663.70
Low Utilizer - Dual	$797.28
Low Utilizer - Non-Dual	$2,436.20
Serious Emotionally Disturbed Child	$1,369.64
Medicaid Expansion	
Granite Advantage - Medically Frail	$1,956.32
Granite Advantage - Non-Medically Frail	$856.45
Maternity /Newborn Kick Payments	
Maternity Kick Payment	$7,117.72
Newborn Kick Payment	$11,795.97
Neonatal Abstinence Syndrome Kick Payment	$36,989.15

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.

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

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for the twelve month contract period covering the State Fiscal Year 2026 period of July 1, 2025 – June 30, 2026 to be served among all contracts is 2,100,862. Accordingly, the price limitation increase for the twelve month contract period July 1, 2025 – June 30, 2026 among all contracts is $25,535,137 based on the projected members per month. The full price limitation is $2,768,763,464.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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Medicaid Care Management Services Contract
Exhibit N - Amendment 4
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 or quarterly, the liquidated damages shall be assessed based on the timeframe below. For example, if the MCO 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 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing or recurring failure to meet minimum Primary Care and Prevention Focused Model of Care general requirements (Section 4.10)	$25,000 per week of violation
	1.6 Continuing or recurring failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including the full continuum of care for members with substance use disorders	$25,000 per week of violation
	1.7 Continuing or recurring failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7)	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan; $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.9 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$10,000 per month of violation (for each month that DHHS determines the MCO is not substantially in compliance)
	1.10 Continuing or recurring failure to resolve member appeals and grievances within specified timeframes	$25,000 per violation
	1.11 Failure to submit timely, accurate, and/or complete encounter data records 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 MCO in that month until such time as the required submission is made)*	$5,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$25,000 per violation
	1.13 Failure to adhere to the Preferred Drug List requirements	$25,000 per violation
	1.14 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 2 violation	$25,000 per violation
	1.15 Continued or recurring failure to comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder	$50,000 per violation for continuing failure
	1.16 Continued or recurring failure to meet the requirements for minimizing psychiatric boarding	$5,000 per day for continuing failure

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.17 Failure to ensure non-emergency medical transportation (NEMT) driver services and vehicle safety requirements conform with Section 4.1.9.3; 4.1.9.8.1.1 - 4.1.9.8.1.7	$25,000 per violation
	1.18 [Amendment #1:] Failure to deliver or recover a confirmed NEMT ride, resulting in disruption to a Covered Service (Section 4.1.9.8.5.~~1~~)	$5,000 per violation for the first five (5) occurrences; $15,000 for each additional violation; No more than 50% of any liquidated damage amount for failing to meet this standard shall be imposed on the Subcontractor by the MCO
	1.19 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled; $500 per additional day provider is not suspended once MCO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.20 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 MCO, its Subcontractor or a Provider	$50,000 per violation
	1.21 Two or more Level 1 violations within a contract year	$75,000 per occurrence

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.22 [Amendment #2:] [Amendment #1:] Failure to make capitated payments to a Community Mental Health Program (CMH Program) or a Certified Community Behavioral Health Clinic (CCBHC) in accordance with Sections 4.16.2.3.1.1 through 4.16.2.3.1.1.2 and Section 4.16.2.3.3.1, respectively; and as directed by, and in amounts determined by, the Department. Any monthly interim payment made by the MCO to a CMH or CCBHC Program shall not be considered as compliance with this standard	[Amendment #1:] $100,000 per violation for the first month of non-compliance. Liquidated Damages double for each month of non-compliance after month 1. For example only, non-compliance in month 1, 2, and 3 would equal a Liquidated Damage of $500,000.
2. LEVEL 2 MCO action(s) or inaction(s) that jeopardize the integrity of the managed care program but does not necessarily jeopardize member(s) health, safety, and welfare or access to care.	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified)
	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 of such information and/or timely report violations in the access, use, and disclosure of PHI	$100,000 per violation
	2.3 Failure to meet prompt payment requirements and standards	$25,000 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	$50,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	provide adequate information to determine cost avoidance percentage as determined by DHHS	
	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	$50,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud or abuse to DHHS annually	$10,000 unless good cause determined by Program Integrity
	2.8 EQR reports with “not met” findings that have been substantiated by DHHS	$10,000 per violation
	2.9 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	2.11 Member in pharmacy “lock-in” program not locked into a pharmacy and no documentation as to waiver or other excuse for not being locked in	$500 per member per occurrence and total pharmacy claims amount paid while not locked-in
	2.12 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 3 violation	$25,000 per week of violation
	2.13 Failure to suspend or terminate providers when instructed by DHHS	$500 per day of violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	2.14 Failure to timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.15 Failure to meet any performance standards in the contract which may include, but not necessarily be limited to: 2.15.1 Care Coordination and Care Management measures (Sections 4.11.3.4, 4.11.5.7); 2.15.2 Claims processing (Sections 4.19.1.4, 4.19.1.5, 4.19.3.2, 4.19.4.2, 4.19.5.2); 2.15.3 Call center performance (Sections 4.4.10.3.1, 4.4.10.3.2, 4.4.10.3.3, 4.14.4.1.3.1, 4.14.4.1.3.2, 4.14.4.1.3.3); 2.15.4 [Amendment #1:] Non-emergency medical transportation (Sections 4.1.9.8.4, 4.1.9.8.4.1, and 4.1.9.8.5.1 ~~4.1.9.8.7 and 4.1.9.8.8~~); 2.15.5 Service authorization processing (Sections 4.2.4.9, 4.8.4.2.1.1, 4.8.4.3.1, 4.8.4.3.5); and 2.15.6 Childhood Lead Testing Requirements (Section 4.8.2.3.2)	$1,000 per violation
	2.16 Failure to meet 99% of claims financial accuracy requirements (Section 4.19.3.1, 4.19.3.2), and 95% of post service authorization processing requirements (Section 4.8.4.3.5)	$1,000 per violation
	2.17 Two or more recurring Level 2 violations within a contract year	$50,000 per occurrence
	2.18 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence
3. LEVEL 3	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories,	$10,000 per violation

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Date 12/5/2025

Medicaid Care Management Services Contract
Exhibit N - Amendment 4
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 or quarterly, the liquidated damages shall be assessed based on the timeframe below. For example, if the MCO 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
MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	provider agreements, etc. requiring DHHS review and/or approval or as requested by an audit	
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	$10,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	$10,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$10,000 per violation
	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$25,000 per violation
	3.7 [Amendment #1:] Failure to submit ~~and obtain DHHS review and~~ applicable Subcontract~~sor~~ contracts for Department review.	$25,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$10,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 4 violation	$25,000 per week of violation
	3.10 Failure to meet minimum social services and community care requirements, as described in Section 4.11.7 (Provider-Delivered Care	$10,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	Coordination and Integration with Social Services and Community Care) of the contract, with respect to unmet resource needs of members	
	3.11 Failure to ensure that clinicians conducting or contributing to a comprehensive assessment are certified in the use of New Hampshire's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within the specified timeframe	$10,000 per violation
	3.12 Two or more Level 3 violations within a contract year	$100,000 per occurrence
4. LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete, 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 submit timely, accurate, and/or complete files to NH CHIS per NH Code of Administrative Rules, Chapter Ins 4000	$2,500 per day the submission or resubmission is late
	4.3 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
	4.4 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

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	4.5 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence
	4.6 Failure to meet staffing requirements of Key Personnel set forth in Section 3.11.1 of the Agreement	$25,000 per violation if the position is not filled on a full-time basis within 90 days of the start of the vacancy. In addition, if the position is not filled on a full-time basis in accordance with the terms of the Agreement within (i) 180 days an additional $50,000 penalty per violation shall apply; (ii) 240 days an additional $75,000 penalty per violation shall apply; and (iii) within 365 days an additional $100,000 penalty per violation shall apply. In addition, if the position is not filled on a full-time basis within 365 days of the initial vacancy a penalty of $100,000 shall be applied each quarter until the position is filled on a full-time basis
	4.7 Failure to ensure provider agreements include all required provisions	$10,000 per violation
	4.8 [Amendment #4:] Failure to meet adherence targets established by the Department for an applicable period as set forth in Section 4.2.3.1.1-4.2.3.1.3	[Amendment #4:] The Department may assess a penalty equal to the

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
		full amount of the lost rebates for the adherence period

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Date 12/5/2025

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders. Addressed through Senate Bill 313.	Legislative Presentation	Agreement Year	Annually	TBD			X						X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan	Varies	Annually	May 1st									X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table	Varies	Quarterly	4 Months after end of Measurement Period									X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report	Agreement Year	Annually	October 31st									X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X			X			
APPEALS.18	Services Authorized within 72 Hours Following a Reversed Appeal	Count and percent of services authorized within 72 hours following a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHDRUG.01	Severe Mental Illness (SMI) and Serious Emotional Disturbance (SED) Drug Prior Authorization	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table	Calendar Year	Annually	January 31st			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCO's program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. The initial Plan shall address but not be limited to how the MCO shall 1) assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare; 2) assure appropriateness of diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; 3) assure promotion of Integrated Care; 4) reduce Psychiatric Boarding; 5) reduce Behavioral Health Readmissions; 6) reduce Behavioral Health related emergency department utilization; 7) support the NH 10-Year Mental Health Plan; 8) assure appropriateness of psychopharmacological medication; 9) assure access to appropriate services; 10) implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and 11) other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.	Plan	Agreement Year	Annually	May 15th									X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table	Calendar Year	Annually	June 30th								X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.1H survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.1H Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.1H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.1H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.06	Adult CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Adult Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	July 15th				X					
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X					X	X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.1H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X					X	
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.1H Survey Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.1H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	
CAHPS_CCC.06	Child w CCC CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Child Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	July 15th				X					
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X	X				X	X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CARECOORD.05	Members Receiving Provider-based Care Coordination	Count and percent of members receiving provider-based care coordination during the measurement quarter.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.06	Members Receiving Provider-based Care Coordination by Provider Group Practice	Count and percent of members receiving provider-based care coordination at the end of the measurement quarter, by Provider Group Practice.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.09	Tracking for Social Service and Community Care Referrals	Standard template capturing quarterly counts of referrals for social services and community care provided to Required Priority Population Members by Member type.	Table	Quarter	Quarterly	TBD									X
CAREMGT.39	Members Enrolled in MCO-Delivered Care Management	Count and percent of members enrolled in MCO-delivered care management on the last day of the measurement period. This measure provides the total count of members receiving care management as a member in a Required Priority Population or at the option of the MCO.	Measure	Month	Monthly	1 Month after end of Measurement Period						X	X		X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.47	Comprehensive Plan: Provider-Delivered Care Coordination; MCO-Delivered Care Management; Health Risk Assessment Screening; and Primary Care and Prevention Focused Model	The MCO shall submit a plan at time of Readiness Review and implement procedures to 1) facilitate integrated Provider-Delivered Care Coordination and MCO-Delivered Care Management, 2) facilitate and operate systems of Provider-Delivered and MCO-Delivered health risk assessments screenings , and 3) implement, administer and facilitate the Primary Care and Prevention Focused Care Model, which must demonstrate authentic engagement between Members and PCPs to ensure each Member has an ongoing source of care appropriate to their needs, and includes procedures for confidentiality, consent, or informed consent. [42 CFR 438.208(b)] The MCO-Delivered Care Management portion must include the plan to implement and operate Care Management for the Required Priority Populations and include how the MCO will take social determinants of health into account.	Plan	Readiness and Agreement Year	Annually	May 1st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.48	Provider-based Care Coordination, MCO-Delivered Care Management, Health Risk Assessment Screening, and Primary Care and Prevention Focused Care Model Report	Narrative report describing: 1) the status of the Provider-based Care Coordination program, including successes and challenges, how it is going with provider engagement, what providers, etc. Include data to illustrate findings. 2) the status of the MCO care management program for Required Priority Populations and members enrolled in other MCO-Delivered Care Management, including successes and challenges, and how the MCO took social determinants of health into account. Include data to illustrate findings. 3) implementation, facilitation and operation of Provider-Delivered and MCO-Delivered health risk assessment screening systems. Include data to illustrate findings. 4) implementation, administration and facilitation of the Primary Care and Prevention Focused Care Model. Include data to illustrate findings and demonstrate the level of authentic engagement between Members and PCPs.	Narrative Report	Quarter for first Agreement Year, then Agreement Year	Quarterly for first Agreement Year, then Annually	2 Months after end of Measurement Period for first Agreement Year, then August 31st									X
CAREMGT.49	MCO-Delivered Care Management Enrollment	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by Required Priority Populations outlined in the Care Management section of the MCM Contract, and members enrolled in other MCO-Delivered Care Management.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
CAREMGT.50	Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.51	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Members with Behavioral Health Hospitalizations	Count and percent of members included in the Members with Behavioral Health Hospitalizations Required Priority Population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.52	Members Receiving MCO-Delivered Care Management in Required Priority Populations: DCYF-Involved Members	Count and percent of members included in the DCYF-Involved Members Required Priority Population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.53	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Low Birth Weight Infants	Count and percent of members included in the Low Birth Weight Infants required priority population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.54	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Adult Community Reentry Waiver Members	Count and percent of members with behavioral health needs (e.g., substance use disorder, mental health) who were incarcerated in the State's prisons and are eligible for participation in the Department's Community Reentry demonstration waiver who are enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.56	Members Receiving MCO-Delivered Care Management in Required Priority Populations: TBD	Count and percent of members included in Yet to Be Determined Required Priority Populations enrolled in MCO-based care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.58	Members Receiving MCO-Delivered Care Management in Required Priority Populations: NAS Infants	Count and percent of members included in the Neonatal Abstinence Syndrome (NAS) Infants required priority population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.59	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Youth Reentry Members	Count and percent of members who were incarcerated youth and are eligible for any Medicaid eligibility group, or determined eligible for the mandatory eligibility group for former foster care children, immediately before becoming an inmate of a public institution or while an inmate of a public institution who are enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.60	Priority Population Members Receiving MCO-Delivered Care Management	Count and percent of members enrolled in MCO-delivered care management on the last day of the measurement period, based on a deduplicated total of members included in one or more Required Priority Population group.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period						X			X
CCBHC_AMM.01	Antidepressant Medication Management - Effective Acute Phase Treatment for CCBHC Clients	Count and percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_AMM.02	Antidepressant Medication Management - Effective Continuation Phase Treatment for CCBHC Clients	Percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months).	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CCBHC_GSD.01	Glycemic Status Assessment for Patients With Diabetes (<8.0%) (GSD-AD)	Provide, at DHHS direction, CCBHC oversample of GSD HEDIS measure to comply with CCBHC demonstration requirements. Applies to data reporting year 2025 forward. Since it is not yet clear if CCBHC reporting will require GSD or older HBD, we will retire unnecessary one once clarified.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_GSD.02	Glycemic Status Assessment for Patients With Diabetes: HbA1c Poor Control (>9.0%) (GSD-AD)	Provide, at DHHS direction, CCBHC oversample of GSD HEDIS measure to comply with CCBHC demonstration requirements. Applies to data reporting year 2025 forward. Since it is not yet clear if CCBHC reporting will require GSD or older HBD, we will retire unnecessary one once clarified.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_HBD.01	Hemoglobin A1c Control for CCBHC Patients with Diabetes: HbA1c Control (<8.0%) (HBD-AD)	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was less than 8.0% during the measurement year. *Utilize the hybrid methodology in the SAMHSA specification for this measure.*	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_HBD.02	Hemoglobin A1c Control for CCBHC Patients with Diabetes: HbA1c Poor Control (>9.0%) (HBD-AD)	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was greater than 9.0% during the measurement year. *Utilize the hybrid methodology in the SAMHSA specification for this measure.*	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_MBR_LVL_DATA.01	CCBHC Demonstration Member Level Data	This file contains member/event level data for select CCBHC measures. Data will reflect the results for these measures in the corresponding CCBHC measures for the same measurement period. The list of DHHS-selected CCBHC measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year. There will be duplication of some data provided to DHHS in other Member Level Data Files.	Member Level Data File	Calendar Year	Annually	9 Months after end of Measurement Period							X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CCBHC_PCR.01	Plan All-Cause Readmissions for CCBHC Patients (PCR-AD)	CCBHC clinic specific calculation of PCR measure components	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure	Month	Monthly	110 Calendar Days after end of Measurement Period			X						X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.28	Timely Processing of Facility-to-Facility Transportation Claims: Thirty Days of Receipt	Count and percent of clean Facility-to-Facility Transportation claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Facility-to-Facility transportation claims are those rides where ambulance companies transport members from hospitals following discharge to other facilities such as rehabilitation facilities or nursing homes. The MCOs process these claims, NEMT brokers are not involved.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period									X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMHC.01	CMHC Capitation Payment Reporting	Template including data reflecting the following: Monthly units by rate cell for each CMHC and Total Monthly Payments by rate cell for each CMHC.	Table	Month	Monthly	1 Day after end of Measurement Period									X
CMHC.02	CMHC Capitation Payment Reporting: Same-Day Eligibility Reconciliations	Template reflecting the results of same-day eligibility reconciliations each quarter by CMHC and the pro-rated capitation amounts paid to each CMHC.	Table	Quarter	Quarterly	8 Months after end of Measurement Period									X
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported)	Measure	Calendar Year	Annually	September 30th				X			X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure	Calendar Year	Annually	September 30th				X	X				
CMS_A_GSD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%). The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_GSD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%). The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_INP_PQI15	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma in Younger Adults Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CH_DEV.02	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure	Calendar Year	Annually	September 30th				X					
CMS_CORE_ SET.01	CMS Core Set Member Level Data	This file contains member/event level data for select CMS Core Set measures. Data will reflect the results for these measures in the corresponding CMS Core Set measures for the same measurement period. The list of DHHS-selected CMS Core Set measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year.	Member Level Data File	Calendar Year	Annually	September 30th				X					X
CMS_PDS.01	Postpartum Depression Screening and Follow-Up: Depression Screening	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PDS.02	Postpartum Depression Screening and Follow-Up: Follow-Up on Positive Screen	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_PRS.01	Prenatal Immunization Status: Influenza	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PRS.02	Prenatal Immunization Status: Tdap	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PRS.03	Prenatal Immunization Status: Combination	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CULTURAL COMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan	Agreement Year	Annually	May 1st									X
DHHS_LEAD.01	Pediatric Lead Screening – One-Year Screenings Completed	Count and percent of pediatric members with a completed one-year lead screening. One-year screenings occur when a member is at least 11 months of age and less than 23 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X
DHHS_LEAD.02	Pediatric Lead Screening – Two-Year Screenings Completed	Count and percent of pediatric members with a completed two-year lead screening. Two-year screenings occur when a member is at least 23 months of age and less than 36 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X
DHHS_LEAD.03	Pediatric Lead Screening – Both One-Year and Two-Year Screenings Completed	Count and percent of pediatric members with both a completed one-year and two-year lead screening. One-year screenings occur when a member is at least 11 months of age and less than 23 months of age. Two-year screenings occur when a member is at least 23 months of age and less than 36 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan	Agreement Year	Annually	May 1st									X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan	Agreement Year	Annually	May 1st									X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report	6 Months	Semi-Annually	1 Month after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
FINANCIAL STMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report	MCO Financial Period	Annually	August 10th									X
FWA.02	Provider Fraud Log	Standard template log of all fraud related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table	Month	Monthly	15 Days after end of Measurement Period			X						X
FWA.04	Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
FWA.05	Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table	Quarter	Quarterly	1 Month after end of Measurement Period			X						X
FWA.06	Waste and Abuse Recovery Report	Standard template reporting waste and abuse identified and recovered by the MCO.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table	Quarter	Quarterly	15 Calendar Days after end of Measurement Period			X		X	X			
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period			X					X	
HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCQA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCQA audited results for all HEDIS measures and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.04	NCQA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCQA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in *Appendix AF - HEDIS Measures Included in HEDIS.06* and is subject to change each measurement year.	Member Level Data File	Calendar Year	Annually	June 30th					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure	1 Year Starting July 1 of Year Prior to Measurement Year to June 30 of Measurement Year.	Annually	June 30th				X			X	X	
HEDIS_AAF-E	Follow-Up After Acute Care and Urgent Care Visits for Asthma	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_ADD-E	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets and CCBHC Demonstration	Measure	1 Year Starting March 1 of Year Prior to Measurement Year to February 28 of Measurement Year.	Annually	June 30th				X			X	X	X
HEDIS_AIS-E	Adult Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CCBHC reporting.	Measure	May 1 of Year Prior to Measurement Year to Oct 31 of Measurement Year.	Annually	June 30th							X		X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X	X		X	X	X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X	X							X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	2 Calendar Years	Annually	June 30th				X				X	X
HEDIS_BPD	Blood Pressure Control for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X							X	X
HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2.	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_CCS-E	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	3 Calendar Years	Annually	June 30th				X				X	X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_CIS-E	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_COL-E	Colorectal Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year with a 10 Year Look-back	Annually	June 30th				X					
HEDIS_COU	Risk of Chronic Opioid Use	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
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HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_DDM	Disability Description of Membership (DDM)	HEDIS Measure (New Health Plan Descriptive Information Measure)	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_EED	Eye Exam for Patients with Diabetes (EED)	HEDIS Measure, also utilized for CMS Core Sets.	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_FMC	Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th									X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Substance Use	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th		X		X	X		X	X	X
HEDIS_FUH	Follow-Up After Hospitalization for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	January 1 to December 1 of Measurement Year	Annually	June 30th				X			X	X	X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	January 1 to December 1 of Measurement Year	Annually	June 30th								X	X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th		X		X			X	X	X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_GSD	Glycemic Status Assessment for Patients With Diabetes	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. Race and ethnicity breakouts as specified in HEDIS Volume 2.	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_IET	Initiation and Engagement of Substance Use Disorder Treatment (IET)	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th	X			X	X		X	X	X
HEDIS_IMA-E	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_LDM	Language Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_MSC	Medical Assistance with Smoking and Tobacco Use Cessation	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_PDS-E	Postpartum Depression Screening and Follow-Up	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_PND-E	Prenatal Depression Screening and Follow-Up	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure	1 Year Starting July 1 of Year Prior to Measurement Year to June 30 of Measurement Year.	Annually	June 30th								X	X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SNS-E	Social Needs Screening and Intervention	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X				X	X
HEDIS_TSC-E	Tobacco Use Screening and Cessation Intervention	The percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user. Two rates are reported: 1) Tobacco Use Screening. The percentage of persons who were screened for tobacco use. 2) Cessation Intervention. The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_W30	Well-Child Visits in the First 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th			X	X					X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th			X	X					X
HRA.12	Successful Completion and Review of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion and review of provider-based health risk assessment screenings during the 12 months tracked in the measurement period, as of the last day of the measurement period.	Measure	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period	X								X
HRA.13	Successful Completion, Review, and Referral or Follow-up as Needed on Provider-based Health Risk Assessment Screenings by Provider Group Practice	Count and percent of members for whom the MCO paid claims for completion, review, and referral or follow-up as needed on provider-based health risk assessment screenings during the measurement year, by provider group practice, as of the last day of the measurement year.	Table	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period									X
HRA.12	Successful Completion and Review of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion and review of provider-based health risk assessment screenings during the 12 months tracked in the measurement period, as of the last day of the measurement period.	Measure	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period	X								X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
IMD DISCHARGE.01	New Hampshire Hospital Discharges - Intake Appointments for New CMHC Patients within 7 Days of Discharge	Count and percent of New Hampshire Hospital discharges where the member had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days post member discharge AND was not a patient of the applicable CMHC at admission to New Hampshire Hospital. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
IMD DISCHARGE.03	New Hampshire Hospital Discharges - Member Received Discharge Instruction Sheet	Count and percent of discharges from New Hampshire Hospital where the member received a discharge instruction sheet prior to discharge, or no later than the next business day following the discharge. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
IMD DISCHARGE.04	New Hampshire Hospital Discharges - Discharge Plan Provided to Aftercare Provider within 7 Days of Discharge	Count and percent of members discharged from New Hampshire Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
INLIEUOF.02	In Lieu of Services: New or Modified Services and Annual Report	Standard report for MCO to submit requests for new or modified in lieu of services. This template will also be used for required annual reporting.	Table	Annually or Ad Hoc as Needed	Annually or Ad Hoc as Needed	March 15th, Ad Hoc			X						X
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan	Agreement Year	Annually	May 1st, Upon Revision			X						

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
INTEGRITY.02	Program Integrity Compliance and Fraud, Waste, and Abuse Narrative Report	A narrative report on the previous year's findings related to the MCO's internal fraud, waste, and abuse monitoring. The report should also include a description of how prior year's barriers to provider auditing were addressed.	Narrative Report	Agreement Year	Annually	August 31st									X
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked into a pharmacy for the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan	Agreement Year	Annually	May 1st									X
MCO_COMP_ ASSESS.02	MCO Comprehensive Assessments Completed for Required Priority Populations	Count and percent of members included in a Required Priority Population for which the MCO completed a comprehensive assessment during the measurement period, by age group and Required Priority Population category or Other MCO-Delivered Care Management.	Measure	Rolling 12 Months	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
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MCO_COMP _ASSESS.04	Timeliness of MCO Comprehensive Assessments	Count and percent of members for which the MCO completed the comprehensive assessments within 30 calendar days of identifying the Member as being part of one or more Required Priority Populations or in need of Other MCO-Delivered Care Management, based on a deduplicated total of members included in one or more Required Priority Population group and members enrolled in Other MCO-Delivered Care Management.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
MCO_COMP _ASSESS.05	Care Management Comprehensive Assessment Results within 14 Calendar Days	Count and percent of members with a comprehensive assessment completed during the measurement period, where the MCO shared the assessment results in writing with the member's care team within 14 calendar days of completion. The member's care team includes but is not limited to the member's PCP, specialists, behavioral health providers, and Area Agencies.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls received during the measurement period and answered by a live voice within 30 seconds, by health plan vendors as follows: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue during the measurement period, by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member calls received during the measurement period and answered by a live voice, by reason for inquiry as follows: A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages received after business hours and responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEM INCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEM INCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Plan	Agreement Year	Annually	May 1st									X
MHACT.04	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least six billed Assertive Community Treatment (ACT) services in each month of the measurement period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MH DISCHARGE.03	ED Visits for Mental Health Preceded by a State of NH IMD or Non-IMD DRF Hospital Stay in Past 30 Days	This file contains member/event level data reflecting mental health related emergency department (ED) visits where: 1) The member was discharged from a State of NH IMD Hospital or Designated Receiving Facility (DRF) up to 30 days prior to the ED visit, and 2) The primary diagnosis for the ED visit was mental health related, and 3) The ED visit did not result in an inpatient admission or direct transfer to a State of NH IMD Hospital or DRF. Data points will include PHI as well as indicators for follow-up received, CMHP Services Received, DCYF Involvement, and Medicare/Medicaid Dual Status. Given this file contains protected health information (PHI), MCOs will submit the file to DHHS via secure means.	Member Level Data File	Quarter	Quarterly	4 Months after end of Measurement Period									X
MH DISCHARGE.04	Follow-up Visits after Hospital Discharge for Mental Health-Related Conditions	This file contains member/event level data reflecting member discharges with a primary diagnosis for a mental health-related condition occurring in the measurement quarter where the member had at least one follow-up visit with a mental health practitioner within 7 and/or 30 days of discharge. Data points will include PHI as well as indicators for follow-up received, CMHP Eligibility (SMI/SED and Non-CMHC subpopulations), DCYF Involvement, and Medicare/Medicaid Dual Status.	Member Level Data File	Quarter	Quarterly	5 Months after end of Measurement Period						X			X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
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MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaiting placement within the prior 30, 60 and 90 days.	Table	TBD	TBD	TBD									X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	This template will provide DHHS with aggregate MCO member population data and member-level data. The MCO member population tab will provide DHHS with aggregate MCO member population data based on age group and member enrollment on the last day of the data period for the reporting period.	Table	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHREADMIT.08	Readmissions for Mental Health Conditions within 30, 90 and 180 Days of Discharge	This file contains member/event level data reflecting member admissions with a primary diagnosis for a mental health condition, where a previous discharge for a mental health-related condition occurred within 30, 90 and/or 180 days. Data points will include PHI as well as indicators for previous discharges, CMHP Services Received, DCYF Involvement, and Medicare/Medicaid Dual Status. Given this file contains protected health information (PHI), MCOs will submit the file to DHHS via secure means.	Member Level Data File	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan	Agreement Year	Annually	May 1st									X

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information.	Table	Quarter	Quarterly	9 Months after end of Measurement Period			X						
MONTHLYOPS.01	Monthly Operations Report	This report will include details about various operational components required by the MCO contract, as determined by DHHS.	Table	Month	Monthly	TBD									X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
NCQA.01	NCQA Accreditation Review Results	Copies of all sections of the most current NCQA accreditation results to reflect 1) accreditation status, to include survey type and level (as applicable); 2) accreditation results, to include recommended actions or improvements, corrective action plans (CAPS) and summaries of findings and 3) expiration date of the accreditation.	Narrative Report	NCQA Accreditation Cycle	NCQA Accreditation Cycle	Within one week of receipt from NCQA								X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.15	NEMT Legs Delivered by Covered Medical Service Provider Type	Count and percent of Non-Emergency Medical Transportation (NEMT) delivery legs completed during the measurement period, by primary covered medical service provider type for the leg. The measure includes nine submeasures: A: Hospital, B: Medical Provider, C: Behavioral Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G. Other, H. Dialysis and I. Medical or DME Supplier. This measure excludes return legs (e.g. legs back to the original pick-up location, typically the member's home).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.22	Family and Friends Program NEMT Legs	Count and percent of Non-Emergency Medical Transportation one-way legs delivered through the Family and Friends Mileage program.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.24	Timeliness of Scheduled and Delivered NEMT Legs	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with and delivered by a contracted transportation provider during the measurement period, with an outcome of delivered on time. This measure excludes legs for methadone treatment, Family and Friends Mileage Reimbursement Program legs, legs provided by Easter Seals or other providers that offer their own NEMT services and directly transport members, and legs scheduled by a medical provider with a vendor other than the health plan's NEMT broker.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.25	NEMT Network Adequacy Report	A narrative report that describes at the county and transportation mode level how the MCO and/or NEMT broker determine fleet size, changes to the NEMT network during the measurement period, and any activities the MCO has performed to ensure adequate NEMT network adequacy.	Narrative Report	Quarter	Quarterly	1 Month after end of Measurement Period									X
NEMT.26	Timely Processing of Electronic NEMT Claims: Thirty Days of Receipt	Count and percent of clean electronic Non-Emergency Medical Transportation (NEMT) claims processed within 30 calendar days of receipt, for those claims received during the measurement period. This includes non-emergency ambulance rides for hospital discharges and any rides for individuals who require an ambulance for non-emergency transport.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.27	NEMT Network Adequacy Table	This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers. This is separate from NETWORK.01.	Table	TBD	TBD	TBD									X
NEMT.28	NEMT Complaint Log	Standard template providing a quarterly report of all Non-Emergency Medical Transportation (NEMT) complaints received from a member, medical provider, or transportation provider during the measurement quarter.	Table	Month	Monthly	15 Days after end of Measurement Period									X
NEMT.29	Timeliness of Scheduled NEMT Legs from Nursing Facilities	Count and percent of Non-Emergency Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests from nursing facilities scheduled and delivered during the measurement period, with an outcome of delivered on time.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.30	NEMT Legs Delivered	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with a contracted transportation provider during the measurement period where the final outcome was a delivered leg. This measure includes legs for Opioid Treatment Programs (OTPs).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.32	Scheduled NEMT Trips with Issues Impacting Delivery	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with a contracted transportation provider during the measurement period where an issue occurred that either resulted in no delivery or extra steps to ensure delivery of the leg. This measure includes legs for Opioid Treatment Programs (OTPs). Issues include: A. Member Canceled or Rescheduled, B. Member No Show, C. Transportation Provider Canceled Outside of Broker Timeframes, D. Transportation Provider No Show, E. Broker Unable to Secure Transportation, F. Incorrect Mode of Transportation Dispatched, and G. Other Reason Leg Wasn't Delivered.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table	Calendar Year	Annually	45 Calendar Days after end of Measurement Period		X	X		X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table	Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X		X	X			

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table	Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X		X	X			
OTPAUDIT.03	OTP Record Audits – Opioid Treatment Program Providers	Case level data from the MCO's audit of clinical records for Members receiving services provided by Opioid Treatment Programs (OTP).	Table	Measurement Year	Biennially (Every Two Years)	November 30th									X
OTPAUDIT.06	Quality and Performance Improvement Monitoring Report for Opioid Treatment Program Providers	Biennial narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.03 and any other provider performance reviews conducted by the MCOs to ensure the Opioid Treatment Program (OTP) full continuum of care is appropriately provided and supports Member access to timely and quality services. The report will include an analysis of the effectiveness of provider engagement activities over the past 12 months toward meeting the desired improved outcomes.	Narrative Report	Measurement Year	Biennially (Every Two Years)	January 31st									X
OTPAUDIT.08	Quality Improvement Progress Report for Opioid Treatment Programs	Biennial narrative report describing the implementation and continued monitoring of the MCO quality improvement activities included in the OTPAUDIT.06 report.	Narrative Report	Measurement Year	Biennially (Every Two Years)	August 31st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PCP_VISITS.01	Member Visits with Designated PCP or PCP Provider Team in the Last 12 Months	Percent of members who had one or more visits with their designated PCP or PCP Provider Team during the measurement period, by age group. This measure includes Non-Symptomatic Office Visits, Non-Urgent, Symptomatic Office Visits, Urgent, Symptomatic Office Visits, and Wellness Visits. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age or Older.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.02	Member Wellness Visits with Designated PCP or PCP Provider Team in the Last 12 Months	Count and percent of members who had one or more wellness visits with their designated PCP or PCP Provider Team during the measurement period, by age group. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age or Older.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.03	New Member Visits with Designated PCP or PCP Provider Team within 90 Days of PCP Selection/Assignment	Percent of new members who had one or more visits with their designated PCP or PCP Provider Team within 90 days of PCP selection/assignment, by age group. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age and Over.	Measure	Quarter	Quarterly	7 Months after end of Measurement Period									~~X~~

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.08	Private Duty Nursing Hospitalization and Network Adequacy Report	This template will capture member detail about hospitalized PDN members and PDN network adequacy.	Table	Month	Monthly	1 Month after end of Measurement Period									X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC-DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure	Calendar Year	Annually	April 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.10	Proportion of Days Covered - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure	Calendar Year	Annually	April 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.14	Proportion of Days Covered - Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite count and composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure	Calendar Year	Annually	April 30th									X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.10A	Child Psychotropic Medication Monitoring Report - Aggregate Data	Standard template of aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.10B	Child Psychotropic Medication Monitoring Report - DCYF PHI Data	Standard template of member specific information related to children 0-18 who have DCYF involvement and have multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.19	Provider-based Comprehensive Medication Review and Counseling Completions	Percent of eligible polypharmacy members who completed one or more comprehensive medication review and counseling (CMR) sessions in the six (6) months following the "Polypharmacy Initiation Date" by age group. This measure excludes Medicare/Medicaid dual enrollees until Medicare data is available. Age Groups include: Age 0-17 Years, Age 18-64 Years, and Age 65 and Over.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PHARMQI.21	Comprehensive Plan for Member Medical Record Information Sharing, Pharmacy Data Sharing, Medication Management, and Comprehensive Medication Reviews	Plan for data sharing efforts between the MCO and PCPs and behavioral health providers for member pharmacy data.	Plan	Agreement Year	Annually	May 1st									X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.22	Pharmacy Data Sharing Report	Narrative report describing outcome of data sharing efforts with providers, including successes and challenges, of the data sharing efforts.	Narrative Report	Quarter for first Agreement Year, then Agreement Year	Quarterly for first Agreement Year, then Annually	2 Months after end of Measurement Period for first Agreement Year, then October 31st									X
PHARMQI.23	Comprehensive Medication Review (CMR) Outcome Summary	Quarterly template providing DHHS with a summary of outcomes for the 6-month period following member comprehensive medication reviews.	Table	Quarter	Quarterly	5 Months after end of Measurement Period		X							X
PHARMQI.26	Comprehensive Medication Review (CMR) Log	Quarterly template that will provide DHHS with a log of members and providers who completed CMRs during the reporting period.	Table	Quarter	Quarterly	3 Months after end of Measurement Period			X						
PHARM UTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM UTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM UTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PMP.01	Program Management Plan	The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.	Plan	Agreement Year	Annually	May 1st									X
POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PRERELEASE.01	Community Reentry Pre-release Activity Log	Standard template for the MCO to report critical pre-release activity for adult and youth community reentry members. Template also includes log of key post-release events.	Table	Month	Monthly	1 Month after end of Measurement Period					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period			X						
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measurement period.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls received during the measurement period and answered by a live voice within 30 seconds by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Manager (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned while waiting in call queue during the measurement period by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider calls received during the measurement period and answered by a live voice by the following reasons for Inquiry: A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info., etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other	Measure	Month	Monthly	1 Month after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages received after business hours and responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROV COMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVOUTNET.01	Out of Network Providers	Standard template providing a listing of out of network providers for which the MCO had paid claims during the measurement month.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period			X						X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan	Calendar Year	Annually	November 30th			X						
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report	Calendar Year	Annually	September 30th			X						
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure	TBD	TBD	TBD									X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of Medical Service, Equipment, and Supply service authorization determinations for urgent requests, made within 72 hours after receipt of request for requests made during the measurement period. Exclude requests for non-emergency medical transportation from this measure. Exclude Pharmacy claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of Medical Service, Equipment, and Supply Service authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measurement period. Exclude authorization requests that extend beyond the 14-day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for Non-Emergency Medical Transportation (NEMT) from this measure. Exclude Pharmacy Claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period. Includes reporting by age breakouts (< Age 21 and Age 21+)	Table	Quarter	Quarterly	2 Months after end of Measurement Period					X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of Post-Delivery service authorization determinations made within 30 calendar days of receipt of routine requests for Medical Services, Equipment, and Supply services. Exclude requests for Non-Emergency Medical Transportation (NEMT) from this measure. Exclude Pharmacy Claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Count and percent of service authorization requests denied or partially denied during the measurement period, by each of the following waiver and non-HCBC waiver groups: A. Non-HCBC Waiver; B. Developmentally Disabled (DD) Waiver; C. Acquired Brain Disorder (ABD) Waiver; D. In-Home Supports (IHS) Waiver; E. Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Count and percent of Physical, Occupational and Speech Therapy service authorizations denied or partially denied during the measurement period, by each of the following waiver and non-HCBC waiver groups: A. Non-HCBC Waiver; B. Developmentally Disabled (DD) Waiver; C. Acquired Brain Disorder (ABD) Waiver; D. In-Home Supports (IHS) Waiver; E. Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.17	Service Authorization Annual Report	A report that lists all items and services requiring prior authorization for the previous calendar year and associated metrics for each item or service. This report will satisfy requirements for 42 CFR 438.210 (f) and will be used for federal MCPAR reporting. The report will be due to NH DHHS by February 28th annually for review and is required to be posted publicly on the MCO's website by March 31st annually.	Narrative Report	Calendar Year	Annually	2 Months after end of Measurement Period			X						X
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
STATEFAIR HEARING.01	MCM Member State Fair Hearing Request Log	Template to provide DHHS with a quarterly report of all member MCM State Fair Hearing requests in process and resolved during the quarter. Include the record in future quarterly reports until the State Fair Hearing request is reported resolved.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period			X						X
SUBROGATION.02	No Lien Report	List of members in which the MCO has a request for subrogation claims for which the MCO sent a letter stating there were no lien.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period									X
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers within their network with high opioid prescribing rates. The report should include the MCO's operational definition of a provider with a high opioid prescribing rate, and the process for identifying and intervening with providers. The report should include aggregate data about the number of providers that are identified with high morphine milligram equivalent dose (MME) rates and the interventions used. Age breakouts are 0-17, 18+; and should exclude duals.	Narrative Report	Federal Fiscal Year	Annually	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
SUD_CMS_ IMD.25	Readmissions among Members with SUD	Number of all-cause readmissions during the measurement period among Medicaid beneficiaries with substance use disorder (SUD), followed by an acute readmission within 30 days. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #25)	Measure	Agreement Year	Annually	4 Months after end of Measurement Period					X				X
SUDAUDIT.01	SUD Treatment Record Audits	This report will be used to provide DHHS with aggregate level data associated with the SUD audits conducted by the MCOs utilizing the NH MCO SUD Audit tool. Follow the instructions in the NH MCO SUD Audit tool to transfer data into the SUDAUDIT.01 report template.	Table	Measurement Year	Biennially (Every Two Years)	November 30th									X
SUDAUDIT.05	Quality and Performance Improvement Monitoring Report for SUD Treatment Providers	Biennial narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.01 and any other provider performance reviews conducted by the MCOs to ensure the SUD full continuum of care is appropriately provided and supports Member access to timely and quality services.	Narrative Report	Measurement Year	Biennially (Every Two Years)	January 31st									X
SUDAUDIT.07	Quality Improvement Progress Report for SUD Treatment Programs	Annual narrative report describing the implementation and continued monitoring of the MCO quality improvement activities included in the SUDAUDIT.05 report.	Narrative Report	Measurement Year	Biennially (Every Two Years)	August 31st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or subcontractor credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period									X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.04	Coordination of Benefits: Dual State Medicaid Enrollment	This template will provide DHHS with a monthly log of active NH Medicaid members in which the MCO has determined that the NH Medicaid member is concurrently enrolled in the corporate entity's other state Medicaid plan(s) (as applicable), or to report any Members discovered to be enrolled in any other State Medicaid program.	Table	TBD	TBD	TBD									X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report	Agreement Year	Annually	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
WELLNESS.01	Adult Preventive Wellness Visits	Count and percent of members 22 years of age and over who had at least one comprehensive wellness visit during the measurement period, by age group. Age groups include 22-44 Years of Age, 45-64 Years of Age, and 65 Years of Age and Over.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X

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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 AMERIHEALTH CARITAS NEW HAMPSHIRE, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on January 07, 2019. 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: **810354**
Certificate Number: **0007325792**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 4th day of November A.D. 2025.

David M. Scanlan
Secretary of State

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CERTIFICATE OF AUTHORITY

I, Pamela Schmidt, hereby certify that:

1. I am the duly elected Treasurer of AmeriHealth Caritas New Hampshire, Inc.;

2. The following is a true copy of a resolution duly adopted by the Board of Directors on November 5, 2025:

   RESOLVED, that Rebecca Engelman and Sonya Nelson, individually, are duly authorized on behalf of AmeriHealth Caritas New Hampshire, Inc. 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 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 **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.

DocuSigned by:
Pamela Schmidt
A0B9B36A8E8B468...

Pamela Schmidt
Treasurer

11/13/2025
Date

Docusign Envelope ID: A850E71C-CC10-4C84-B0BB-1A03B7E13E88

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
11/24/2025

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 Marsh USA LLC 30 South 17th Street Philadelphia, PA 19103 Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307 CN102240002-GAU-CAS-25-26	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED AMERIHEALTH CARITAS NEW HAMPSHIRE, INC. 25 SUNDIAL AVENUE, SUITE 130W MANCHESTER, NH 03103	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** American Guarantee and Liability Insurance Company — 26247 **INSURER B :** N/A — N/A **INSURER C :** N/A — N/A **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-006880345-07 **REVISION NUMBER:** 3

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** CLAIMS-MADE [X] OCCUR X 2M GenAgg.Per Loc. subj.to max 20M Gen. Agg.-All Loc.Combined GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT [X] LOC OTHER:			CPO440395207	11/30/2025	11/30/2026	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $

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

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

Marsh USA LLC

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Client#: 555456 AMERICARIT

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/27/2024

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Jenna Jachimiak	
Conner Strong & Buckelew PO Box 99106 Camden, NJ 08101 877 861-3220	PHONE (A/C, No, Ext): 877 861-3220	FAX (A/C, No):
	E-MAIL ADDRESS: jJachimiak@connerstrong.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : American Guarantee & Liability Ins. Co.	26247
INSURED AmeriHealth Caritas New Hampshire, Inc. 25 Sundial Avenue, Suite 130W Manchester, NH 03103	INSURER B :	
	INSURER C :	
	INSURER D :	
	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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WC050294807	01/01/2025	01/01/2026	X PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

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

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

W. Michael Hammond

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THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

License No: 89279754

Presents that Amerihealth Caritas New Hampshire, Inc.
is hereby authorized to transact HMO lines of Insurance
in accordance with State Statute RSA 420-B
Exclusions: 8. Restricted to Medicaid Managed Care.

Effective Date: 06/15/2025
Expiration Date: 06/14/2026

David J. Bettencourt
Commissioner of Insurance

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY

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

Denis Goulet, *Commissioner*

December 5, 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 AmeriHealth Caritas New Hampshire Inc., Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan, and Granite State Health Plan Inc. d/b/a New Hampshire Healthy Families, as described below and referenced as DoIT No. 2024-020D.

The purpose of this request is to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management.

The Total Price Limitation shall increase by $25,535,136 for a New Total Price Limitation of $2,768,763,464, effective upon Governor and Council approval with no change to the contract end date of August 31, 2029.

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 #2024-020D

cc: Ken Gagne, IT Manager, DoIT

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

This Amendment to the Medicaid Care Management contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Boston Medical Center Health Plan Inc., d/b/a WellSense Health Plan ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on January 10, 2024 (Tabled Item 33), as amended on July 10, 2024 (Item #11A), as amended on December 18, 2024 (Item #13A) and most recently amended on June 25, 2025 (Item # 199A) 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:

   $2,768,763,464

2. Modify Exhibit B Scope of Services, Amendment #3 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 Scope of Services, Amendment #4 are outlined below:

3. Modify Exhibit B, Section 4.1.2.4, Summary of Covered Services by indicating Psychiatric Residential Treatment Facility Services are “Not Included in Managed Care (DHHS Covered).

4. Modify Exhibit B, Section 4.1.4.2.1 through 4.1.4.2.4, to read:

   4.1.4.2.1 A Copayment of four dollars ($4.00) shall be required for each preferred prescription drug and each refill of a preferred prescription drug; and

   4.1.4.2.2 A Copayment of four dollars ($4.00) shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug.

   4.1.4.2.3 Intentionally left blank.

   4.1.4.2.4 Intentionally left blank.

5. Modify Exhibit B, by adding Section 4.1.4.3.7, to read:

   4.1.4.3.7 Recommended medications, services, and items graded A or B by the U.S. Preventive Services Task Force, including nicotine cessation products and oral and injectable formulations of Pre-Exposure Prophylaxis (PrEP) for persons who are at high risk of HIV acquisition.

6. Modify Exhibit B, Section 4.1.4.4.6, to read:

   4.1.4.4.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within twelve (12) months after the month the pregnancy ended;

7. Modify Exhibit B, Section 4.1.9.3.2, to read:

   4.1.9.3.2 Has undergone a satisfactory safety inspection in accordance with the mutually agreed comprehensive safety checklist at the time of transportation provider enrollment into the Subcontractor's network, at least annually thereafter, and when a safety issue is

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reported for the transportation provider vehicle; and

8. Modify Exhibit B, Section 4.1.9.8.1, by adding Section 4.1.9.8.1.9, to read:

   4.1.9.8.1.9 Any vehicles used for the purpose of transporting individuals with disabilities must meet the requirements set forth in the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles. [49 CFR 38]

9. Modify Exhibit B, Section 4.2.3.1, by adding Sections 4.2.3.1.1 through 4.2.3.1.3, to read:

   4.2.3.1.1 In addition to the MCO's PDL compliance obligations under this Agreement, the MCO shall achieve Department specified minimum adherence targets for specific Department identified drugs' initial adherence targets measured from January 1, 2026 through June 30, 2026. The Department may update adherence targets annually and shall be maintained by the MCO annually thereafter as described in separate guidance.

   4.2.3.1.2 The MCO shall provide quarterly reporting on MCO's adherence targets in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

   4.2.3.1.3 Failure to meet adherence to targets will subject the MCO to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

10. Modify Exhibit B, Section 4.4.13, by adding Section 4.4.13.6, to read:

    4.4.13.6 Beginning March 31, 2026 and annually thereafter, the MCO shall report prior authorization data from the prior calendar year in accordance with Exhibit O: Quality and Oversight Reporting Requirements, excluding any and all drugs covered by the MCO. In addition, the MCO shall make this data accessible by posting the information on its website. [42 CFR 210(f)]

11. Modify Exhibit B, Section 4.5.1, by adding Section 4.5.1.14, to read:

    4.5.1.14 Beginning March 31, 2026, the MCO shall report for the prior calendar year publicly accessible prior authorization data on its plan website, excluding data on any and all drugs covered by the MCO. [42 CFR 438.210]

12. Modify Exhibit B, Section 4.5.3.5, to read:

    4.5.3.5 The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

13. Modify Exhibit B, Section 4.5.6.1, by adding Section 4.5.6.1.1, to read:

    4.5.6.1.1 Effective July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), in accordance with the timeframes established in 42 CFR 438.210(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information) as if such requirements applied directly to the MCO according to the decision timeframes in 42 CFR 438.210(d). [42 CFR 438.242(b)(8)]

14. Modify Exhibit B, Section 4.5.7.3, to read:

    4.5.7.3 Beginning July 1, 2026, for standard service authorization decisions, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed seven (7) calendar days following the date of receipt of 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 from the date of receipt of the request for service is permissible, if:

15. Modify Exhibit B, Section 4.5.9.2, to read:

    4.5.9.2 Under no circumstances may the MCO extend the appeal determination bey[illegible]forty-four (44) calendar days from the day the MCO receives the appeal request e[illegible] the

MCO does not have all the information necessary to make the decision.

16. Modify Exhibit B, Section 4.7, by adding Section 4.7.12 through 4.7.12.1, to read:

    4.7.12 Rural Health Care

    4.7.12.1 Beginning as early as January 1, 2026, the MCO shall support the Department's Rural Health Care activities authorized through the 2025 federal budget reconciliation bill as described in separate guidance. [H.R. 1; P.L. 119-21]

17. Modify Exhibit B, Section 4.8.4.3.1, to read:

    4.8.4.3.1 Beginning July 1, 2026 the determination of all other authorizations for per-service benefits (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed seven (7) fourteen calendar days for ninety-five percent (95%) of standard requests after the receipt of a request. [42 CFR 438.210(d)]

18. Modify Exhibit B, Section 4.8.4.3.2, to read:

    4.8.4.3.2 Beginning July 1, 2026, an extension of up to fourteen (14) calendar days after receiving the request is permissible for if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

19. Modify Exhibit B, Section 4.8.4.3.3, to read:

    4.8.4.3.3 Intentionally left blank.

20. Modify Exhibit B, Section 4.8.4.3.4, to read:

    4.8.4.3.4 Beginning July 1, 2026 notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than seven (7) calendar days after the earlier of:

21. Modify Exhibit B, Section 4.8.4.3.7, to read:

    4.8.4.3.7 Beginning July 1, 2026, the MCO shall notify the requesting provider, and give the enrollee written notice of any decision as expeditiously as the Member's condition requires, but may not exceed seven (7) calendar days after receiving the request for service.

22. Modify Exhibit B, Section 4.8.4.3.7, by adding Section 4.8.4.3.7.1, to read:

    4.8.4.3.7.1 Beginning July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), the MCO shall provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request to the MCO. [42 CFR 438.210(d)] Reasons may be communicated via portal (may include existing payer messaging portal), fax, email, mail, or phone. [42 CFR 438.242(b)(8)]

23. Modify Exhibit B, Section 4.11.2.2.2, to read:

    4.11.2.2.2 Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care

24. Modify Exhibit B, Section 4.11.4.2, to read:

    4.11.4.2 Intentionally left blank.

25. Modify Exhibit B, Section 4.14.3.8.1, to read:

    4.14.3.8.1 For PCPs, (and mental health providers effective January 1, 2026), within (30)

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calendar days of receipt of clean and complete credentialing applications; RSA 420-J:4, I(h)

26. Modify Exhibit B, Section 4.15.14.3.1.1, to read:

    4.15.14.3.1.1 Appropriate use of emergency departments relative to low acuity non-emergent visits.

27. Modify Exhibit B, Section 4.15.14.3.1.6, to read:

    4.15.14.3.1.6 Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing preferred drug prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing Polypharmacy, as described in Section 4.2.6 (Medication Management);

28. Modify Exhibit B, Section 4.15.15.3.3, to read:

    4.15.15.3.3 Effective July 1, 2026, all of MCO's Physician Incentive Plans to a Provider must adhere to the following requirements: (i) have defined performance period that can be tied to the applicable MLR reporting periods; (ii) the Provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCO; (iii) the physician incentive contract with the Provider must include a specific dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including an expected date of payment for meeting the required metrics; and (iv) the physician incentive contracts with the Provider must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e. defined and linked to an applicable MLR reporting period or periods). [42 438.608(e); 42 CFR 438.3(i)(3) and (4)]

29. Modify Exhibit B, Section 4.16.1.11, to read:

    4.16.1.11 The MCO shall implement and maintain arrangements or procedures for prompt reporting within 30 calendar days of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste or Abuse, to the Department. [42 CFR 438.608(a)(2)]

30. Modify Exhibit B, Section 4.18.8.2.1, by adding Sections 4.18.8.2.1.1 through 4.18.8.2.1.1.3 to read:

    4.18.8.2.1. Effective July 1, 2026, implement and maintain a Patient Access Application Programming Interface (API) required in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the MCO, and:

        4.18.8.2.1.1. Include all encounter data, including encounter data from any network providers compensated by the MCO based on capitation payments and adjudicated claims and encounter data from any Subcontractors.

        4.18.8.2.1.2 Exclude covered outpatient drugs as defined in section 1927(k)(2) of the Act.

        4.18.8.2.1.3 Report metrics specified in 42 CFR 431.60(f) (total members whose data are transferred to an API and total members whose data were transferred more than once). [42 CFR 438.242(b)(5)]

31. Modify Exhibit B, Section 5.3.2.2.5, to read:

    5.3.2.2.5 A provision for the prompt reporting within 30 calendar days of all Overpayments identified and recovered, specifying the Overpayments due to potential [illegible] [42

CFR 438.608(a)(2)]

32. Modify Exhibit B, Section 5.3.3.6, to read:

5.3.3.6 The Department may recover Overpayments that are not recovered by or returned to the MCO within ninety (90) calendar days of the end of the appeal timeframe unless the MCO has a recovery agreement with the Provider, or is actively recovering through claims recoupment. The Department will notify MCO if the Department has plans to pursue recovery.

33. Modify Exhibit B, Section 5.3.6.4.2, to read:

5.3.6.4.2 The MCO shall report at least annually to the Department and as otherwise required by this Agreement on all Overpayments identified and recovered. 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

34. Modify Exhibit B, by adding Section 5.4.8, to read:

5.4.8 In accordance with RSA 126-A:3, the Department will seek to implement an outpatient procedure incentive program beginning as early as January 1, 2026, subject to review and approval from the fiscal committee of the general court.

35. Modify Exhibit B, Section 6.2.16.9, to read:

6.2.16.9 Beginning for services effective January 1, 2025, for the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each of three (3) new kick payments to cover juveniles and adults who are incarcerated to comply with new service requirements as part of the implementation of the expansion of its Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance Treatment and Recovery Access 1115 Demonstration Waiver

36. Modify Exhibit B, Section 6.3.4.2.11.1.3, to read:

6.3.4.2.11.1.3 For the July 1, 2025 through June 30, 2026 rating period, the capitation rates reflect an average target MLR, which measures the projected medical service costs as a percentage of the total at-risk capitation rates. The minimum MLR will limit MCO gains if the actual MLR is lower than the minimum MLR. The maximum MLR will limit MCO losses if the actual MLR is higher than the maximum MLR. The average target MLR for at-risk services is 91.2% for Standard Medicaid and 90.3% for GAHCP based on the SFY 2026 projected enrollment distribution. The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs for the rating period, the minimum MLR will be 88.7% for the Standard Medicaid population and 87.8% for the GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCO will have a maximum loss of 2%. Based on the target MLRs for the rating period, the average maximum MLR will be 94.7% for the Standard Medicaid population and 93.8% for the GAHCP population

37. Modify Exhibit B, Section 6.4. by adding Section 6.4.1.1, to read:

6.4.1.1 For both Medicare Part A and Part B Claims, if the Member responsibility amount is “0” then the MCO shall make no payment.

38. Modify Exhibit B, Section 6.3.4.2.10, to read:

6.3.4.2.10 The MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available. At the Department’s discretion, a final revi[illegible]LR settlement calculation may occur upon completion of an MLR audit for t[illegible]od,

if applicable, to consider any adjustments identified during the MLR audit impacting the final MLR settlement calculation.

39. Modify Exhibit B, Section 6.4.2.3, to read:

    6.4.2.3 Intentionally left blank.

40. Modify Exhibit B, Section 6.4.4, to read:

    6.4.4 For all claims (medical and pharmacy) with other insurance or Medicare Advantage plans, the MCO shall follow coordination of benefits processes described in the entirety of this Section 6.4, unless otherwise stipulated in this Agreement.

41. Modify Exhibit B, Section 6.4.4.2, to read:

    6.4.4.2 Beginning March 1, 2026, the MCO shall pay as primary payer for Medicare Part A and Part B claims when the provider is not enrolled with Medicare on the Date of service.

42. Modify Exhibit B, Section 6.4. by adding Section 6.4.4.3, to read:

    6.4.4.3 Beginning March 1, 2026, the MCO is responsible for Member Cost Sharing, (e.g., Copayment, deductible) (excluding Medicare Part D medications), as applicable, when other insurance, Medicare Part A or Part B, or Medicare Advantage pays as primary for a Covered Service via an automated crosswalk table or other methodology to effectuate payment regardless of whether the primary payer uses a different billing code for the same Covered Service.

43. Modify Exhibit B, Section 6.4. by adding Section 6.4.5, to read:

    6.4.5 The MCO shall not pay Member Cost Sharing for Medicare Part D covered medications regardless of whether the Member has one or both Medicare Part A and/or Medicare Part B.

44. Modify Exhibit B, Section 6.10.11.4, to read:

    6.10.11.4 The MCO shall have five (5) months from the original paid date to bill private insurance. The MCO shall have six (6) years to recover funds with the following exceptions:

45. Modify Exhibit B, Section 6.10.11.4 by adding Section 6.10.11.4.3, to read:

    6.10.11.4.3 The Department may directly bill and recover the private insurance amount paid by the MCO if the MCO has not billed the private insurance within five (5) months from the MCO original paid date. The Department shall inform the MCO in writing of any claims in which the Department plans to pursue Pay and Case recovery and retain any recovered funds.

46. Modify Exhibit C Payment Terms, Amendment #3 by replacing it in its entirety with Exhibit C Payment Terms, Amendment #4, which is attached hereto and incorporated by reference herein.

47. Modify Exhibit N Liquidated Damages Matrix, Amendment #2 by replacing it in its entirety with Exhibit N Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

48. Modify Exhibit O: Quality and Oversight Reporting Requirements, Amendment #3 by replacing it in its entirety with Exhibit O: Quality and Oversight Reporting Requirements Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

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 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

12/9/2025
Date

DocuSigned by:
Henry D. Lipman
CF5D44D4F70D4E4...

Name: Henry D. Lipman
Title: Medicaid Director

Boston Medical Center Health Plan Inc., d/b/a WellSense Health Plan.

12/9/2025
Date

Signed by:
Diana Cruz
2D2DCF4FD6C1433...

Name: Diana Cruz
Title: Acting President

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

OFFICE OF THE ATTORNEY GENERAL

12/9/2025

DocuSigned by:
Robyn Guarino
748734844941460...

Date

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:

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Medicaid Care Management

EXHIBIT B – AMENDMENT #4

SCOPE OF SERVICES

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1 INTRODUCTION

1.1 Purpose

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

1.2 Term

1.2.1. The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed MCM Agreement or, if the MCO 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 MCO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.1.1 If the MCO 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 MCO.

1.2.2. The Program Start Date shall begin September 1, 2024, and the Agreement term shall continue through August 31, 2029.

1.2.3. The MCO's participation in the MCM program is contingent upon approval by the Governor and Executive Council, the MCO'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.

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

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

2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 Abuse

2.1.1.1. Practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program or in reimbursement for goods services that are not medically necessary or that fail to meet professionally recognized standards for care; or recipient practices that result in unnecessary cost to the Medicaid program.

2.1.2 Adults with Special Health Care Needs

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2.1.2.1. 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.

2.1.2.2. This includes but is not limited to Members diagnosed 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**

2.1.3.1. 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**

2.1.4.1. 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 MCO to act on a grievance or an appeal within the time limits defined in this Agreement.

2.1.5 **Affordable Care Act**

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

2.1.6 **Agreement**

2.1.6.1. This entire written Agreement between the Department and the MCO duly executed and legally binding.

2.1.7 **Alternative Payment Model (APM)**

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

2.1.8 **Alternative Payment Model Implementation Plan**

2.1.8.1. A MCO's plan for meeting the APM requirements described in this Agreement.

2.1.9 **American Society of Addiction Medicine (ASAM) Criteria**

2.1.9.1. The National set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

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2.1.10 Americans with Disabilities Act (ADA)

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

2.1.11 Area Agency

2.1.11.1. An entity established as a nonprofit corporation in the State of New Hampshire which is established by rules adopted by the Commissioner to provide services to developmentally disabled persons in the area as defined in RSA 171-A:2.

2.1.12 ASAM Level of Care

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

2.1.13 Assertive Community Treatment (ACT)

2.1.13.1. The evidence-based practice of delivering comprehensive and effective services to Members with SMI by a multidisciplinary team primarily in Member homes, communities, and other natural environments.

2.1.14 Automatic Assignment (or Auto-Assign)

2.1.14.1. The enrollment of an eligible Medicaid recipient, for whom enrollment is mandatory, in a MCO chosen by the Agency or its agent, and/or the assignment of a new enrollee to a PCP chosen by the MCO. In addition, Auto-Assignment may occur based on MCO performance as described in Section 4.3.4 (Auto-Assignment).

2.1.15 Auxiliary Aids

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

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

2.1.16 Behavioral Health Services

2.1.16.1. Mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.17 Bright Futures

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2.1.17.1. A National health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.18 **Capitation Payment**

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

2.1.18.2. Capitation payments are made only for Medicaid-eligible Members and retained by the MCO 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]

2.1.19 **Care Coordination**

2.1.19.1. A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a Member's physical, behavioral health and psychosocial needs using communication, closed-loop referral processes, and all available resources to promote quality cost-effective outcomes.

2.1.20 **Care Management**

2.1.20.1. Direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.21 **Care Manager**

2.1.21.1. A qualified and trained individual who is primarily responsible for providing Member supportive services as defined by this Agreement.

2.1.22 **Care Plan**

2.1.22.1. A document prepared and updated by a Member's Provider and interdisciplinary Care Team with input from the Member which summarizes the Member's health conditions, specific care needs, and current treatments. The Care Plan outlines what is needed to manage the Member's care needs and helps organize and prioritize care and treatment, including referrals relative to health-related social needs as defined in this Agreement.

2.1.23 **Care Team**

2.1.23.1. Chosen and/or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships. The care team shall include the PCP.

2.1.24 **Case Management**

2.1.24.1. Service provided for supervising or coordinating care on behalf of Members, including gaining access to needed waivers and other Medicaid

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State Plan services, as well as monitoring the continuity of patient care services. 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.

2.1.25 **Centers for Medicare & Medicaid Services (CMS)**

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

2.1.26 **Certified Community Behavioral Health Clinic (CCBHC)**

2.1.26.1. [Amendment #2:] A state certified clinic that is responsible for providing all required CCBHC services in a manner that meets or exceeds CCBHC criteria. CCBHCs must either directly or through its Designated Collaborating Organizations (DCOs) provide, in a manner reflecting person-centered and family-centered care: crisis services; screening, assessment, and diagnosis; person-centered and family-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management services; psychiatric rehabilitation services; peer supports and family/caregiver supports; and community care for uniformed service members and veterans. CCBHCs may also be a CMH Program if authorized to deliver the comprehensive array of services described in He-M 426, and is designated to cover a region as described in He-M 425.

2.1.27 **Children with Special Health Care Needs**

2.1.27.1. Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

2.1.27.2. [Amendment #1:] This includes, but is not limited to, children or infants; infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children, Youth and Families (DCYF), including those in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.28 **Children's Health Insurance Program (CHIP)**

2.1.28.1. A program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.29 **Choices for Independence (CFI)**

2.1.29.1. Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors

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and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

2.1.29.2. 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.

2.1.30 **Chronic Condition**

2.1.30.1. A physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.31 **Clean Claim**

2.1.31.1. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a health plan's claims system. 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).

2.1.32 **Cold Call Marketing**

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

2.1.33 **Community Mental Health Services**

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

2.1.34 **Community Mental Health Program (“CMH Program”)**

2.1.34.1. Synonymous with Community Mental Health Center, means a program established and administered by the State of New Hampshire, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, Case Management, and psychotherapy services, [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.35 **Community Mental Health Provider (“CMH Provider”)**

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

2.1.36 **Comprehensive Assessment**

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2.1.36.1. A person-centered assessment to help identify a Member's health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.37 **Comprehensive Medication Review (CMR)**

2.1.37.1. A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber.

2.1.37.2. The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other qualified individual, such as a prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve a patient's knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements; identify, and address problems or concerns the patient may have, and empower them to self-manage their medications and health conditions.

2.1.38 **Confidential Information and Confidential Data**

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

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

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

2.1.40 **Continuity of Care**

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

2.1.41 **Continuous Quality Improvement (CQI)**

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

2.1.42 **Copayment**

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

2.1.43 **Corrective Action Plan (CAP)**

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2.1.43.1. Plan that the MCO 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.

2.1.44 **Cost Sharing**

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

2.1.45 **Covered Services**

2.1.45.1. Health care services as defined by the Department and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, including authorized In Lieu of Services and Value-Added Services and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.46 **Cultural Competence**

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

2.1.47 **Data**

2.1.47.1. 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.

2.1.48 **Data Breach**

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

2.1.49 **Designated Receiving Facility (DRF)**

2.1.49.1. A hospital-based psychiatric unit or a non-hospital-based residential treatment program designated by the Commissioner to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system as defined in He-M 405. A DRF may also provide care for persons admitted to the facility voluntarily.

2.1.50 **Determinants of Health/Health-related Social Needs**

2.1.50.1. 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.

2.1.51 **Disenrollment**

2.1.51.1. 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.

2.1.52 **Data Certification**

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2.1.52.1. Encounter Data submitted to the Department, which must be certified by one of the following: MCO's CEO, CFO, or an individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO [42 CFR 438.604; 42 CFR 438.606(a)].

2.1.53 **Dual-Eligible Members**

2.1.53.1. Members who are eligible for both Medicare and Medicaid.

2.1.54 **Emergency Medical Condition**

2.1.54.1. 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)]

2.1.54.2. With respect to a pregnant woman, an emergency medical condition exists when:

2.1.54.2.1 There is inadequate time to effect safe transfer to another Provider prior to delivery;

2.1.54.2.2 Transfer may pose a threat to the health and safety of the patient or fetus; or

2.1.54.2.3 There is evidence of onset of uterine contractions or rupture of the membranes.

2.1.55 **Emergency Services**

2.1.55.1. 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)]

2.1.56 **Encounter Data**

2.1.56.1. A record of Covered Services provided to a MCO Member. An "encounter" is an interaction between a patient and a provider (MCO, 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.

2.1.57 **Enrollment**

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

2.1.58 **Equal Access**

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

2.1.59 **Evidence-Based Supported Employment (EBSE)**

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2.1.59.1. The provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by Dartmouth Medical School to promote successful competitive employment in the community.

2.1.60 **Exclusion Lists**

2.1.60.1. 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).

2.1.61 **External Quality Review (EQR)**

2.1.61.1. 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 MCO or its Subcontractors furnish to Medicaid recipients.

2.1.62 **Facility**

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

2.1.63 **Family Planning Services**

2.1.63.1. Services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include: Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

2.1.63.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

2.1.63.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

2.1.63.4. Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

2.1.63.5. Immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine.

2.1.64 **Federally Qualified Health Centers (FQHCs)**

2.1.64.1. 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.

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2.1.65 **Fraud**

2.1.65.1. 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.

2.1.66 **Granite Advantage Members**

2.1.66.1. 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.

2.1.67 **Grievance Process**

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

2.1.68 **Home and Community Based Services (HCBS)**

2.1.68.1. 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 (IHS) waiver program.

2.1.69 **Hospital-Acquired Conditions and Provider Preventable Conditions**

2.1.69.1. 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.

2.1.70 **Implementation**

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

2.1.71 **In Lieu of Services**

2.1.71.1. An alternative medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan. The utilization and

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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. A Member cannot be required by the MCO to use the alternative service or setting.

2.1.72 **Incomplete Claim**

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

2.1.73 **Indian Health Care Provider (IHCP)**

2.1.73.1. 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)]

2.1.74 **Integrated Care**

2.1.74.1. The systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.[1]

2.1.75 **Licensed**

2.1.75.1. 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.

2.1.76 **Limited English Proficiency (LEP)**

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

2.1.77 **List of Excluded Individuals and Entities (LEIE)**

2.1.77.1. 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.

2.1.78 **Long Term Services and Supports (LTSS)**

2.1.78.1. 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).

2.1.79 **Managed Care Information System (MCIS)**

2.1.79.1. A comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides

[1] SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?"

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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.

2.1.80 **Managed Care Organization (MCO)**

2.1.80.1. 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 MCM program.

2.1.81 **Marketing**

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

2.1.82 **Marketing Materials**

2.1.82.1. Materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as Marketing to potential Members.

2.1.83 **MCO Formulary or Prescription Drug List (PDL)**

2.1.83.1. List of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the Department-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.84 **MCO Quality Assessment and Performance Improvement (QAPI) Program**

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

2.1.85 **MCO Utilization Management Program**

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

2.1.86 **Medicaid Director**

2.1.86.1. The State Medicaid Director of NH DHHS.

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2.1.87 **Medicaid Management Information System (MMIS)**

2.1.87.1. 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.

2.1.88 **Medicaid State Plan**

2.1.88.1. 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 establishes 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.

2.1.89 **Medical Loss Ratio (MLR)**

2.1.89.1. 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) for the application of the minimum federal loss ratio provision.

2.1.90 **Medically Necessary**

2.1.90.1. 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:

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

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

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

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

2.1.90.2. [Amendment #1:] For Members under twenty-one (21) years of age in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, any service that is included within the categories of

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mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.91 **Medication Assisted Treatment (MAT)**

2.1.91.1. The use of medications in combination with treatment planning, counseling and behavioral therapies or referral thereto for the treatment of Substance Use Disorder.

2.1.92 **Member**

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

2.1.93 **Member Advisory Board**

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

2.1.94 **Member Appeal Process**

2.1.94.1. 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.

2.1.95 **Member Encounter Confidential Data (Encounter Data)**

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

2.1.96 **Member Handbook**

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

2.1.97 **National Committee for Quality Assurance (NCQA)**

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

2.1.98 **NCQA Health Plan Accreditation**

2.1.98.1. MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.99 **Neonatal Abstinence Syndrome (NAS)**

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2.1.99.1. A constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.

2.1.100 **Non-Covered Service**

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

2.1.101 **Non-Emergency Medical Transportation (NEMT)**

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

2.1.102 **Non-Participating Provider**

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

2.1.103 **Non-Symptomatic Office Visits**

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

2.1.104 **Non-Urgent, Symptomatic Office Visits**

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

2.1.105 **Ongoing Special Condition**

2.1.105.1. 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; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.106 **Overpayments**

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2.1.106.1. 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.

2.1.107 **Participating Provider**

2.1.107.1. A person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the MCO to provide services to Members under the terms of this Agreement.

2.1.108 **Pay and Chase**

2.1.108.1. Recovery of claims paid in which the Standard Medicare, Medicare Advantage plan or private insurance was not known at the time the claim was adjudicated.

2.1.109 **Peer Recovery Program**

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

2.1.110 **Performance Improvement Project (PIP)**

2.1.110.1. 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)].

2.1.111 **Physician Group**

2.1.111.1. 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.

2.1.112 **Physician Incentive Plan**

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

2.1.113 **Post-Stabilization Services**

2.1.113.1. 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]

2.1.114 **Practice Guidelines**

2.1.114.1. Evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health

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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.

2.1.115 **Prescription Drug Monitoring Program (PDMP)**

2.1.115.1. The program operated by the Department that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in New Hampshire.

2.1.116 **Primary Care**

2.1.116.1. All health services and laboratory services, including periodic examinations, preventive health care services and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care by the PCP, record maintenance, and initiation and coordination of closed loop referrals to specialty providers, including but not limited to Behavioral Health Service providers, and collaboration with such providers, for maintaining continuity of the Member's care and to collaboratively support achievement of the Member's whole-person health care goals.

2.1.117 **Primary Care and Prevention Focused Care Model**

2.1.117.1. Model of Care as described in Section 4.10 of this Agreement.

2.1.118 **Primary Care Provider (PCP)**

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

2.1.119 **Prior Authorization**

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

2.1.120 **Program Start Date**

2.1.120.1. The date when the MCO is responsible for coverage of Covered Services to its Members in the MCM program, contingent upon Agreement approval by

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

2.1.121 **Post Payment Recovery**

2.1.121.1. The process of seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). Also known as "Cost Recovery" or "pay and chase".

2.1.122 **Provider Appeal Process**

2.1.122.1. The procedure for handling, processing, collecting and tracking Provider appeal requests in accordance with Section 4.6 (Provider Appeals) of this Agreement.

2.1.123 **Provider Directory**

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

2.1.124 **Psychiatric Boarding**

2.1.124.1. The continued presence of a Member experiencing a mental health crisis in a hospital emergency room while waiting for admission in a designated receiving facility.

2.1.125 **Qualified Bilingual/Multilingual Staff**

2.1.125.1. An employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that 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.

2.1.126 **Qualified Interpreter for a Member with a Disability**

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

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

2.1.127 **Qualified Interpreter for a Member with LEP**

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2.1.127.1. 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.

2.1.128 **Qualified Translator**

2.1.128.1. 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]

2.1.129 **Qualifying APM**

2.1.129.1. 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.

2.1.130 **Quality**

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

2.1.131 **Quality Assessment and Performance Improvement (QAPI) Program**

2.1.131.1. An ongoing and comprehensive program for the Covered Services the MCO furnishes to Members consistent with the requirements of this Agreement.

2.1.132 **Quality Improvement (QI)**

2.1.132.1. The process of monitoring that the delivery of oral, behavioral, and physical health care services are available, accessible, timely, and medically necessary. The MCO 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 health care outcomes for Members.

2.1.133 **Readiness Review**

2.1.133.1. The review process through which the MCO demonstrates, to the Department's satisfaction, the MCO's 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) and the terms and conditions of this Agreement.

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2.1.134 **Recovery**

2.1.134.1. A process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.[2]

2.1.135 **Referral Provider**

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

2.1.136 **Required Priority Population**

2.1.136.1. The population mandated by the Department for MCO-Delivered Care Management services as described in this Agreement (Section 4.11.2). The MCO may provide Care Management services for other Members or populations at the plan's option.

2.1.137 **Rural Health Clinic (RHC)**

2.1.137.1. 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.

2.1.138 **Second Opinion**

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

2.1.139 **Health-related Social Needs**

2.1.139.1. 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.

2.1.140 **Software**

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

2.1.141 **Specifications**

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

2.1.142 **State**

2.1.142.1. The State of New Hampshire and any of its agencies.

2.1.143 **State Data**

[2] SAMHSA, "Recovery and Recovery Support".

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2.1.143.1. 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

2.1.144 **Subcontract**

2.1.144.1. 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.

2.1.145 **Subcontractor**

2.1.145.1. 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.

2.1.146 **Substance Use Disorder**

2.1.146.1. A cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in He-W 513.02.

2.1.147 **Substance Use Disorder Provider**

2.1.147.1. All Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.

2.1.148 **System**

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

2.1.149 **Term**

2.1.149.1. The duration of this Agreement.

2.1.150 **Third Party Liability (TPL)**

2.1.150.1. 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.

2.1.150.2. 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.

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2.1.150.3. 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.

2.1.151 **Transitional Care Management**

2.1.151.1. The responsibility of the MCO 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.

2.1.151.2. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.152 **Transportation**

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

2.1.153 **Transitional Health Care**

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

2.1.154 **Transitional Home Care**

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

2.1.155 **Trauma Informed Care**

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

2.1.156 **Urgent, Symptomatic Office Visits**

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

2.1.157 **Utilization Management**

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

2.1.158 **Value-Added Services**

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

2.1.159 **Verification**

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

2.1.160 **Waste**

2.1.160.1. The thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

2.1.161 **Wellness Visit**

2.1.161.1. A PCP visit that includes health risk and social determinant of health needs assessments, evaluation of the Member's physical and behavioral health, including screening for depression, mood, suicidality, and Substance Use Disorder.

2.1.162 **Willing Provider**

2.1.162.1. A Provider credentialed as a qualified treatment provider according to the requirements of the Department and the MCO, who agrees to render Covered Services as authorized by the MCO and in compliance with terms of the MCO's Provider Agreement, including reimbursement rates and policy manual.

2.1.163 **Withhold**

2.1.163.1. [Amendment #3:] The actuarially sound amount retained as a percent of the MCO's risk adjusted total Capitation ~~for a rating period~~ which is withheld ~~annually~~ from the applicable rating period and ~~may be~~ made available for distribution to the MCO ~~in future contract years~~ through the Quality Withhold Program and upon meeting specific quality performance criteria.

2.1.164 **Work Plan**

2.1.164.1. Documentation that details the activities for the Project created in accordance with the Agreement. 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.

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2.2 Acronym List

2.2.1 AAP means American Academy of Pediatrics.
2.2.2 ABD means Acquired Brain Disorder.
2.2.3 ACT means Assertive Community Treatment.
2.2.4 ADA means Americans with Disabilities Act.
2.2.5 ADL means Activities of Daily Living.
2.2.6 ADT means Admission, Discharge and Transfer.
2.2.7 AIDS means Acquired Immune Deficiency Syndrome.
2.2.8 ANSA means Adult Needs and Strengths Assessment.
2.2.9 APM means Alternative Payment Model.
2.2.10 ARNP means Advanced Registered Nurse Practitioner.
2.2.11 ASAM means American Society of Addiction Medicine.
2.2.12 ASC means Accredited Standards Committee.
2.2.13 ASFRA means Assisted Suicide Funding Restriction Act.
2.2.14 ASL means American Sign Language.
2.2.15 BCCP means Breast and Cervical Cancer Program.
2.2.16 CAHPS means Consumer Assessment of Healthcare Providers and Systems.
2.2.17 CANS means Child and Adolescent Needs and Strengths Assessment.
2.2.18 CAP means Corrective Action Plan.
2.2.19 CAPRSS means Council on Accreditation of Peer Recovery Support Services.
2.2.20 CARC means Claim Adjustment Reason Code.
2.2.21 CCBHC means Certified Community Behavioral Health Clinic
2.2.22 CEO means Chief Executive Officer.
2.2.23 CFI means Choices for Independence.
2.2.24 CFO means Chief Financial Officer.
2.2.25 CHIP means Children's Health Insurance Program.
2.2.26 CHIS means Comprehensive Health Care Information System.
2.2.27 CMH means Community Mental Health.
2.2.28 CMO means Chief Medical Officer.
2.2.29 CMR means Comprehensive Medication Review.
2.2.30 CMS means Centers for Medicare & Medicaid Services.
2.2.31 COB means Coordination of Benefits.
2.2.32 COBA means Coordination of Benefits Agreement.

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2.2.33 CPT means Current Procedural Terminology.

2.2.34 CQI means Continuous Quality Improvement.

2.2.35 DBT means Dialectical Behavioral Therapy.

2.2.36 DCO means Designated Collaborating Organization.

2.2.37 DCYF means New Hampshire Division for Children, Youth and Families.

2.2.38 DD means Developmental Disability.

2.2.39 DEA means Drug Enforcement Administration.

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

2.2.41 DME means Durable Medical Equipment.

2.2.42 DOB means Date of Birth.

2.2.43 DOD means Date of Death.

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

2.2.45 DRA means Deficit Reduction Act.

2.2.46 DSM means Diagnostic and Statistical Manual of Mental Disorders.

2.2.47 DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.

2.2.48 DUR means Drug Utilization Review.

2.2.49 EBSE means Evidence-Based Supported Employment.

2.2.50 ECI means Elderly and Chronically Ill.

2.2.51 ED means Emergency Department.

2.2.52 EDI means Electronic Data Interchange.

2.2.53 EFT means Electronic Funds Transfer.

2.2.54 EOB means Explanation of Benefits.

2.2.55 EPSDT means Early and Periodic Screening, Diagnostic and Treatment.

2.2.56 EQR means External Quality Review.

2.2.57 EQRO means External Quality Review Organization.

2.2.58 ERISA means Employees Retirement Income Security Act of 1974.

2.2.59 EST means Eastern Standard Time.

2.2.60 ETL means Extract, Transformation and Load.

2.2.61 FAR means Federal Acquisition Regulation.

2.2.62 FCA means False Claims Act.

2.2.63 FDA means Food and Drug Administration for the United States Department of Health and Human Services.

2.2.64 FFATA means Federal Funding Accountability & Transparency Act.

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2.2.65 FFS means Fee-for-Service.

2.2.66 FPL means Federal Poverty Level.

2.2.67 FQHC means Federally Qualified Health Center.

2.2.68 HEDIS means Healthcare Effectiveness Data and Information Set.

2.2.69 HCBS means Home and Community Based Services.

2.2.70 HCBS-I means Home and Community Based Services In Home Supports.

2.2.71 HCPCS means Health Care Common Procedure Coding System.

2.2.72 HCQI means Health Care Quality Improvement.

2.2.73 HHS means United States Department of Health and Human Services.

2.2.74 HIPAA means Health Insurance Portability and Accountability Act.

2.2.75 HIPP means Health Insurance Premium Payment.

2.2.76 HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.

2.2.77 HIV means Human Immunodeficiency Virus.

2.2.78 HMO means Health Maintenance Organization.

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

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

2.2.81 IADL means Instrumental Activities of Daily Living.

2.2.82 IBNR means Incurred But Not Reported.

2.2.83 ICF means Intermediate Care Facility.

2.2.84 ID means Intellectual Disabilities.

2.2.85 IEA means Involuntary Emergency Admission.

2.2.86 IHCP means Indian Health Care Provider.

2.2.87 IHS means Indian Health Service.

2.2.88 IMD means Institution for Mental Disease.

2.2.89 IVR means Interactive Voice Response.

2.2.90 LEIE means List of Excluded Individuals & Entities.

2.2.91 LEP means Limited English Proficiency.

2.2.92 LTSS means Long-Term Services and Supports.

2.2.93 MACRA means Medicare Access and CHIP Reauthorization Act of 2015.

2.2.94 MAT means Medication Assisted Treatment.

2.2.95 MCIS means Managed Care Information System.

2.2.96 MCM means Medicaid Care Management.

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2.2.97 MCO means Managed Care Organization.

2.2.98 MED means Morphine Equivalent Dosing.

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

2.2.100 MLADCs means Masters Licensed Alcohol and Drug Counselors.

2.2.101 MLR means Medical Loss Ratio.

2.2.102 MMIS means Medicaid Management Information System.

2.2.103 NAS means Neonatal Abstinence Syndrome.

2.2.104 NCPDP means National Council for Prescription Drug Programs.

2.2.105 NCQA means National Committee for Quality Assurance.

2.2.106 NEMT means Non-Emergency Medical Transportation.

2.2.107 NH means New Hampshire.

2.2.108 NHID means New Hampshire Insurance Department.

2.2.109 NPI means National Provider Identifier.

2.2.110 NPPES means National Plan and Provider Enumeration System.

2.2.111 OB/GYN means Obstetrics/Gynecology or Obstetricians/ Gynecologists.

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

2.2.113 OTP means Opioid Treatment Program.

2.2.114 PBM means Pharmacy Benefits Manager.

2.2.115 PCA means Personal Care Attendant.

2.2.116 PCP means Primary Care Provider.

2.2.117 PDL means Preferred Drug List.

2.2.118 PDMP means Prescription Drug Monitoring Program.

2.2.119 PHI means Protected Health Information.

2.2.120 PI means Personal Information.

2.2.121 PIP means Performance Improvement Plan.

2.2.122 POS means Point of Service.

2.2.123 PRSS means Peer Recovery Support Services.

2.2.124 QAPI means Quality Assessment and Performance Improvement.

2.2.125 QI means Quality Improvement.

2.2.126 QM means Quality Management.

2.2.127 QOS means Quality of Service.

2.2.128 RARC means Reason and Remark Codes.

2.2.129 RFP means Request for Proposal.

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2.2.130 RHC means Rural Health Clinic.

2.2.131 SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.

2.2.132 SBIRT means Screening, Brief Intervention, and Referral to Treatment.

2.2.133 SED means Serious Emotional Disturbance.

2.2.134 SFY means State Fiscal Year.

2.2.135 SHIP means State's Health Insurance Assistance Program.

2.2.136 SIU means Special Investigations Unit.

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

2.2.138 SMDL means State Medicaid Director Letter.

2.2.139 SMI means Severe Mental Illness.

2.2.140 SNF means Skilled Nursing Facility.

2.2.141 SPMI means Severe or Persistent Mental Illness.

2.2.142 SSADMF means Social Security Administration Death Master File.

2.2.143 SSAE means Statement on Standards for Attestation Engagements.

2.2.144 SSI means Supplemental Security Income.

2.2.145 SSN means Social Security Number.

2.2.146 TAP means Technical Assistance Publication.

2.2.147 TDD means Telecommunication Device for Deaf Persons.

2.2.148 TPL means Third Party Liability.

2.2.149 TTY means Teletypewriter.

2.2.150 UAT means User Acceptance Testing.

2.2.151 Utilization Management means Utilization Management.

2.2.152 UDS means Urine Drug Screenings.

2.2.153 VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO.

3.1.1.2 The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and

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delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 **Representation and Warranties**

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

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

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

3.1.3.2 The MCO 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.

3.1.3.3 The Program Management Plan shall:

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

3.1.3.3.2 Describe how the MCO 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;

3.1.3.3.3 Describe how the MCO shall ensure timely notification to the Department regarding:

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

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

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

3.1.3.3.3.4. On an annual basis, the MCO 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.

3.1.4 Key Personnel Contact List

3.1.4.1 The MCO shall submit a Key Personnel Contact List to the Department that includes the positions and associated information indicated in Section 3.11.1. (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program.

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

3.2 Agreement Elements

3.2.1 [Amendment #1:] The Agreement between the parties shall consist of the following, including subsequent Amendments:

3.2.1.1. General Provisions, Form Number P-37

3.2.1.2. [Amendment #1:] Exhibit A: ~~Revisions to Standard Agreement~~ Special Provisions

3.2.1.3. Exhibit B: Scope of Services

3.2.1.4. Exhibit C: Payment Terms

3.2.1.5. [Amendment #1:] Exhibit D: ~~Certification Regarding Drug Free Workplace Requirements~~Federal Requirements

3.2.1.6. [Amendment #1:] Exhibit E: ~~Certification Regarding Lobbying~~DHHS Information Security Requirements

3.2.1.7. [Amendment #1:] Exhibit F: ~~Certification Regarding Debarment, Suspension, and Other Responsibility Matters~~Business Associate Agreement

3.2.1.8. [Amendment #1:] Exhibit G: ~~Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections~~Additional Requirements

3.2.1.9. [Amendment #1:] ~~Exhibit H: Certification Regarding Environmental Tobacco Smoke~~Reserved

3.2.1.10. [Amendment #1:] ~~Exhibit I: Health Insurance Portability Act Business Associate Agreement~~Reserved

3.2.1.11. [Amendment #1:] Exhibit J: ~~Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance~~Vendor Risk Assessment Report (VRAR)

3.2.1.12. [Amendment #1:] Exhibit K: ~~DHHS Information Security Requirements~~ Technical Requirements Workbook

3.2.1.13. Exhibit L: MCO Implementation Plan

3.2.1.14. Exhibit M: MCO Proposal submitted in response to RFP, by reference

3.2.1.15. Exhibit N: Liquidated Damages Matrix

3.2.1.16. Exhibit O: Quality and Oversight Reporting Requirements

3.2.1.17. Exhibit P: MCO Program Oversight Plan

3.2.1.18. [Amendment #1:] Exhibit Q: ~~DoIT Technical Requirements Workbook~~Reserved

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3.3 **Delegation of Authority**

3.3.1 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.

3.4 **Authority of the New Hampshire Insurance Department**

3.4.1 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 MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.4.2 The MCO 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 New Hampshire Insurance Department (NHID); and the NH Comprehensive Health Care Information System (CHIS) Confidential Data reporting submission under NHID rules and/or bulletins.

3.5 **Time of the Essence**

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

3.6 **CMS Approval of Agreement and Any Amendments**

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

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

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

3.6.2.2 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.

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

3.6.4 The Department shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement

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initiatives based on the Department's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.7 **Cooperation with Other Vendors and Prospective Vendors**

3.7.1 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 MCO 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.

3.7.2 The MCO 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 MCO, its subcontractor or a Provider.

3.7.3 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.

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

3.8 **Renegotiation and Re-Procurement Rights**

3.8.1 **Renegotiation of Agreement**

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

3.8.1.2. Upon the MCO's receipt of any Department notice pursuant to this section to renegotiate this Agreement, the MCO 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.

3.8.2 **Re-Procurement of the Services or Procurement of Additional Services**

3.8.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not the Department has accepted or rejected MCO'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 MCO under the Agreement.

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

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3.8.2.3. 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 MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.9 Organization Requirements

3.9.1 General Organization Requirements

3.9.1.1. As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by 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.

3.9.1.2. As a condition to entering into this Agreement, and during the entire Agreement Term, the MCO 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.

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

3.9.1.4. At the Department's discretion and at a Member effective date to be determined, the MCO shall initiate a Centers for Medicare and Medicaid Services defined application process to implement a highly integrated dual eligible special needs plan (HIDE SNP) or an alternate dual-eligible special needs plan (D-SNP) as defined at 42 CFR 422.2.

3.9.2 Articles

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

3.9.3 Ownership and Control Disclosures

3.9.3.1. The MCO 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 MCO that:

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

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

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

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

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

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

3.9.3.2.3 Tax identification number(s) of any corporation;

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

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

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

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

3.9.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.9.3 (Ownership and Control Disclosures) to the Department is accurate to the best of his or her information, knowledge, and belief.

3.9.3.3. The MCO shall disclose the information set forth in this Section 3.9.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to the Department at the following times:

3.9.3.3.1 At the time of Agreement execution;

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

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

3.9.3.3.4 Upon request of the Department during the revalidation of the Provider enrollment; and

3.9.3.3.5 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)]

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

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

3.9.4 Change in Ownership or Proposed Transaction

3.9.4.1. The MCO 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 MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO shall receive prior written approval from the Department and the NHID prior to taking such action.

3.9.5 Prohibited Relationships

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

3.9.5.2. The MCO shall not have an individual:

3.9.5.2.1 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

3.9.5.2.2 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-

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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

3.9.5.2.3 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

3.9.5.2.4 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

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

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

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

3.9.5.4. Within five (5) calendar days of discovery, the MCO shall provide written disclosure to the Department, and Subcontractors shall provide written disclosure to the MCO, 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]

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

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3.9.5.5.1 Terminate the existing Agreement with the MCO;

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

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

3.9.6 **Background Checks**

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

3.9.6.2. The MCO 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 MCO and Subcontractors do not employ or contract with any individual or entity, in accordance with Prohibited Relationship provisions in Section 3.9.5 of this Agreement, on an Exclusion List who are:

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

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

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

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

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

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3.9.6.3.2 The System of Award Management;

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

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

3.9.6.4. The MCO 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 MCO nor its Subcontractors, including contractor employees of MCO Subcontractors, have any employees, directly or indirectly, with:

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

3.9.6.4.2 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;

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

3.9.6.4.4 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

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

3.9.6.5. In the event that the MCO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.9.6 (Background Checks) or Section 3.9.3 (Ownership and Control Disclosures) above, then the MCO 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.

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

3.9.7 Conflict of Interest

3.9.7.1. The MCO 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 MCO shall report transactions between the MCO and parties in interest to the Department

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and any other agency as required, and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.9.7.2. The MCO 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 MCO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

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

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

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

3.9.8 **Compliance with State and Federal Laws**

3.9.8.1. General Requirements

3.9.8.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.9.8 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement.

3.9.8.1.2 The MCO 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)]

3.9.8.1.3 The MCO shall comply, at a minimum, with the following:

3.9.8.1.3.1. 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;

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3.9.8.1.3.2.	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);
3.9.8.1.3.3.	CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397aa; Regulations promulgated thereunder: 42 CFR 457;
3.9.8.1.3.4.	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;
3.9.8.1.3.5.	State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;
3.9.8.1.3.6.	State administrative rules and laws pertaining to confidentiality;
3.9.8.1.3.7.	American Recovery and Reinvestment Act;
3.9.8.1.3.8.	Title VI of the Civil Rights Act of 1964;
3.9.8.1.3.9.	The Age Discrimination Act of 1975;
3.9.8.1.3.10.	The Rehabilitation Act of 1973;
3.9.8.1.3.11.	Title IX of the Education Amendments of 1972 (regarding education programs and activities);
3.9.8.1.3.12.	The ADA;

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3.9.8.1.3.13. 42 CFR Part 2; and

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

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

3.9.8.1.5 The MCO shall comply with all aspects of the Department Sentinel Event Reporting and Review Policy PO.1003, and any subsequent versions and/or amendments;

3.9.8.1.6 The MCO shall cooperate with review of any reported sentinel event, and provide any additional reporting information requested by the Department, and participate in a Department sentinel event review, if requested;

3.9.8.1.7 The MCO 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 MCO's responsibility to notify the appropriate authority if the MCO suspects a crime has occurred;

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

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

3.9.9 Non-Discrimination

3.9.9.1. The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.9.8 (Compliance with State and Federal Laws) 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)]

3.9.10 Reporting Discrimination Grievances

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3.9.10.1. The MCO 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 MCO.

3.9.10.2. 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).

3.9.11 Americans with Disabilities Act

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

3.9.11.2. 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.

3.9.11.3. 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.

3.9.11.4. 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.

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

3.9.11.6. The MCO 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 MCO and shall be available for inspection by the Department.

3.9.11.7. [Amendment #1:] The MCO shall, in accordance with Exhibit ~~G~~D (Federal Requirements ~~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 3.9.11 (Americans with Disabilities Act) of the Agreement, and that it

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has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.9.11.8. The MCO 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 MCO to be in compliance with the ADA.

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

3.9.12 **Non-Discrimination in Employment**

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

3.9.12.2. The MCO 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.

3.9.12.3. 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.

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

3.9.12.5. The MCO shall, in all solicitations or advertisements for employees placed by or on behalf of the MCO, 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.

3.9.12.6. The MCO 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 MCO's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.9.12.7. The MCO 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.

3.9.12.8. The MCO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and

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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.

3.9.12.9. The MCO shall include the provisions described in this Section 3.9.12 (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.

3.9.12.10. The MCO 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 MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.9.13 Non-Compliance

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

3.9.14 Changes in Law

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

3.10 Subcontractors

3.10.1 MCO Obligations

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

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

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3.10.1.3. 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.

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

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

3.10.2 **Contracts with Subcontractors**

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

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

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

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

3.10.2.1.4 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);

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

3.10.2.1.6 In accordance with Prohibited Relationship provisions in Section 3.9.5.

3.10.2.1.7 Requirements for the Subcontractor

3.10.2.1.7.1. Provided that the Department makes timely payments to the MCO 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 MCO;

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3.10.2.1.7.2. 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.

3.10.2.1.8 Requirements that provide that:

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

3.10.2.1.8.2. 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)]

3.10.2.1.8.3. The MCO, the Department, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit 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)]

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

3.10.2.1.8.5. Require Subcontractor to submit ownership and controlling interest information as required by Section 3.9.3 (Ownership and Control Disclosures);

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

3.10.2.1.8.6.1 A person who has an ownership or control interest in the

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Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)];

3.10.2.1.8.6.2 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)];

3.10.2.1.8.6.3 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

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	day-to-day operation of, the Subcontractor or Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)];
3.10.2.1.8.6.4	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 MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved

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waiver program;

3.10.2.1.8.6.5 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;

3.10.2.1.8.6.6 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;

3.10.2.1.8.6.7 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 MCO or the Department;

3.10.2.1.8.6.8 Subcontractor's agreement to comply with the ADA, as required by Section 3.9.11 (Americans with Disabilities Act) above;

3.10.2.1.8.6.9 Include provisions of this Section 3.10.2 (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.

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11246 of September 24, 1965;

3.10.2.1.8.6.10 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as 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;

3.10.2.1.8.6.11 Require any Subcontracto

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r 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

3.10.2.1.8.6.12 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]

3.10.2.2. The MCO 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.

3.10.2.3. If any of the MCO's activities or obligations under this Agreement are delegated to a Subcontractor:

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

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3.10.2.3.2 The contract or written arrangement between the MCO 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 MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i)-(iii); 42 CFR 438.3(k)]

3.10.2.4. [Amendment #3:] Any Subcontractor performing utilization review must comply with the licensure or certification requirements set forth in this Agreement. ~~Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire~~.

3.10.3 **Subcontractor Agreement Notification**

3.10.3.1. The MCO shall submit all Subcontractor agreements and Subcontractor Provider agreements to the Department for review at least sixty (60) calendar days prior to the agreement's anticipated implementation date, or change in scope or terms, of the Subcontractor agreement.

3.10.3.2. The MCO remains responsible for ensuring that all Agreement requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.10.3.3. The MCO 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.

3.10.3.4. Review and authorization by the Department of a Subcontractor agreement does not relieve the MCO from any obligation or responsibility regarding the Subcontractor or its Subcontractor oversight, and does not imply any obligation by the Department regarding the Subcontractor or Subcontractor agreement.

3.10.3.5. The Department may grant a written exception to the notice requirements of this Section 3.10.3 (Subcontractor Agreement Notification) if, in the Department's reasonable determination, the MCO has shown good cause for a shorter notice period.

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

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

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

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

3.10.4 **MCO Oversight of Subcontractors**

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

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

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

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

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

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

3.10.4.4. If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the MCO shall notify the Department within seven (7) calendar days and require the Subcontractor to develop a CAP. The MCO 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]

3.11 **Staffing**

3.11.1 **Key Personnel**

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

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

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

3.11.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures.

3.11.1.1.3.1. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the Department's Medical Director.

3.11.1.1.3.2. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).

3.11.1.1.3.3. The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

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

3.11.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with the Department and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.11.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement.

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3.11.1.1.5.1. The Compliance Officer shall report directly to the NH-based CEO or the executive director thereof.

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

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

3.11.1.1.7.1. The Provider Relations Manager shall have prior experience with individual physicians, Provider groups and facilities.

3.11.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities.

3.11.1.1.8.1. The Member Services Manager shall have prior experience with Medicaid populations.

3.11.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities.

3.11.1.1.9.1. [Amendment #3:] The UM Director shall be under the direct supervision of the Medical Director. and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

3.11.1.1.9.2. [Amendment #3:] As soon as possible, but no later than January 1, 2026, the MCO shall ensure any person, including Subcontractors, performing medical necessity determinations must hold an active professional license issued by the applicable board or committee of the New Hampshire Office of Professional Licensure and

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Certification for such person's applicable scope of practice. ~~The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.~~

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

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

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

3.11.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and shall have a minimum of five (5) years pharmacy experience as a practicing pharmacist.

3.11.1.1.13.1. The Pharmacy Manager shall be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.12.24 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

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3.11.1.1.14 Substance Use Disorder Physician: Individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine and participate under the terms of this Agreement.

3.11.1.1.14.1. The SUD Physician's responsibilities shall include, but are not limited to:

3.11.1.1.14.1.1 In-person and in-state presence for greater than .50 FTE to meet with SUD Providers and PCPs to help expand SUD services. Discussion subjects shall include, but are not limited to, appropriate prescribing of medications for the treatment of opioid use disorder (MOUD);

3.11.1.1.14.1.2 In person and in-state to educate SUD Providers regarding appropriate treatment plans, and documentation, and billing practices;

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3.11.1.1.14.1.3 Responsibility for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for Members who visit an ED or are hospitalized for an overdose;

3.11.1.1.14.1.4 Active meeting participation, and at least yearly, meetings with organizations that support persons with a substance use disorder, including OTPs,

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hospitals, harm reduction organizations, The Doorway program sites, CMHCs, sober living homes, and other non-profit and for-profit organizations assisting persons with substance use disorder; and

3.11.1.1.14.1.5 Provide consultative support for the MCM program on a routine basis, including but not limited to, clinical policy related to Substance Use Disorders and individual Member cases, as needed.

3.11.1.2. MCO coordinators, also considered key personnel, shall be responsible for overseeing Care Coordination and Care Management activities, and also serve as liaisons to Department staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis unless otherwise specified:

3.11.1.2.1 Special Needs Coordinator at the Department's option: Individual shall have a minimum of a Master's Degree from a recognized college or university with

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major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.1.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

3.11.1.2.1.2. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.11.1.2.1.3. The Developmental Disability and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.1.3.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the Special Needs and Developmental Disabilities Coordinator positions may be either consolidated or established as individual

part-time positions.

3.11.1.2.2 [Amendment #1:] Developmental Disability Coordinator at the Department's option: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.2.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

3.11.1.2.2.2. The Developmental Disability Coordinator shall be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.11.1.2.2.3. The Developmental Disability and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.2.3.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the

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Developmental Disabilities and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability.

3.11.1.2.3.1. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.3.2. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services.

3.11.1.2.3.3. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and

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interpretation of clinical policies and procedures; and Health-related social needs Health-related social needs and community-based resources.

3.11.1.2.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues.

3.11.1.2.4.1. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder.

3.11.1.2.4.2. The individual shall have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders.

3.11.1.2.4.3. The individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases.

3.11.1.2.4.4. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management;

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Provider relations; and Health-related social needs health-related social needs and community-based resources.

3.11.1.2.5 Long Term Care Coordinator at the Department's option: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs.

3.11.1.2.5.1. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

3.11.1.2.5.2. [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the Long Term Care Coordinator position is not required.

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

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

3.11.1.2.8 Transportation Coordinator: Individual shall oversee the delivery of NEMT services to Members to ensure that there is a single point of oversight and accountability for all transportation and NEMT services.

3.11.1.2.8.1. The Transportation Coordinator shall be the primary individual responsible for ensuring the MCO's NEMT program is

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operating effectively, and shall be expected to proactively identify and propose operational improvements.

3.11.1.2.8.1.1 The Transportation Coordinator shall be the primary individual responsible for identifying, securing, and maintaining transportation for Members, including but not limited to overseeing the MCO's NEMT Subcontractor and shall have the authority to take any action warranted to resolve an NEMT issue.

3.11.1.2.8.2. The Transportation Coordinator is responsible for ensuring the integration of transportation services into Member Care Plans.

3.11.1.2.8.3. The Transportation Coordinator shall ensure that the NEMT Subcontractor meets all NEMT requirements, including requirements as described in Section 4.1.9 (Non-Emergency Medical Transportation (NEMT)) and Exhibit O: Quality and

Oversight Reporting Requirements of this Agreement as well as all other requirements in guidance provided by the Department.

3.11.1.2.8.4. The Transportation Coordinator shall be responsible for providing resolution to issues requiring immediate attention, including:

3.11.1.2.8.4.1 Resolution of complaints made by Members and transportation Providers.

3.11.1.2.8.4.2 Service delivery failures, including real-time assistance with rescheduling service appointments and/or transportation

3.11.1.2.8.5. The Transportation Coordinator shall have a minimum of four (4) years' experience relevant to the oversight of transportation services for vulnerable populations.

3.11.1.2.9 Housing Coordinator at the Department's option: The individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options. The Housing Coordinator shall:

3.11.1.2.9.1. Act as the MCO's central housing expert/resource,

providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues.

3.11.1.2.9.2. Be a dedicated staff person whose primary responsibility is housing-related work.

3.11.1.2.9.3. Be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

3.11.1.2.9.4. At as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building.

3.11.1.2.9.5. Have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing.

3.11.1.2.9.6. [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~, the Housing Coordinator position is not required. ~~Be familiar with the relevant public and private housing resources and stakeholders.~~

3.11.1.2.10 Prior Authorization Coordinator: Individual shall be responsible for all MCO Utilization Management activities and shall work under the direct supervision of the Medical Director.

3.11.1.2.10.1. [Amendment #3:] The Prior Authorization Coordinator shall ensure that all staff performing prior authorization functions meet requirements for Section 3.11.1.1.9.2 and ~~have the necessary clinical backgrounds~~

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needed to apply established coverage criteria to and make appropriate decisions based on Mmedical Necessity. necessary.

3.11.1.2.10.2. The individual shall be licensed by the NH Board of Nursing and have a minimum of eight (8) years of demonstrated experience in both the provision of direct clinical services as well as progressively increasing levels of management responsibilities with a particular focus on performance of a variety of utilization functions including conducting inter-rater reliability quality audits.

3.11.1.2.11 Third Party Liability (TPL) Coordinator: Individual shall be responsible for ensuring the MCO and its subcontractors are performing all required TPL functions when processing claims, that MCOs are properly identifying and recovering on claims not cost avoided, that the MCO has a system in place to manage subrogation cases and comply with contract requirements, and act as liaison between the Department's TPL unit and the MCO. This person shall have claims experience and a financial background.

3.11.2 **Other MCO Required Staff**

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

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

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

3.11.2.2. Behavioral Health Staff: The MCO shall designate one (1) or more staff who have behavioral health specific managed care experience to provide assistance to Members who are homeless and oversee:

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3.11.2.2.1 Behavioral health Care Management;

3.11.2.2.2 Behavioral health Utilization Management;

3.11.2.2.3 Behavioral health network development; and

3.11.2.2.4 The behavioral health Subcontract, as applicable.

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

3.11.3 **On-Site Presence**

3.11.3.1. The MCO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this section of the Agreement means that the MCO's full-time equivalent (1.0 FTE) personnel for each position identified below regularly reports to work in the State of New Hampshire unless otherwise specified:

3.11.3.1.1 CEO/Executive Director;

3.11.3.1.2 Medical Director;

3.11.3.1.3 Network Management Director;

3.11.3.1.4 Provider Relations Manager;

3.11.3.1.5 Pharmacy Manager;

3.11.3.1.6 Substance Use Disorder Physician;

3.11.3.1.7 Special Needs Coordinator (at Department's option);

3.11.3.1.8 Mental Health Coordinator;

3.11.3.1.9 Substance Use Disorder Coordinator

3.11.3.1.10 Developmental Disabilities Coordinator (at Department's option);

3.11.3.1.11 Long Term Care Coordinator (at Department's option);

3.11.3.1.12 Transportation Coordinator;

3.11.3.1.13 Housing Coordinator (at Department's option);

3.11.3.1.14 Grievance Coordinator; and

3.11.3.1.15 Fraud, Waste, and Abuse Coordinator

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

3.11.3.3. The MCO 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.

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

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

3.11.4 **General Staffing Provisions**

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

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

3.11.4.3. 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.

3.11.4.4. 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.

3.11.4.5. The MCO 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.

3.11.4.6. The MCO 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.

3.11.4.7. If a member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform 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.

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

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

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

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3.11.4.8.3 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 MCO shall provide and be responsible for the cost of managed care 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, and as required by newly enacted state and federal laws, rules and regulations including expanded eligibility coverage for the postpartum period, effective October 1, 2023 (RSA 167:68); lawfully residing pregnant women and children, effective January 1, 2024 (RSA 126-A:4-i); and 12 months of continuous eligibility for children, effective January 1, 2024 (section 5112 of the Consolidated Appropriations Act of 2023).

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

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Incarcerated individuals in the State's prison system eligible for participation in the Department's Community Reentry demonstration waiver	X	
Medicaid Children Funded through the Children's Health Insurance Program	X	
Medicaid for Employed Adults with Disabilities Non-Dual	X	
Medicaid for Employed Older Adults with Disabilities	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

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4.1.2.1. The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.12 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management).

4.1.2.2. The MCO 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 MCO shall cover services consistent with 45 CFR 92.207(b).

4.1.2.3. While the MCO 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 MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. The Department reserves the right to alter this list at any time by providing reasonable notice to the MCO. [42 CFR 438.210(a)(1)-(3), (4)(i), (5) (i)-(ii)(A)-(C) and (b).

4.1.2.4. Summary of Covered Services

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
[Amendment #2:] Certified Community Behavioral Health Clinic (CCBHC) Services[3]	X	
Certified Non-Nurse Midwife	X	

[3] [Amendment #2:] Effective January 1, 2025, ARPA compliant mobile crisis services provided by CCBHCs are carved out of the MCM Program. For additional information, refer to https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/nh-ccbhc-demonstration-application-v2.pdf.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT		X
[Amendment #1:] Community Mental Health Services[4]	X	
[Amendment #2:] Community Reentry Services[5]	X	
Crisis Intervention–Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services[6]		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage[7]	X	
Family Planning Services	X	
Freestanding Birth Centers	X	
Furnished Medical Supplies & Durable Medical Equipment	X	
Glencliff Home		X

[4] [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

[5] [Amendment #2:] Effective for dates of service January 1, 2025 through June 30, 2029, in accordance with 1115 Medicaid Demonstration authority for Community Reentry (CRE), the State's "Reentry Demonstration Initiative" approved by CMS on July 16, 2024, as part of the extension for the New Hampshire's Substance Use Disorder Serious Mental Illness (SMI) and Serious Emotional Disturbance (SUD) Treatment Recovery and Access Section 1115 Demonstration Waiver, as specified in separate guidance. Demonstration information is available at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-images/nh-sud-treatment-recovery-access-ext-appvl-06162024_0.pdf.

[6] Certain preventive, restorative, denture and other oral health services are carved-out of the MCM program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages are Covered Services under the MCM program.

[7] [Amendment #2:] Inclusion of anesthesia medical benefit services ancillary to pediatric oral health services covered under Medicaid fee-for-service.

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Home Based Therapy–Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	
Hospice	X	
Home and Community-Based In Home Support Services		X
[Amendment #2:] Incarcerated Youth Services[8]	X	
Inpatient Hospital[5a]	X	
Inpatient Hospital Swing Beds, Intermediate Care		X
Inpatient Hospital Swing Beds, Skilled Nursing		X
Inpatient Psychiatric Facility Services Under Age Twenty-One (21)[9]	X	
[Amendment #3:] Inpatient Psychiatric Treatment in State-owned New Hampshire Hospital ~~and Hampstead Hospital,~~ and Other State Determined IMD for Mental Illness[10]	X	
Intensive Home and Community-Based Services–Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities (e.g., Cedarcrest)		X

[8] [Amendment #2:] Effective January 1, 2025, in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) as specified in separate guidance. [SHO #24-004]
As described under "Mandatory Requirements of Section 5121 of the CAA," and detailed in SMDL 21-002, section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old). As mentioned above, the term "eligible juveniles" is not used in the amendments to the CHIP statute effectuated by section 5121 of the CAA, 2023. However, under the section 5121 amendments to section 2102(d) of the Act, the same eligibility policies that apply to "eligible juveniles" in Medicaid also apply to targeted low-income children in CHIP.

[9] Under age 22 if individual admitted prior to age 21.

[10] [Amendment #3:] Medicaid managed care inpatient psychiatric treatment at State-owned New Hampshire Hospital ~~and Hampstead Hospital.~~ and other State determined IMD for mental illness are covered up to sixty (60) days for adults age 21-64 due to a primary diagnosis of mental illness.

[5a] Including coverage for inpatient long-term acute care services in a long-term care hospital.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X
Medical Services Clinic (e.g., Opioid Treatment Program)	X	
Mental health services (e.g., psychology, psychotherapy, psychological and neurological testing)	X	
[Amendment #2:] [Amendment #1:] Mobile Crisis Services	X[11]	X
Non-Emergency Medical Transportation[12]	X	
Occupational Therapy[13]	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital[14]	X	
[Amendment #4:] Psychiatric ~~Pediatric~~ Residential Treatment Facility Services		X
Personal Care Services	X	
Physical Therapy[15]	X	
Physicians Services	X	
Placement Services–Division for Children, Youth & Families		X
Podiatrist Services	X	

[11] [Amendment #2:] Effective January 1, 2025, non-ARPA compliant mobile crisis services are a MCO CCBHC Covered Service only when provided by a State certified CCBHC.
[12] Also includes mileage reimbursement for Medically Necessary travel.
[13] Services are limited to twenty (20) visits per benefit year for each type of therapy including combined habilitation services and outpatient rehabilitation services.
[14] Including facility and ancillary services for dental procedures.
[15] Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Prescribed Drugs	X	
Preventative Services (e.g., nicotine cessation, SBIRT, transitional care management, chronic care management)[16]	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children–Division for Children, Youth & Families		X
Psychology	X	
Qualified Residential Treatment Program Services		X
Rehabilitative Services Post Hospital Discharge	X	
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy[17]	X	
Substance Use Disorder Services (Per He-W 513), including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

[16] See Law of the State of New Hampshire 2023, Chapter79:203 (HB2) (authorizing preventative services which may include, but is not necessarily limited to those listed).
[17]Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

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

4.1.3.2. The MCO 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 MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS.

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

4.1.3.4.1 Covered services shall be consistent with State laws and regulations in effect.

4.1.3.5. In Lieu of Services

4.1.3.5.1 The MCO may provide Members with services or settings that are "In Lieu of" Services or settings with prior approval and in accordance with federal regulations.

4.1.3.5.2 The MCO may cover In Lieu of Services if:

4.1.3.5.2.1. The alternative service or setting is a medically appropriate and cost-effective substitute;

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

4.1.3.5.2.3. The In Lieu of Service has been authorized by the Department and/or CMS, as appropriate; and

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

4.1.3.5.3 For the MCO to obtain approval for In Lieu of Services not previously authorized by the Department, the MCO shall submit an In Lieu of Service request to the Department for each proposed In Lieu of Service not yet authorized.

4.1.3.5.4 [Amendment #1:] The Department has authorized medical nutrition, partial hospitalization for eating

disorders, alternative therapies for pain management, partial hospitalization for youth with behavioral health diagnoses, critical time intervention (CTI) services, and diabetes self-management, ~~and assistance in finding and keeping housing (not including rent),~~ as In Lieu of Services (subject to CMS approval, as appropriate). This list may be expanded upon or otherwise modified by the Department and with CMS approval, as appropriate, and incorporated into this Agreement.

4.1.3.5.5 The MCO shall monitor the cost-effectiveness of each approved In Lieu of Service in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.3.5.6 [Amendment #1:] The MCO shall utilize a consistent process to ensure that a Provider (either the MCO's clinical staff or network Provider) using their professional judgment determines and documents that the ~~ILOS~~ In Lieu of Service is medically appropriate for the specific enrollee, based on any defined target population eligible for the ~~ILOS~~ In Lieu of Service. The documentation may be included, for example, in a Member's Care Plan or medical record.

4.1.3.6. Telemedicine

4.1.3.6.1 The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Members in certain circumstances.

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

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

4.1.3.7. Non-Participating Indian Health Care Providers

4.1.3.7.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health Care Providers (IHCP)

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from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.7.2 The MCO 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)]

4.1.3.8. Moral and Religious Grounds

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

4.1.3.8.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO 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)]

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

4.1.3.9. [Amendment #2:] Community Reentry Services

4.1.3.9.1 [Amendment #2] For services effective January 1, 2025, MCO shall implement the incarcerated youth community re-entry benefit for Members in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328), CMS guidance, and Department guidance.

4.1.3.9.2 [Amendment #2:] Effective for dates of service January 1, 2025 through June 30, 2029, MCO shall implement the adult community re-entry benefit for Members in accordance with 1115 Medicaid Demonstration authority for Community Reentry

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(CRE), the State's "Reentry Demonstration Initiative" approved by CMS on July 16, 2024, as part of the extension for the New Hampshire's Substance Use Disorder (SUD), Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Treatment Recovery and Access Section 1115 Demonstration Waiver, Department guidance, and applicable CMS guidance.

4.1.3.9.3 [Amendment #2:] Effective for dates of service beginning on or after January 1, 2025, for Members eligible for both the (i) adult community re-entry benefit in accordance with 1115 Medicaid Demonstration authority for Community Reentry (CRE), and (ii) incarcerated youth community re-entry benefit in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328), the MCO shall integrate and make available both adult and youth CRE program Covered Services to such Members.

4.1.4 **Cost Sharing**

4.1.4.1. 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.

4.1.4.2. With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) 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:

4.1.4.2.1 [Amendment #4:] A Copayment of four dollars ($4.00) ~~one dollar ($1.00)~~ shall be required for each preferred prescription drug and each refill of a preferred prescription drug; and

4.1.4.2.2 [Amendment #4:] A Copayment of four dollars ($4.00) ~~two dollars ($2.00)~~ shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug~~, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug shall be one dollar ($1.00)~~;

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4.1.4.2.3 [Amendment #4:] Intentionally left blank. ~~A Copayment of one dollar ($1.00) shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and~~

4.1.4.2.4 [Amendment #4:] [Amendment #3:] ~~Intentionally left blank. A Copayment of one dollar ($1.00) for each preferred prescription drug to two dollars ($2.00) for each non-preferred prescription drug or such other amount(s) as required by state law or the applicable New Hampshire State Plan Amendment.~~

4.1.4.3. The following services are exempt from cost-sharing:

4.1.4.3.1 Emergency services,

4.1.4.3.2 Family planning services,

4.1.4.3.3 Preventive services provided to children,

4.1.4.3.4 Pregnancy-related services,

4.1.4.3.5 Services resulting from potentially preventable events, and,

4.1.4.3.6 Cloraril (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.3.7 [Amendment #4:] Recommended medications, services, and items graded A or B by the U.S. Preventive Services Task Force, including nicotine cessation products and oral and injectable formulations of Pre-Exposure Prophylaxis (PrEP) for persons who are at high risk of HIV acquisition.

4.1.4.4. Members are exempt from Copayments when:

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

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

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

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

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

4.1.4.4.6 [Amendment #4:] The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within twelve (12)

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months ~~sixty (60) calendar days~~ after the month the pregnancy ended;

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

4.1.4.4.6.2. The Member is receiving hospice care; or

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

4.1.4.5. 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]

4.1.5 **Emergency Services**

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

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

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

4.1.5.4. The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the 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]

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

4.1.5.6. The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A-B)].

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

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4.1.5.8. The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or 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)]

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

4.1.5.10. 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)]

4.1.6 **Post-Stabilization Services**

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

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

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

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

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

4.1.6.1.3.2. The MCO cannot be contacted; or

4.1.6.1.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is not available for consultation. In this situation, the MCO shall give the treating

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physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

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

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

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

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

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

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

4.1.7 **Value-Added Services**

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

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

4.1.8 **Early and Periodic Screening, Diagnostic, and Treatment**

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

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4.1.8.2. The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

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

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

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

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

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

4.1.8.5. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria.

4.1.8.6. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

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

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

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

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

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

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

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

4.1.8.11.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.11.4 Comprehensive, unclothed physical examination;

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

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

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

4.1.8.12.1 The benefits of preventive health care;

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

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

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

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4.1.8.13. The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis.

4.1.8.13.1 The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.14. The MCO shall submit its EPSDT plan for the Department's review and approval as part of its Readiness Review and in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.9 **Non-Emergency Medical Transportation (NEMT)**

4.1.9.1. The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO.

4.1.9.1.1 The MCO shall deem NEMT Medically Necessary for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

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

4.1.9.3. The MCO shall ensure that each vehicle providing NEMT Covered Services meets the following requirements:

4.1.9.3.1 Has a valid vehicle registration;

4.1.9.3.2 [Amendment #4:] Has undergone a satisfactory safety inspection in accordance with the mutually agreed comprehensive safety checklist at the time of transportation provider enrollment into the Subcontractor's network, at least annually thereafter, and when a safety issue is reported for the transportation provider vehicle ~~laws of the state of New Hampshire~~; and

4.1.9.3.3 Has no apparent need for maintenance that affects safety including, but not limited to, visible holes in the body of the vehicle, defective brakes, worn or underinflated tires, leaking fluids, or illuminated check engine light.

4.1.9.4. The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family

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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:

4.1.9.4.1 Does not have a valid driver's license;

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

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

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

4.1.9.5. The Family and Friends mileage reimbursement rate shall be 62.5 cents per mile. The MCO shall create incentive programs to encourage the utilization of the Family and Friends Program with a target of fifty percent (50%) utilization.

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

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

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

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

4.1.9.7. Exceptions the above public transportation requirement are:

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

4.1.9.7.2 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

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

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

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

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

4.1.9.7.3.4. Visually impaired;

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4.1.9.7.3.5. Developmentally delayed;

4.1.9.7.3.6. Significant and incapacitating degree of mental illness; or

4.1.9.7.3.7. Other exception by Provider approval only.

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

4.1.9.8.1 For NEMT driver services, excluding public transit drivers, the MCO shall ensure:

4.1.9.8.1.1. Background checks are performed for all NEMT drivers;

4.1.9.8.1.2. 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;

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

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

4.1.9.8.1.5. 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];

4.1.9.8.1.6. Each such individual driver consistently utilizes a Global Positioning System device (GPS) to document the date, time and location for each pick up and drop off to track on-time

performance and ensure that trips take place as scheduled;

4.1.9.8.1.7. All vehicles utilized in the delivery of NEMT services shall be compliant with all federal and state safety requirements during the provision of the NEMT ride; and

4.1.9.8.1.8. Once a ride has been confirmed for a Member, the ride shall be provided unless cancelled by the Member.

4.1.9.8.1.9. [Amendment #4:] Any vehicles used for the purpose of transporting individuals with disabilities must meet the requirements set forth in the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles. [49 CFR 38]

4.1.9.8.2 The Department may require the procurement of an independent evaluator to measure and report on how NEMT services are being provided.

4.1.9.8.3 The Department reserves the right to reject, suspend, or terminate any Transportation Provider and/or individual driver from participation in the NEMT Program.

4.1.9.8.4 The MCO shall submit a weekly issue log for NEMT services as specified in Exhibit O: Quality and Oversight Reporting Requirements, and guidance issued by the Department.

4.1.9.8.4.1. NEMT Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement. In addition the MCO shall submit data on one hundred (100%) percent of the outcomes of scheduled NEMT trips, including, but not limited to trips delivered on-time, delivered late, rescheduled, rescued,

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cancelled, to the Department through NEMT Encounter Data or other means and schedule specified by the Department.

4.1.9.8.5 The Transportation Coordinator shall ensure there are no disruptions to Covered Services due to NEMT issues which shall be subject to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.1.9.8.5.1. The MCO, 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 or shall otherwise be subject to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.1.9.9. The Department reserves the right to require the use of a single transportation Subcontractor.

4.1.9.9.1 The MCO shall subcontract with and provide remuneration to the single transportation Subcontractor designated by the Department for NEMT services. The Department has the sole discretion to establish the subcontract terms.

4.1.9.9.2 The MCO shall not make amendments to the single transportation contract without prior written approval from the Department.

4.1.9.10. Failure of the MCO to meet any of these requirements shall subject the MCO to liquidated damages as specified in Exhibit N: Liquidated Damages Matrix.

4.1.9.11. The MCO 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.

4.1.9.12. [Amendment #1:] The MCO shall perform monitoring and oversight activities of trips provided to Members, including Family and Friends Program reimbursement, to ensure transportation Providers and Members are in compliance with the requirements of the NEMT Medicaid State Plan, including all State and federal regulations.

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4.2 Pharmacy Management

4.2.1 General

4.2.1.1. The Department reserves the right to require the use of a single Pharmacy Benefits Manager (PBM) starting in Year 3 or Year 4 of this Agreement.

4.2.1.1.1 The MCO shall subcontract with and provide remuneration to the Single PBM designated by the Department for pharmacy claims payment and administrative services. The Department has the sole discretion to establish the subcontract terms.

4.2.1.1.2 The MCO shall not make amendments to the Single PBM subcontract without prior written approval from the Department.

4.2.2 MCO and DHHS Covered Prescription Drugs

4.2.2.1. The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which the Department provides coverage as defined in Section 1927(k)(2) of the Social Security Act [42 CFR 438.3(s)(1)]. The MCO shall not include drugs by manufacturers not participating in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) Medicaid rebate program on the MCO formulary without the Department's consent.

4.2.2.2. [Amendment #3:] The Department shall include a High-Cost Pharmacy Risk Pool (HCPRP) for purposes of risk mitigation as described in Section 6.3.4.1.1~~6.3.5.1.1~~ of this Agreement.

4.2.2.3. The MCO shall pay for all prescription drugs, including specialty and office administered drugs consistent with the MCO's formulary, pharmacy edits and Prior Authorization criteria reviewed and approved by the Department, and are consistent with the Department's Preferred Drug List (PDL) as described in Section 4.2.3 (MCO Formulary) below.

4.2.2.4. Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

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

4.2.2.6. The MCO shall ensure Members diagnosed with opioid use disorder, Substance Use Disorder, and behavioral health conditions treated at Community Mental Health Programs, FQHCs, FQHC look-alikes, and Doorway network facilities with integrated on-site pharmacies have immediate access to covered specialty drugs to treat related conditions.

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4.2.3 **MCO Formulary**

4.2.3.1. The Department shall establish the PDL and shall be the sole party responsible for negotiating rebates for drugs on the PDL.

4.2.3.1.1. [Amendment #4:] In addition to the MCO's PDL compliance obligations under this Agreement, the MCO shall achieve Department specified minimum adherence targets for specific Department identified drugs' initial adherence targets measured from January 1, 2026 through June 30, 2026. The Department may update adherence targets annually and shall be maintained by the MCO annually thereafter as described in separate guidance.

4.2.3.1.2. [Amendment #4:] The MCO shall provide quarterly reporting on MCO's adherence targets in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.2.3.1.3. [Amendment #4:] Failure to meet adherence to targets will subject the MCO to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.2.3.2. The MCO shall use the Department's PDL and shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs on the PDL.

4.2.3.3. The Department shall be responsible for invoicing any pharmaceutical manufacturers for federal rebates mandated under federal law and for PDL supplemental rebates negotiated by the Department.

4.2.3.4. The MCO shall develop a formulary that adheres to the Department's PDL for drug classes included in the PDL and is consistent with Section 4.2.2 (MCO and DHHS Covered Prescription Drugs). In the event that the Department makes changes to the PDL, the Department shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.3.5. Negative changes shall apply to new starts within thirty (30) calendar days of notice from the Department. The MCO shall have ninety (90) calendar days to notify Members and prescribers currently utilizing medications that are to be removed from the PDL if current utilization is to be transitioned to a preferred alternative.

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

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

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4.2.3.8. The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary shall be available to Members and Participating Providers electronically, in a machine-readable file and format, and shall, at minimum, contain information related to:

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

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

4.2.3.9. The MCO shall adhere to all relevant State and federal law, including without limitation, with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, laws of 2004, Senate Bill 383-FN, Section IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

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

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

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

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

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

4.2.3.9.6 An age-specific indication;

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

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

4.2.3.10. [Amendment #1:] Through September 30, 20243, the cost of COVID-19 at-home test kits, vaccines, and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

4.2.4 **Pharmacy Clinical Policies and Prior Authorizations**

4.2.4.1. The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and

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complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.8.1.6 (Prior Authorization).

4.2.4.1.1 The MCO's clinical pharmacy team shall periodically review drug Prior Authorization denials issued by any Subcontractor(s) to ensure the denial is appropriate. This does not include Prior Authorization requests denied because the authorization request is incomplete or does not contain enough information to determine Medical Necessity.

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

4.2.4.3. The MCO's pharmacy Prior Authorization criteria shall be no more restrictive than the Prior Authorization criteria of the Fee for Service (FFS) program's medically accepted indication(s) for a covered outpatient drug in accordance with 1927(k)(6).

4.2.4.4. The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.12.34.3 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.4.4.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship.

4.2.4.4.2 The MCO shall conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT.

4.2.4.4.3 The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, Vivitrol®, etc.).

4.2.4.5. The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the Department-approved modification effective date.

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4.2.4.6. Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the Department -approved modification effective date.

4.2.4.7. The MCO shall implement and operate a DUR program that shall be in compliance with Section 1927(g) of the Social Security Act, address Section 1004 provisions of the SUPPORT for Patient and Communities Act, and include:

4.2.4.7.1 Prospective DUR;

4.2.4.7.2 Retrospective DUR;

4.2.4.7.3 An educational program for Participating Providers, including prescribers and dispensers; and

4.2.4.7.4 DUR program features in accordance with Section 1004 provisions of the SUPPORT for Patient and Communities Act, including:

4.2.4.7.4.1. Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.2.4.7.4.2. Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.2.4.7.4.3. A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.2.4.7.4.4. A program to monitor and manage the appropriate use of antipsychotic medications by all

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children including foster children enrolled under the State Plan;

4.2.4.7.4.5. Fraud and abuse identification processes that identifies potential Fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies; and

4.2.4.7.4.6. Operate like the State's Fee-for-Service DUR program. [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)].

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

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

4.2.4.10. The MCO shall develop and/or participate in other State of New Hampshire pharmacy-related quality improvement initiatives, as required by the Department and in alignment with the MCO's QAPI, further described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.2.4.11. For the HEDIS Measure "Use of Opioids from Multiple Providers", the MCO shall achieve performance that is less than or equal to the average rate of New England HMO Medicaid health plans as reported by NCQA Quality Compass for the previous calendar year.

4.2.4.12. The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed by the Department, and complies with requirements included in Section 4.12.34.3 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from the Department, implement Lock-In Programs for other medical services.

4.2.4.13. Members shall not be required to change covered prescription drugs more than once per calendar year, with the following exceptions:

4.2.4.13.1 When a Member is new to Medicaid, or switches from one Medicaid MCO to another Medicaid MCO;

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4.2.4.13.2 When a covered prescription drug change is initiated by the Member's provider;

4.2.4.13.3 When a biosimilar becomes available to the market;

4.2.4.13.4 When FDA boxed warnings or new clinical guidelines are recognized by CMS;

4.2.4.13.5 When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and

4.2.4.13.6 When a covered prescription is not available due to a supply shortage.

4.2.5 **Pharmacy Systems, Data, and Reporting Requirements**

4.2.5.1. Systems Requirements

4.2.5.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to:

4.2.5.1.1.1. Systems maintenance,

4.2.5.1.1.2. Software upgrades, and

4.2.5.1.1.3. National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP).

4.2.5.1.2 Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.5.2. Pharmacy Data and Reporting Requirements

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

4.2.5.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, the Department shall be responsible for collecting OBRA 90 CMS rebates, inclusive of supplemental, from drug manufacturers on MCO pharmacy claims.

4.2.5.2.3 The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the

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Encounter Data file within fourteen (14) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement.

4.2.5.2.4 The drug utilization information reported to the Department shall, at a minimum, include information on:

4.2.5.2.4.1. The total number of units of each dosage form,

4.2.5.2.4.2. Strength, and

4.2.5.2.4.3. Package size by National Drug Code of each covered outpatient drug dispensed, per Department encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.5.2.5 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to the Department. [42 CFR 438.3(s)(3)]

4.2.5.2.6 The MCO shall implement a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program.

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

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

4.2.5.2.9 The MCO shall provide the Department reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.2.5.2.10 [Amendment #1:] The MCO shall provide to the Department a detailed plan describing the exchange of Member pharmacy and medical record information between the PCP, behavioral health Provider, and other appropriate parties for the purpose of medication management. This information shall be provided in a streamlined manner across the MCOs ~~prescribed by the Department~~ as permitted by State and federal law.

4.2.5.2.10.1. All Member medical records and other medication management information exchanged between parties shall be shared with the Member's PCP in an easily identifiable format.

4.2.5.2.10.2. The MCO shall retain oversight and accountability of the medication management program, including data exchanges between parties.

4.2.5.2.10.3. The MCO shall submit its medication management plan for the Department's review and authorization at time of readiness, and prior to implementation when changes to the MCO's medication management program are proposed.

4.2.5.2.10.4. [Amendment #1:] The MCO shall have all processes and systems in place for related information sharing of data between parties no later than December 1, 2024.

4.2.6 **Medication Management**

4.2.6.1. Medication Management for All Members

4.2.6.1.1 Polypharmacy criteria for Members are defined as follows:

4.2.6.1.1.1. Child Members dispensed four (4) or more maintenance drugs based on GPI 10 or an equivalent product identification code (such as HICL) over a rolling sixty (60) day period, each

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drug filled for at least ninety (90) days duration, allowing each drug up to one fifteen (15) day gap between fills;

4.2.6.1.1.2. Adult Members dispensed five (5) or more maintenance drugs based on Generic Product Identifier (GPI) 10 or an equivalent product identification code (such as HICL) over a rolling sixty (60) day period; and

4.2.6.1.1.3. Brand and equivalent generics (or similar relationship such as reference product and biosimilar) within same GPI or equivalent product identification code shall not be counted as separate drugs within the five (5) maintenance drugs.

4.2.6.2. The MCO shall support medication management for Members meeting Polypharmacy criteria, and for other Members requesting medication review to ensure the PCP, pharmacist, or other qualified health care individual pharmacist has the information necessary to conduct Polypharmacy and medication management for child/adolescent and adult Members.

4.2.6.3. Comprehensive Medication Review (CMR) is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. This systematic process shall be used for each CMR.

4.2.6.3.1 [Amendment #1:] The MCO is responsible to ensure that a Member receives at least one Comprehensive Medication Review (CMR) from the PCP, community pharmacist or other qualified individual within six (6) months from the date~~/quarter~~ in which the Member was identified as meeting Polypharmacy criteria and the MCO shall be responsible for providing medication history to the PCP, pharmacist or other qualified individual.

4.2.6.3.2 [Amendment #1:] The PCP, community pharmacist, or other qualified individual shall participate in Polypharmacy and medication management.

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4.2.6.3.3 [Amendment #1:] The PCP, community pharmacist or other qualified individual shall provide counseling with any Member or authorized representative upon request, as described in this section, and in Exhibit O: Quality Oversight Reporting Requirements.

4.2.6.3.4 [Amendment #1:] The MCO shall report to the Department on a quarterly basis the total number of CMRs completed, including total number of counselling interactions with any Member, the Member names, and Provider (PCP, community pharmacist, or other qualified health care provider) who performed the CMR and/or counselling interaction with the Member or authorized representative.

4.2.6.3.5 The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the Member, authorized representative, and the PCP, pharmacist and/or other qualified individual with the intent to improve a Member's knowledge of their prescriptions, over-the-counter medications, herbal therapies, and dietary supplements; identify, and address problems or concerns the patient may have; and empower them to self-manage their medications and health conditions. These items shall be addressed for each Member during each CMR counselling interaction.

4.2.6.3.6 [Amendment #1:] Intentionally left blank. ~~In the event a Member identified for Polypharmacy does not participate in such review offered by a PCP, pharmacist, or other qualified individual at least once annually, the MCO shall offer CMR and counseling at least monthly until the Member actively accepts or denies receipt of CMR services.~~

4.2.6.3.6.1. [Amendment #1:] Intentionally left blank. ~~When the Member does not engage with the PCP, pharmacist, or other qualified individual for the purpose of satisfying medication management requirements of this Agreement, the MCO may subcontract with an appropriately credentialed and licensed professional or entity to support such engagement with~~

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~~prior approval from the Department.~~

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

4.2.6.5. The MCO shall provide to the qualified individual conducting CMR contact information for at least five (5) in-network child/adolescent psychiatrists for the purpose of peer-to-peer consulting whenever a child/adolescent Member is identified for Polypharmacy and is prescribed behavioral health prescriptions.

4.2.6.6. The MCO shall monitor Members who meet criteria for Polypharmacy three (3), six (6), and twelve (12) months after the CMR is completed to see if the member continues to meet criteria for Polypharmacy, or if it has been resolved. The MCO shall report the number of members who continue to meet criteria for Polypharmacy, and the number of members who no longer meet criteria on a quarterly basis.

4.2.7 **Medication Management for Children with Special Health Care Needs**

4.2.7.1. [Amendment #1:] The MCO shall be responsible to ensure~~for~~ active and comprehensive medication management for Children with Special Health Care Needs. In the event the PCP, community pharmacist or other qualified individual has not completed a CMR, t~~T~~he MCO shall offer to Members, their parents, and/or caregivers, comprehensive medication management services for Children with Special Health Care Needs. If comprehensive medication management services are accepted by the Member or authorized representative, the MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that shall include, but not be limited to, the following:

4.2.7.1.1 Performing or obtaining necessary health assessments;

4.2.7.1.2 [Amendment #1:] Formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the Member, parent and/or caregiver with a special focus on safe prescribing of psychotropic medications;

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

4.2.7.1.4 Monitoring, which could include lab assessments and evaluating the Member's response to therapy;

4.2.7.1.5 Consulting with social service agencies on medication management services;

4.2.7.1.6 [Amendment #1:] Initial and on-going CMR to prevent medication-related problems and address drug

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reconciliation, including adverse drug events, followed by targeted medication reviews, including peer-to-peer when requested;

4.2.7.1.7 [Amendment #1:] Requesting medical records, dDocumenting and communicating information about care delivered byto other appropriate health care Providers;

4.2.7.1.8 [Amendment #1:] Member and/or authorized representative education to enhance understanding and appropriate use of medications; and

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

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

4.2.7.2.1 Pharmacy claims;

4.2.7.2.2 Provider progress reports;

4.2.7.2.3 Comprehensive Assessments and Care Plans;

4.2.7.2.4 Contact with the Member's Providers;

4.2.7.2.5 Current diagnoses;

4.2.7.2.6 Current behavioral health functioning;

4.2.7.2.7 [Amendment #1:] Information from the family, placement pProvider, the Department, and residential or other treatment entities or Providers; and

4.2.7.2.8 [Amendment #1:] For infants, children and youth who are involved in the State's protective services and juvenile justice system, and Division for Children Youth and Families (DCYF), including those in foster care who meet red flag criteria[18]: ~~Information shared with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship, to the extent permissible by State and federal law.~~

4.2.7.2.8.1. [Amendment #1:] Information shared with DCYF around oversight, monitoring and managing the use of

[18] [Amendment #1:] SafeRx: Psychotropic Medication Oversight, available on March 27,2023 at https://www.dhhs.nh.gov/programs-services/child-protection-juvenile-justice/foster-care-health-mental-health-programs-0

psychotropic medications, including activity that occurs after identifying the criteria, how to document the activity, and the action plan that will be initiated and monitored to the extent permissible by State and federal law.

4.2.7.2.8.2. [Amendment #1:] The MCO shall provide to DCYF a written behavioral health CMR for each child and youth meeting red flag criteria in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1. 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 MCM program. The MCO shall comply with eligibility decisions made by the Department.

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

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

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

4.3.1.5. The MCO 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)]

4.3.1.6. In accordance with separate guidance, the MCO shall outreach to Members forty-five (45) calendar days prior to each Member's Medicaid

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eligibility expiration date to assist the Member with completion and submission of required paperwork. The MCO shall submit their outbound call protocols for the Department's review during the Readiness Review process.

4.3.1.6.1 The MCO shall not conduct outreach to address the backlog of pending Medicaid eligibility cases to Members in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits. [CMS State Health Official Letter].

4.3.2 Enrollment

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

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

4.3.2.2.1 [Amendment #1:] The MCO shall accept temporarily auto re-enrolled Members into their managed care plan after the individual's loss of Medicaid coverage for a period of 120 days or less. The temporary auto re-enrollment mechanism shall remain effective until the later of December 31, 2024 or expiration of the State's 1902(e)(14) in accordance with CMS guidance. [Section 1902(e)(14) of the Act]

4.3.2.3. The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not

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select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member.

4.3.2.4. When assigning a PCP, the MCO shall include the following methodology in selecting a PCP for the Member, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.3 Non-Discrimination

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

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

4.3.3.3. The MCO 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)]

4.3.3.4. The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has a discriminatory effect. [42 CFR 438.3(d)(4)] [RSA 354-A]

4.3.4 Auto-Assignment

4.3.4.1. In its sole discretion, the Department shall use the following factors for auto-assignment in an order to be determined by the Department:

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

4.3.4.1.2 Previous MCO enrollment, when applicable;

4.3.4.1.3 Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438 54(d)(7);

4.3.4.1.4 Any members earned through the Performance-Based Auto-Assignment Program; and

4.3.4.1.5 Equitable distribution among the MCOs as determined appropriate solely by the Department.

4.3.4.2. The Performance-Based Auto-Assignment Program determined solely by the Department and communicated to the MCO in guidance issued by the Department, rewards one or more MCOs that demonstrate exceptional performance on one (1) or more key dimensions of performance determined at the Department's sole discretion.

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4.3.4.2.1 High-performing MCO(s) may be rewarded with preferential auto-assigned membership in accordance with separate guidance. Such an award would potentially precede any equitable distribution of Members who do not self-select an MCO across.

4.3.5 Disenrollment

4.3.5.1. Member Disenrollment Request

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

4.3.5.1.1.1. The Member moves out of state;

4.3.5.1.1.2. 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;

4.3.5.1.1.3. 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

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

4.3.5.1.2 For Member disenrollment requests "with cause" as described in in this section of the Agreement, the Member shall first seek redress through the MCO's grievance system.

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

4.3.5.1.3.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into

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the MCO or the date of the Department Member notice of the initial auto-assignment/enrollment, whichever is later;

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

4.3.5.1.3.3. Once every twelve (12) months;

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

4.3.5.1.3.5. 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

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

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

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4.3.5.1.5 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)]

4.3.5.1.6 The MCO 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.

4.3.5.1.7 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.

4.3.5.1.8 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)]

4.3.5.2. MCO Disenrollment Request

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

4.3.5.2.1.1. Member has established out of state residence;

4.3.5.2.1.2. Member death;

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

4.3.5.2.1.4. Fraudulent use of the Member identification card; or

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

4.3.5.2.2 The MCO shall not request disenrollment because of:

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

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4.3.5.2.2.2. The Member's utilization of medical services;

4.3.5.2.2.3. The Member's diminished mental capacity;

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

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

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

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

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

4.3.5.2.3.3. 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 MCO files the request.

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

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4.4 Member Services

4.4.1 Member Information

4.4.1.1. The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members.

4.4.2 PCP Information

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

4.4.3 Member Identification Card

4.4.3.1. The MCO shall issue a hardcopy identification card to all New Members 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.

4.4.3.2. 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:

4.4.3.2.1 The Member's name;

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

4.4.3.2.3 The name of the MCO;

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

4.4.3.2.5 The toll-free telephone number for transportation; and

4.4.3.2.6 How to file an appeal or grievance.

4.4.3.3. The MCO shall reissue a Member identification card if:

4.4.3.3.1 A Member reports a lost card;

4.4.3.3.2 A Member has a name change; or

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

4.4.3.4. [Amendment #2:] Effective July 1, 2026, the MCO shall assign and exclusively use unique Medicaid-specific Bank Identification Number (BIN) and Processor Control Number (PCN) combination, and group number identifiers for all Member identification cards for pharmacy benefits. [42 CFR 438.3(s)(7)]

4.4.4 Member Handbook

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

4.4.4.2. The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other Department initiatives. The MCO 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.

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

4.4.4.3.1 General information;

4.4.4.3.2 A table of contents;

4.4.4.3.3 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)];

4.4.4.3.4 The Department developed definitions, including but not limited to: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

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

4.4.4.3.6 A reminder to report to the Department any change of address, as Members may be liable for premium payments paid during period of ineligibility;

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

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4.4.4.3.8 Appointment procedures;

4.4.4.3.9 How to contact 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;

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

4.4.4.3.11 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;

4.4.4.3.12 The policies and procedures for disenrollment;

4.4.4.3.13 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];

4.4.4.3.14 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];

4.4.4.3.15 A description of utilization review policies and procedures used by the MCO;

4.4.4.3.16 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];

4.4.4.3.17 Information on how to report suspected Fraud or abuse [42 CFR 438.10(g)(2)(xiii-xvi)];

4.4.4.3.18 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];

4.4.4.3.19 Non-Participating Providers and cost-sharing on any benefits carved out and provided by the Department [42 CFR 438.10(g)(2)(i-ii)];

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

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

4.4.4.3.22 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.12.19. (Parity);

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

4.4.4.3.24 Benefits:

4.4.4.3.24.1. How and where to access any benefits provided, including Maternity services, Family Planning Services and NEMT services [42 CFR 438.10(g)(2)(i-ii), (vi-vii)];

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

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

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

4.4.4.3.24.5. 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)];

4.4.4.3.24.6. Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO shall inform Members that the

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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)];

4.4.4.3.24.7. A description of pharmacy policies and pharmacy programs; and

4.4.4.3.24.8. How emergency care is provided, including:

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

4.4.4.3.24.8.2 What constitutes an Emergency Service and an Emergency Medical Condition; The extent to which, and how, after hours and emergency coverage are provided;

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

4.4.4.3.24.8.4 The Member's

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

4.4.4.3.25 Service Limitations:

4.4.4.3.25.1. An explanation of any service limitations or exclusions from coverage;

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

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

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

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

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

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

4.4.4.3.26 Rights and Responsibilities:

4.4.4.3.26.1. Member rights and protections, outlined in Section 4.4.8 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i-vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)]

4.4.4.3.27 Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.4.3.27.1. The right to file grievances and appeals;

4.4.4.3.27.2. The requirements and timeframes for filing grievances or appeals;

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

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

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

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4.4.5 Member Handbook Dissemination

4.4.5.1. The MCO 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)]

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

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

4.4.5.3.1 Information contained in the Member Handbook;

4.4.5.3.2 Information on how to file grievances and appeals;

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

4.4.5.3.3.1. Names and any group affiliations;

4.4.5.3.3.2. Street addresses;

4.4.5.3.3.3. Office hours;

4.4.5.3.3.4. Telephone numbers;

4.4.5.3.3.5. Website (whenever web presence exists);

4.4.5.3.3.6. Specialty (if any),

4.4.5.3.3.7. Description of accommodations offered for people with disabilities;

4.4.5.3.3.8. The cultural and linguistic capabilities of Participating Providers, including languages

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(including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office;

4.4.5.3.3.9. Gender of the Provider;

4.4.5.3.3.10. Identification of Providers that are not accepting new Members; and

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

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

4.4.5.5. The MCO 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 MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. The MCO shall utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.6 Provider Directory

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

4.4.6.2. [Amendment #2:] The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers (including CCBHCs), FQHCs, RHCs):

4.4.6.2.1 Names and any group affiliations;

4.4.6.2.2 Street addresses;

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4.4.6.2.3 Office hours;

4.4.6.2.4 Telephone numbers;

4.4.6.2.5 Website (whenever web presence exists);

4.4.6.2.6 Specialty (if any),

4.4.6.2.7 Gender;

4.4.6.2.8 Description of accommodations offered for people with disabilities;

4.4.6.2.9 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;

4.4.6.2.10 Hospital affiliations (if applicable);

4.4.6.2.11 Board certification (if applicable);

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

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

4.4.6.3. The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from 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 MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request and free of charge.

4.4.6.4. The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2 (Practice Guidelines and Standards). [42 CFR 438.236(c)]

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

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

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

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

4.4.6.9. 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 MCO 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 MCO shall submit the final website Provider Directory.

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

4.4.7 Language and Format of Member Information

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

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

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

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

4.4.7.5. 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.

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

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

4.4.7.8. 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 Members, to explain the availability of written translation or oral interpretation, and include

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

4.4.7.9. 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 MCO 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)]

4.4.7.10. Written Member information shall include at a minimum:

4.4.7.10.1 Provider Directories;

4.4.7.10.2 Member Handbooks;

4.4.7.10.3 Appeal and grievance notices; and

4.4.7.10.4 Denial and termination notices.

4.4.7.11. The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that 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)]

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

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

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

4.4.8 Member Rights

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

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

4.4.8.1.2 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;

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

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

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

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

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

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

4.4.8.1.9 Request and receive a Second Opinion; and

4.4.8.1.10 Exercise these rights without the MCO or its Participating Providers treating the Member adversely. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)-(vi]); 42 CFR 438.100(c); 42 CFR 438.10(f)(3); 42 CFR 438.10(g)(2)(vi)-(vii); 42 CFR 438.10(g)(2)(ix); 42 CFR 438.3(i)]

4.4.9 Member Communication Supports

4.4.9.1. During the Readiness Review period, the MCO shall provide a blueprint of its website, including Member portal, for review by the Department.

4.4.9.2. [Amendment #1:] The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal.

4.4.10 Member Call Center

4.4.10.1. The MCO shall operate a toll-free Member Call Center Monday through Friday, and be operational on all days the Department Customer Service Center is open.

4.4.10.2. The MCO shall ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.4 (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:

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4.4.10.2.1 Two (2) days per week: eight (8:00) am Eastern Standard Time (EST) to five (5:00) pm EST;

4.4.10.2.2 Three (3) days per week: eight (8:00) am EST to eight (8:00) pm EST; and

4.4.10.2.3 During major program transitions, additional hours and capacity shall be accommodated by the MCO.

4.4.10.3. The Member Call Center shall meet the following minimum standards, which the Department reserves the right to modify at any time:

4.4.10.3.1 Call Abandonment Rate: Fewer than five percent (5%) of calls shall be abandoned;

4.4.10.3.2 Average Speed of Answer: Eighty-five percent (85%) of calls shall be answered with live voice within thirty (30) seconds; and

4.4.10.3.3 Voicemail or answering service messages shall be responded to no later than the next business day.

4.4.10.4. The MCO shall coordinate its Member Call Center with the Department Customer Service Center, and community-based and statewide crisis lines, and at a minimum, include the development of a warm transfer protocol for Members.

4.4.11 Welcome Call

4.4.11.1. The MCO shall make a welcome call or an interactive voice recognition (IVR) call to each new Member within ninety (90) calendar days of the Member's enrollment in the MCO, and include a means for the Member to request immediate live MCO representative support during the welcome call.

4.4.11.2. In accordance with applicable law, the MCO may communicate with Members by text, email, phone or other digital or electronic communications.

4.4.11.3. The welcome call shall, at a minimum:

4.4.11.3.1 Assist the Member in selecting a PCP or confirm selection of a PCP;

4.4.11.3.2 [Amendment #1:] ~~Arrange~~ Assist with scheduling ~~for~~ a Wellness Visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs)~~., which shall include:~~

4.4.11.3.2.1. [Amendment #1:] Initial screening ~~Assessments~~ of both physical and behavioral health, including identification of urgent health care needs;

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4.4.11.3.2.2. [Amendment #1:] Initial sScreening for depression, mood, suicidality, and Substance Use Disorder;

4.4.11.3.2.3. Support development of a Member's plan of care with the PCP;

4.4.11.3.2.4. Arrange for the completion of a HRA Screening in accordance with the terms of this Agreement and Section 4.10.2 (Health Risk Assessment (HRA) Screening).

4.4.11.3.2.5. [Amendment #1:] Initial sScreening for adverse health needs, special needs, physical and behavioral health, and services of the Member. The MCO shall share the results of screening findings with the Member's PCP to support the Member's plan of care with the Provider;

4.4.11.3.2.6. [Amendment #1:] Answer any ~~other~~ Member questions about the MCO;

4.4.11.3.2.7. Ensure Members can access information in their preferred language; and

4.4.11.3.2.8. Remind Members to report to the Department any change of address, as Members shall be liable for premium payments paid during period of ineligibility.

4.4.11.3.3 Regardless of the completion of the welcome call by the MCO, the PCP shall complete HRA Screenings as stipulated in Section 4.10.2 (Health Risk Assessment (HRA) Screening), and documented by a claim encounter.

4.4.12 Member Hotline

4.4.12.1. The MCO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays.

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4.4.12.2. 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.

4.4.12.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day.

4.4.12.4. The MCO may substitute a live answering service in place of an automated system.

4.4.13. Program Website

4.4.13.1. The MCO shall develop a website, in compliance with Section 7.7 (Website and Social Media) in this Agreement, to provide general information about the MCO's program, its Participating Provider network, its formulary, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance Process and Member Appeal Process.

4.4.13.2. The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit N (Liquidated Damages Matrix).

4.4.13.3. If the MCO chooses to provide required information electronically to Members, it shall:

4.4.13.3.1 Be in a format and location that is prominent and readily accessible;

4.4.13.3.2 Be provided in an electronic form which can be electronically retained and printed;

4.4.13.3.3 Be consistent with content and language requirements;

4.4.13.3.4 Notify the Member that the information is available in paper form without charge upon request; and

4.4.13.3.5 Provide, upon request, information in paper form within five (5) business days. [42 CFR 438.10(c)(6)(i-v)]

4.4.13.4. The MCO program content included on the website shall be:

4.4.13.4.1 Written in English and Spanish;

4.4.13.4.2 Culturally appropriate;

4.4.13.4.3 Appropriate to the reading literacy of the population served; and

4.4.13.4.4 Geared to the health needs of the enrolled MCO program population.

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4.4.13.5. The MCO's website shall be compliant with the federal DOJ "Accessibility of State and Local Government Websites to People with Disabilities."

4.4.13.6. [Amendment #4:] Beginning March 31, 2026 and annually thereafter, the MCO shall report prior authorization data from the prior calendar year in accordance with Exhibit O: Quality and Oversight Reporting Requirements, excluding any and all drugs covered by the MCO. In addition, the MCO shall make this data accessible by posting the information on its website. [42 CFR 210(f)]

4.4.14. Marketing

4.4.14.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The MCO shall submit all MCO Marketing material to the Department for approval before distribution.

4.4.14.2. 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 MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i-ii), 42 CFR 438.104(b)(1)(iv-v)]

4.4.14.3. The MCO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

4.4.14.4. The MCO Marketing Materials shall not contain false or materially misleading information. The MCO shall not offer other insurance products as inducement to enroll.

4.4.14.5. The MCO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or the Department. The MCO's Marketing Materials shall not contain any written or oral assertions or statements that:

4.4.14.5.1 The recipient shall enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

4.4.14.5.2 The MCO is endorsed by CMS, the State or federal government, or a similar entity. [42 CFR 438.104(b)(2)(i-ii)]

4.4.14.6. The MCO shall distribute Marketing Materials to the entire State. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO 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)]

4.4.15. Member Engagement Strategy

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4.4.15.1. The MCO shall develop and facilitate an active Member Advisory Board that is composed of Members who represent its Member population.

4.4.16 Member Advisory Board

4.4.16.1. Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program.

4.4.16.2. The Member Advisory Board shall meet at least four (4) times per year.

4.4.16.3. 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 MCO's QAPI program changes (as further described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.4.16.4. All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.17 Regional Member Meetings

4.4.17.1. The MCO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the MCO can ask questions and obtain feedback from Members.

4.4.17.2. Regional meetings shall be held at least twice each Agreement year in demographically different locations in New Hampshire. The MCO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the MCO shall use alternate technologies as available for all meetings.

4.4.18. Cultural and Accessibility Considerations

4.4.18.1. The MCO 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)]

4.4.18.2. The MCO shall ensure that Participating Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities. [42 CFR 438.206(c)(3)]

4.4.19 Cultural Competency Plan

4.4.19.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and linguistically competent manner to all Members, including those with LEP or a disability, using qualified staff, medical interpreters, and translators in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.4.19.2. The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity.

4.4.19.3. The MCO shall work with the Department Office of Health Equity to address cultural and linguistic considerations.

4.4.20 Communication Access

4.4.20.1. To ensure equitable access to benefits and services for all of the MCO's Members, the MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

4.4.20.2. The MCO shall develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking Members' needs for communication assistance for health encounters including preferred spoken language for all encounters, need for interpreter, and preferred language for written information.

4.4.20.3. The MCO 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.

4.4.20.4. The MCO shall ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. For any Member who requires interpretation or translation services, the MCO shall not::

4.4.20.4.1 Require a Member with LEP or a disability to provide their own interpreter or translator;

4.4.20.4.2 Rely on an adult accompanying a Member with LEP or a Member with a Disability to interpret or facilitate communication, except:

4.4.20.4.2.1. In an emergency involving an imminent threat to the safety or welfare of the Member or the public where the MCO has attempted to obtain a Qualified Interpreter for the Member with LEP or Qualified Interpreter for the Member with a Disability, as applicable, and no Qualified

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Interpreter for the Member with LEP or Qualified Interpreter for the Member with a Disability is immediately available. In such cases, the MCO shall continue to make good faith attempts at obtaining a Qualified Interpreter for the Member with a Disability or Qualified Interpreter for the Member with LEP, as applicable, to interpret or facilitate communication for the Member where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.20.4.2.2. Rely on a minor to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of a Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.20.4.2.3. Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.101(b)(2)]

4.4.20.5. The MCO shall ensure services provided by Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services, exclusive of inpatient services.

4.4.20.6. The MCO shall recognize that no one interpreter, language, or assistive 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) or assistance will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.4.20.7. Accordingly, the MCO shall provide the most appropriate interpretation or assistive service possible under the circumstances. In all cases, the MCO shall provide interpreter services of Qualified Bilingual/Multilingual Staff, Qualified

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Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators when deemed clinically necessary by the Provider of the encounter service.

4.4.20.8. The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, or Qualified Translators are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.20.8.1 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;

4.4.20.8.2 A sharply delineated image that is large enough to display the Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, or Qualified Translator's face and the participating Member's face regardless of the Member's body position;

4.4.20.8.3 A clear, audible transmission of voices; and

4.4.20.8.4 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)]

4.4.20.9. The MCO shall bear the cost of interpretive services and communication access including SSL, ASL, Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translator interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

4.4.20.10. The MCO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.4.20.11. If the Member declines free interpretation services offered by the MCO, the MCO 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.

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4.4.20.12. Interpreter services shall be offered by the MCO at every new contact. Every declination requires new documentation by the MCO of the offer and decline.

4.4.20.13. The MCO 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 MCO from discriminating on the basis of race, color, or national origin.

4.4.20.14. 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 MCO shall take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

4.4.20.15. Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The MCO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the MCO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.4.20.16. [Amendment #1:] Digital, video, and phone interpretation services must comply with Exhibit EK: Information Security Requirements and Exhibit KQ: ITTechnical Requirements Workbook.

4.5. **Member Grievances and Appeals**

4.5.1. General Requirements

4.5.1.1. The MCO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The MCO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, State law as applicable, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.5.1.2. The MCO 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.

4.5.1.3. The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a

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Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement.

4.5.1.4. In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

4.5.1.5. The MCO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The MCO shall:

4.5.1.5.1 Provide Members with all reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to, providing qualified or certified interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.5.1.5.2 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)];

4.5.1.5.3 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)];

4.5.1.5.4 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)];

4.5.1.5.5 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:

4.5.1.5.5.1. An appeal of a denial based on lack of medical necessity;

4.5.1.5.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

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4.5.1.5.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A-C); 42 CFR 438.228(a)]

4.5.1.5.6 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]

4.5.1.6. The MCO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

4.5.1.7. The MCO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contact or Subcontract. The information shall include, but is not limited to:

4.5.1.7.1 The Member's right to file grievances and appeals and requirements and timeframes for filing;

4.5.1.7.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.5.1.7.3 The availability of assistance with filing;

4.5.1.7.4 The toll-free numbers to file oral grievances and appeals;

4.5.1.7.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.5.1.7.6 The Provider's right to appeal the failure of the MCO to pay for or cover a service.

4.5.1.8. The MCO shall make available training to Providers in supporting and assisting Members in the Grievance System.

4.5.1.9. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)]

4.5.1.10. 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)]

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4.5.1.11. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.5.1.12. The MCO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The MCO shall regularly review appeals Confidential Data for process improvement which should include but not be limited to reviewing:

4.5.1.12.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

4.5.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.13. The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.1.14. [Amendment #4:] Beginning March 31, 2026, the MCO shall report for the prior calendar year publicly accessible prior authorization data on its plan website, excluding data on any and all drugs covered by the MCO. [42 CFR 438.210].

4.5.2. **Member Grievance Process**

4.5.2.1. The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2. The MCO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3. The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

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4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance 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 MCO 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)]

4.5.2.5. The MCO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.5.2.5.1 If the Member requests the extension; or

4.5.2.5.2 If the MCO 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)]

4.5.2.6. If the MCO extends the timeline for a grievance not at the request of the Member, the MCO shall:

4.5.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.5.2.6.2 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)]

4.5.2.7. If the Member requests disenrollment, then the MCO 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)]

4.5.2.8. The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3. **Member Appeal Process**

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4.5.3.1. The MCO shall develop, implement, and maintain an Member Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2. The MCO shall 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 MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3. The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4. The MCO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)]

4.5.3.5. [Amendment #4:] The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals ~~and confirm those inquires in writing, unless the Member or the authorized Provider requests expedited resolution~~. [42 CFR 438.406(b)(3)]

4.5.3.6. If the Department receives a request to appeal an action of the MCO, the Department shall forward relevant information to the MCO and the MCO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.8. The MCO 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 MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.9. The MCO shall provide the Member and/or the Member's representative an opportunity to receive the Member's case file, free of charge prior to and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b-c)]

4.5.3.10. [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO may offer peer-to-peer review support with a like clinician who is actively licensed by the New Hampshire Office of Professional Licensure and Certification, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

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4.5.3.11. The MCO shall resolve ninety-eight percent (98%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.5.3.12. 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.

4.5.3.13. Members who believe the MCO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.5.3.14. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.5.4. **Member Adverse Actions**

4.5.4.1. The MCO shall permit the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 Denial, in whole or in part, of payment for a service;

4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that the Department has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1) MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5. **Expedited Member Appeal**

4.5.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

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4.5.5.2. The MCO 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)]

4.5.5.3. The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.5.5.4. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. The MCO shall also make reasonable efforts to provide oral notice. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)]

4.5.5.5. 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.

4.5.5.6. If the MCO extends the timeframes not at the request of the Member, it shall:

4.5.5.6.1 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 MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.6.2 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;

4.5.5.6.3 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)]

4.5.5.7. The MCO shall meet the timeframes above for ninety-eight percent (98%) of requests for expedited appeals.

4.5.5.8. The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.9. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

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4.5.5.10. The Member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6. **Content of Member Appeal Notices**

4.5.6.1. The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.1.1 [Amendment #4:] Effective July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), in accordance with the timeframes established in 42 CFR 438.210(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.) as if such requirements applied directly to the MCO according to the decision timeframes in 42 CFR 438.210(d). [42 CFR 438.242(b)(8)]

4.5.6.2. The MCO shall utilize NCQA compliant Department model notices for all adverse actions and appeals. MCO 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:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b-c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request

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that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. [42 CFR 438.404(b)(6)]

4.5.6.3. The MCO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.5.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 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.

4.5.6.4. The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

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4.5.6.4.9 The transfer or discharge from a facility shall occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7. **Timing of Member Notices**

4.5.7.1. For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable Fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2. In accordance with 42 CFR 438.404(c)(2), the MCO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.5.7.3. [Amendment #4:] Beginning July 1, 2026, For standard service authorization decisions ~~denials or partial denials~~, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed seven (7) ~~fourteen (14)~~ calendar days following the date of receipt of 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 from the date of receipt of the request for service is permissible, if:

4.5.7.3.1 The Member, or the Provider, requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4. When the MCO extends the timeframe, the MCO 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 MCO 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)]

4.5.7.5. For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than

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seventy-two (72) hours after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7. The MCO 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)]

4.5.8. **Continuation of Member Benefits**

4.5.8.1. The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2. The intended effective date of the MCO's proposed action;

4.5.8.1.1.3. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.1.4. The services was ordered by an authorized Provider;

4.5.8.1.1.5. The authorization period has not expired;

4.5.8.1.1.6. The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

4.5.8.1.1.7. 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)]

4.5.8.2. If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

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4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1-3); 42 CFR 438.408(d)(2)]

4.5.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4. A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9. **Resolution of Member Appeals**

4.5.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it shall:

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4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2. [Amendment #4:] Under no circumstances may the MCO extend the appeal determination beyond forty-four (44) ~~forty-five (45)~~ calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.5.9.4. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.5.9.5. For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6. For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision

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upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.5.10. **State Fair Hearing for Member Appeals**

4.5.10.1. The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.5.10.2. The parties to the State fair hearing include the MCO as well as the Member and their representative or the representative of a deceased Member's estate.

4.5.10.3. The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.3.1 That Members shall exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with the Department; and

4.5.10.3.2 [Amendment #2:] That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the MCO's notice of the resolution of the appeal. [42 CFR 438.408(f)(2)]

4.5.10.4. If the Member requests a State fair hearing, the MCO shall provide to the Department and the Member, upon request, within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.5. 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:

4.5.10.5.1 The MCO adversely resolved the Member's appeal wholly or partially; or

4.5.10.5.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.6. If the Member requests an expedited State fair hearing, the MCO shall provide to the Department and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but

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not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.7. 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 MCO the case file and any other necessary information. [He-W 506.09(g)]

4.5.10.8. The MCO shall appear and defend its decision before the Department AAU. The MCO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to the Department for the duration of the appeal at no additional cost.

4.5.10.9. The Department AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11. **Effect of Adverse Decisions of Member Appeals and Hearings**

4.5.11.1. If the MCO 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 MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2. If the MCO or 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 MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12. **Survival of Member Appeals and Grievances**

4.5.12.1. The obligations of the MCO 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.

4.6. **Provider Appeals**

4.6.1. **General**

4.6.1.1. The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

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4.6.1.2. The MCO shall provide a complete written description of its Provider Appeals Process, including all policies and procedures, and notices and forms, for the Department's review and approval during the Readiness Review period.

4.6.1.3. Any proposed changes to the Provider Appeals Process shall be approved by the Department at least thirty (30) calendar days in advance of implementation.

4.6.1.4. The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference it in the Provider and Subcontractor agreements.

4.6.1.5. The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.6.1.5.2 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;

4.6.1.5.3 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

4.6.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

4.6.2. **Provider Adverse Actions**

4.6.2.1. [Amendment #1:] The Provider shall have the right to file an appeal with the MCO within sixty (60) calendar days of the date of the MCO's notice of adverse action to the Provider, and may utilize the Provider Appeals Process for any adverse action, ~~in accordance with RSA 126-A:5, VIII~~, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). ~~The Provider shall have the right to file an appeal within sixty (60) calendar days of the date of the MCO's notice of adverse action to the Provider.~~ Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when the Department, MFCU or other government agency has required the MCO to terminate such agreement;

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4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2. The MCO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.6.3. **Provider Appeal Process**

4.6.3.1. The MCO shall provide written notice, and electronic notice if available, 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.

4.6.3.2. Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within sixty (60) calendar days of:

4.6.3.2.1 The date of the MCO's written notice advising the Provider of the adverse action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3. The MCO shall be permitted to extend the decision deadline to issue the Resolution Notice by an additional sixty (60) calendar days to allow the Provider to submit additional evidence or supportive documentation, and for other good cause determined by the MCO.

4.6.3.4. The MCO shall ensure that all Provider Appeal Process decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider appeal.

4.6.3.5. [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO may offer peer-to-peer review support with a like clinician who is actively licensed by the New Hampshire Office of Professional Licensure and Certification, upon request, for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal Process or State fair hearing process.

4.6.3.6. The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

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4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7. If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Provider Appeal Process and may initiate a State fair hearing.

4.6.4. **MCO Resolution of Provider Appeals**

4.6.4.1. The MCO shall provide timely written notice of Provider appeal resolution (Resolution Notice) at a rate of ninety-five percent (95%) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.4.2. The Resolution Notice shall include, without limitation:

4.6.4.2.1 The MCO's decision;

4.6.4.2.2 The reasons for the MCO's decision;

4.6.4.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.4.2.4 For overturned appeals, the MCO shall take all steps to reverse the adverse action within ten (10) calendar days.

4.6.5. **State Fair Hearing for Provider Appeals**

4.6.5.1. The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.6.5.2. The parties to the State fair hearing include the MCO as well as the Provider.

4.6.5.3. The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing.

4.6.5.4. If a Participating Provider requests a State fair hearing, the MCO shall provide to the Department and the Participating Provider, upon request, within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.6.5.5. The MCO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO

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shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.6.5.6. The MCO shall appear and defend its decision before the Department AAU. Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.5.7. [Amendment #2:] ~~The Department AAU shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.~~ The Department AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.6.5.8. The MCO shall:

4.6.5.8.1 Not object to the State intervening in any such appeal;

4.6.5.8.2 Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.5.8.3 Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.6.5.9. Reporting

4.6.5.9.1 The MCO 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)]

4.7. Access

4.7.1. Participating Provider Network

4.7.1.1. The MCO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2. The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its Participating Provider network, the MCO shall consider and address the following factors to ensure network adequacy for each Member:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH Medicaid population;

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4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Participating Providers limiting NH Medicaid patients' access to the Participating Provider or not accepting new or any NH Medicaid patients;

4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, in compliance with Exhibit K: Information Security Requirements and Exhibit Q: IT Requirements Workbook;

4.7.1.2.8 Adequacy of the primary care Participating Provider network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

4.7.1.2.9 Access standards identified in this Agreement; and

4.7.1.2.10 Required access standards set forth by the NHID, including RSA. 420-J; and N.H. Code of Administrative Rules Ins 2700

4.7.1.3. The MCO shall meet the Participating Provider network adequacy standards included in this Agreement in all geographic areas in which the MCO operates for all Provider types covered under this Agreement.

4.7.1.4. The MCO shall ensure that services are as accessible to Members in terms of timeliness, amount, duration and scope as those that are available to Members covered by the Department under FFS Medicaid within the same service area.

4.7.1.5. The MCO shall ensure Participating Providers comply with the accessibility standards of the ADA. Participating Providers 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)]

4.7.1.6. The MCO 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

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services. If Members are permitted by the MCO to access out-of-state IHCPs, or if this circumstance is deemed to be good cause for disenrollment, the MCO shall be considered to have met this requirement. [42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory, as specified in Section 4.4.6 (Provider Directory) of this Agreement.

4.7.2. **Assurances of Adequate Capacity and Services**

4.7.2.1. The MCO's Participating Provider network shall have Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all Covered Services to meet the geographic standards in Section 4.7.3 (Time and Distance Standards), the timely provision of services requirements in Section 4.7.5 (Timely Access to Service Delivery), Equal Access, and reasonable choice by Members to meet their needs [42 CFR 438.207(a)].

4.7.2.2. The MCO shall submit documentation to the Department, in the format and frequency specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, that fulfills the following requirements:

4.7.2.2.1 The MCO 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)]

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with the Department's requirements for availability, accessibility of services, and adequacy of the Participating Provider network including pediatric subspecialists as described in Section 4.7.5.11 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 [Amendment #2:] The MCO is complying with the Department's requirements for Behavioral Health Services, as specified in Section 4.12, including but not limited to Substance Use Disorder treatment services and recovery, Mental Health services,

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Community Mental Health services, CCBHC services, and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3. To permit the Department to determine if access to private duty nursing services is increasing, as indicated by the Department in Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide to the Department the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4. The MCO shall submit documentation to 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 MCO. [42 CFR 438.207(b-c)]

4.7.2.5. For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by the Department.

4.7.3. **Time and Distance Standards**

4.7.3.1. At a minimum, the MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members, subject to alternative CMS requirements. [42 CFR 438.68(b)(1)(i-viii); 42 CFR 438.68(b)(3)]

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Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
[Amendment #2] Certified Community Behavioral Health Clinics (CCBHC)	All certified CCBHCs in New Hampshire
Community Mental Health Programs	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
[Amendment #1:] Intentionally Left Blank~~Mobile Crisis Service Providers~~[19]	~~One (1) within sixty (60) driving minutes or forty-five (45) driving miles~~
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
Tertiary or Specialized Services (e.g., Trauma, Neonatal)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

[19] [Amendment #1:] Intentionally left blank~~Mobile crisis services are provided by CMH Programs but subject to a different Geographic Access Standard requirement pursuant to the Department's selected Mobile Crisis System model~~.

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Geographic Access Standards	
Provider/Service	Requirement
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupation-al Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2. The MCO 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.

4.7.3.3. 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 MCO regarding its Participating Provider network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.4. The MCO shall contract with qualified Substance Use Disorder Providers who request to join its Participating Provider network pending the Substance Use Disorder Provider's agreement to the terms of the MCO's contract.

4.7.3.5. Additional Behavioral Health Provider Standards

Provider/Service	Requirement
MLADCs	The MCO's Participating Provider network shall include seventy percent (70%) of all such Providers licensed and practicing in NH
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH
Buprenorphine Prescribers	The Participating Provider network shall include seventy-five percent (75%) of all such Providers actively prescribing Buprenorphine in their practice and licensed and practicing in NH
Residential Substance Use Disorder Treatment Programs	The MCO's Participating Provider network shall include fifty percent (50%) of all such Providers licensed and practicing in NH
Peer Recovery Programs	The MCO's Participating Provider network shall include one hundred percent (100%) of all such willing Programs in NH
Residential Programs for Serious Mental Illness	The MCO's Participating Provider network shall include 100% of all such Providers, located in NH, if they are operated by or under contract with Community Mental Health Programs, and 100% of all such Providers if they are otherwise under contract with the Department and are appropriately licensed or certified by the Department under He-P 800 or He-M 1000.

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Provider/Service	Requirement
[Amendment #3:] Intentionally left blank ~~Psychiatric Residential [Treatment Facilities~~	[Amendment #3:] Intentionally left blank ~~The MCO's Participating Provider network shall include 100% of all such Providers, located in NH, if they are owned or operated by, under contract with, or are otherwise determined or designated by the Department to provide this service, and are appropriately licensed or certified by the Department or a Department approved alternative certification entity.~~

4.7.4. **Standards for Geographic Accessibility**

4.7.4.1. The MCO may request reasonable exceptions from the Agreement's Participating Provider 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 MCO be unable to contract a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, with the assistance of the Department and after good faith negotiations, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days 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: Liquidated Damages Matrix shall apply.

4.7.4.3. Except within a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with assistance of the Department, continue to be unable to meet geographic and timely access to service delivery standards the Department may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4. At any time the provisions of this section may apply, the MCO shall ensure Members have reasonable access to Covered Services.

4.7.4.5. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6. Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the Participating Provider 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)]

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4.7.4.6.2 The Department may grant the MCO an exception in the event that:

4.7.4.6.2.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the Participating Provider network adequacy standards in this Agreement and as otherwise defined by the NHID and the Department;

4.7.4.6.2.2. The MCO demonstrates, to the satisfaction of the Department, that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.2.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

4.7.4.6.2.4. The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies

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reviewed and approved by the Department, but the MCO shall not use telemedicine to meet the Participating Provider network adequacy standards unless the Department has specifically approved a Request for Exception.

4.7.4.6.3 The MCO shall report on Participating Provider network adequacy and exception requests in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.5. **Timely Access to Service Delivery**

4.7.5.1. The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2. The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3. The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)]

4.7.5.4. The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5. The MCO's Participating Provider network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6. The MCO shall have in its Participating Provider network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., diagnostic, preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

4.7.5.6.2 A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

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4.7.5.6.3 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.4 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.5 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.6.6 Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.

4.7.5.6.7 Obstetrics and gynecological care shall be available within fifteen (15) calendar days from the date of the Member's appointment request.

4.7.5.7. The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards.

4.7.5.8. The MCO shall regularly monitor its Participating Provider 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.

4.7.5.9. The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.10. The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

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4.7.5.11. Access Standards for Children with Special Health Care Needs

4.7.5.11.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

4.7.5.11.2 In addition to the "specialty care" Participating Provider network adequacy requirements, the MCO shall contract with Providers who offer the following specialty services:

4.7.5.11.2.1. Pediatric Critical Care;

4.7.5.11.2.2. Pediatric Child Development;

4.7.5.11.2.3. Pediatric Genetics;

4.7.5.11.2.4. Pediatric Physical Medicine and Rehabilitation;

4.7.5.11.2.5. Pediatric Ambulatory Tertiary Care;

4.7.5.11.2.6. Neonatal-Perinatal Medicine;

4.7.5.11.2.7. Pediatrics-Adolescent Medicine; and

4.7.5.11.2.8. Pediatric Psychiatry.

4.7.5.11.3 The MCO shall have adequate Participating Provider networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.11.4 The MCO shall specify, in their listing of mental health and Substance Use Disorder Provider directories, which Providers specialize in children's services.

4.7.5.11.5 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.11.6 The MCO shall permit a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

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4.7.5.11.7 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.11.8 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.12. Access Standards for Behavioral Health

4.7.5.12.1 The MCO shall have in its Participating Provider network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.12.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its Participating Provider network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.12.2.1. Within six (6) hours for a non-life threatening emergency;

4.7.5.12.2.2. Within forty-eight (48) hours for urgent care; and

4.7.5.12.2.3. Within ten (10) business days for a routine office visit appointment.

4.7.5.12.3 American Society of Addiction Medicine (ASAM) Level of Care

4.7.5.12.3.1. The MCO shall ensure Members timely access to care through a network of Participating Providers in each ASAM Level of Care. During the Readiness

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Review process and in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.7.5.12.3.1.1 The MCO shall submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of Substance Use Disorder service Providers so that services are accessible without unreasonable delays; and

4.7.5.12.3.1.2 The MCO shall have a specified number of Providers able to provide services at each level of care required; if supply precludes compliance, the MCO shall notify the Department and, within

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thirty (30) calendar days, submit an updated plan that identifies the specific steps that shall be taken to increase capacity, including milestones by which to evaluate progress.

4.7.5.12.4 The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.

4.7.5.12.5 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.

4.7.5.12.6 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential

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services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.12.7 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider, and the ordering Provider does not make a referral for the Covered Service within three (3) business days from initial contact, then the MCO is responsible, in collaboration with the Member's care team, for making a closed loop referral for that type of service (for the identified level of care), and to the applicable Doorway Program location within three (3) business days thereafter. The MCO is responsible for ensuring that the Member has access to interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

4.7.5.12.8 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.12.9 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

4.7.5.12.9.1. Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching

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out to identify Providers on the behalf of the Member;

4.7.5.12.10 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

4.7.5.12.11 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6. **Women's Health**

4.7.6.1. The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services provide necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist. [42 CFR 438.206(b)(2)]

4.7.6.2. The MCO shall provide access to Family Planning Services to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3. Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

4.7.6.4. The MCO shall only provide for abortions in the following situations:

4.7.6.4.1 If the pregnancy is the result of an act of rape or incest; or

4.7.6.4.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.5. The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement.

4.7.7. **Access to Special Services**

4.7.7.1. The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the

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equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3. The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8. **Non-Participating Providers**

4.7.8.1. If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2. The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3. The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider,

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the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.3.3 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network. [42 CFR 438.206(b)(5)]

4.7.9. **Access to Providers During Transitions of Care**

4.7.9.1. The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 [Amendment #1:] In the case of a child or youth who qualifies as a target population~~with Special Health Care Needs as~~ defined in Section 4.11.2 (MCO-Delivered Care Management for Required Priority Populations).

4.7.9.2. The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with the Department) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, 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;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her

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Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3. The MCO shall permit that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4. The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing their Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5. The MCO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition plan shall describe how Members shall be identified by the MCO and how Continuity of Care shall be provided.

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4.7.9.6. The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7. The MCO shall make a good faith effort to give written notice of termination of a contracted Provider, as follows:

4.7.9.7.1 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

4.7.9.7.2 Written notice to each Member who received their care from, or was seen on a regular basis by, the terminated Provider, the later of:

4.7.9.7.2.1. Thirty (30) calendar days prior to the effective date of the termination; or

4.7.9.7.2.2. Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated Provider.

4.7.9.8. The MCO shall have a transition plan in place for affected Members described in this section within three (3) calendar days prior to the effective date of the termination.

4.7.9.9. In addition to notification of the Department of Provider terminations, the MCO shall provide reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.9.10. If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.9.11. If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.11.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.11.2 Explain that the Member shall be assigned to an alternative PCP if they do not actively select one; and

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4.7.9.11.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.12. If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.13. The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Management team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant.

4.7.9.14. To minimize disruptions in care, the MCO shall:

4.7.9.14.1 With the exception of Members in their second or third trimester of pregnancy, 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; and

4.7.9.14.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10. **Second Opinion**

4.7.10.1. The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook. [42 CFR 438.206(b)(3)]

4.7.11. **Provider Choice**

4.7.11.1. The MCO shall permit each Member to choose their Provider to the extent possible and appropriate. [42 CFR 438.3(l)]

4.7.12. [Amendment #4:] **Rural Health Care**

4.7.12.1. [Amendment #4:] Beginning as early as January 1, 2026, the MCO shall support the Department's Rural Health Care activities authorized through the 2025 federal budget reconciliation bill as described in separate guidance. [H.R. 1; P.L. 119-21]

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4.8. Utilization Management

4.8.1. Policies and Procedures

4.8.1.1. The MCO'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 MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3. Amount, Duration, and Scope

4.8.1.3.1 The MCO 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)]

4.8.1.3.2 The MCO shall also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services shall be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.3 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.3.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.3.2. Personal Care Attendant (PCA) authorizations shall be issued for no less that one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

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4.8.1.3.3.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

4.8.1.4. Written Utilization Management Policies

4.8.1.4.1 The MCO 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 MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (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

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(including health-related social needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.13.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs;

4.8.1.4.2.2. Pre-hospital admission certification;

4.8.1.4.2.3. Pre-inpatient service eligibility certification;

4.8.1.4.2.4. Concurrent hospital review to determine appropriate length of stay;

4.8.1.4.2.5. The process used by the MCO 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 MCO to the Department for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the MCO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.8.1.4.6 The MCO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The MCO'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 MCO shall provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.66 (c)(7)]

4.8.1.5. Service Limits

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6. Prior Authorization

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4.8.1.6.1 The MCO 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. Any Prior Authorization for Substance Use Disorder shall comply with RSA 420-J:17 and RSA 420-J:18 as described in Section 4.12.34.3 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

4.8.1.6.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including health-related social needs and a subsequent person-centered planning process.

4.8.1.6.3 The MCO's Prior Authorization requirements shall comply with parity in mental health and Substance Use Disorder, as described in Section 4.12.19.4 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.4 The MCO shall use the NH MCM standard Prior Authorization form, as applicable. The MCO shall also 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.

4.8.1.6.5 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

4.8.1.6.7 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely

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because of the diagnosis, type of illness, or condition of the Member.

4.8.1.6.8 The MCO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.8.1. The MCO shall not deny service authorization requests based solely on cost.

4.8.1.6.9 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.1.6.10 The MCO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.1.6.11 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)]

4.8.1.6.12 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.1.6.13 The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.14 Upon receipt of Prior Authorization information from the Department, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.2 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.15 In the event that the Prior Authorization specifies a specific Provider, that MCO shall continue to utilize

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that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network.

4.8.1.6.16 The MCO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.17 [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO shall ensure that medical necessity determinations by Subcontractors or any other party performing utilization review are made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease, and is actively licensed ~~are licensed in NH~~ in accordance with Section 3.10.2.4 (Contracts with Subcontractors) and Section 3.11.1.1.9.2 of this Agreement.

4.8.1.6.18 The MCO shall ensure that Subcontractors or any other party performing utilization reviews applicable to inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:

4.8.1.6.18.1. For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.

4.8.1.6.18.2. Reauthorization of the Member's continuous admission, shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.

4.8.2. **Practice Guidelines and Standards**

4.8.2.1. The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO shall:

4.8.2.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

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4.8.2.1.2 Consider the needs of the MCO's Members,

4.8.2.1.3 Be adopted in consultation with Participating Providers, and

4.8.2.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1-3); 42 CFR 438.236(b)(4)]

4.8.2.2. The MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

4.8.2.3. The MCO 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:

4.8.2.3.1 ASAM, as further described in Section 4.12.27 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.3.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adult, adolescent, and pediatric populations, rated A or B; as well as State specified requirements which include, but are not limited to, pediatric lead testing rates of fifty-five percent (55%) for 12-month olds and forty-four percent (44%) for 24 month olds in the first year of the Agreement, increasing by five percent 5% each year thereafter until the final year of the Agreement when the goals will be seventy-five percent (75%) for 12-month olds and sixty-four percent (64%) for 24-month olds.

4.8.2.3.3 The preventive services recommended by the AAP Bright Futures program; and

4.8.2.3.4 The Zero Suicide Consensus Guide for Emergency Departments.

4.8.2.4. The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is reviewed by the Department prior to implementation.

4.8.2.5. The MCO shall disseminate Practice Guidelines to the Department and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

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4.8.2.6. The MCO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3. **Medical Necessity Determination**

4.8.3.1. The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.3.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2. For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Section 2.1 (Definitions).

4.8.3.3. For Members under twenty-one (21) years of age, per EPSDT, "Medically Necessary" shall be as defined in Section 2.1 (Definitions).

4.8.4. **Notices of Coverage Determinations**

4.8.4.1. The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2. Urgent Determinations and Continued/Extended Services

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4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.4.2.1.2. In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request and shall advise the Member or Member's representative of the specific information necessary to make a coverage determination.

4.8.4.2.1.3. 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.

4.8.4.2.1.4. 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 MCO's receipt of the specified additional information; or the end of the period afforded the

Member or Member's representative to provide the specified additional information.

4.8.4.2.1.5. 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.

4.8.4.3. All Other Determinations

4.8.4.3.1 [Amendment #4:] Beginning July 1, 2026,t~~T~~he determination of all other authorizations for pre-service benefits (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed seven (7) ~~fourteen (14)~~ calendar days for ninety-five percent (95%) of standard requests after the receipt of a request. [42 CFR 438.210(d)]

4.8.4.3.2 [Amendment #4:] Beginning July 1, 2026, An extension of up to fourteen (14) calendar days after receiving the request is permissible ~~for non-diagnostic radiology determinations~~ if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.3 [Amendment #4:] Intentionally left blank.~~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-~~

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~~five (45) calendar days from receipt of the notice within which to provide the specified information.~~

4.8.4.3.4 [Amendment #4:] Beginning July 1, 2026, Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than seven (7) ~~fourteen (14)~~ calendar days after the earlier of:

4.8.4.3.4.1. The MCO's receipt of the specified additional information; or

4.8.4.3.4.2. The end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.3.4.3. When the MCO extends the timeframe, the MCO 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 MCO 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.

4.8.4.3.5 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 MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.4.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.7 [Amendment #4:] Beginning July 1, 2026, ~~Whenever there is an adverse determination, the MCO shall~~

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~~notify the ordering Provider and the Member. For an adverse standard authorization decision,~~ the MCO shall notify the requesting provider, and give the enrollee written notice of any decision ~~provide written notification~~ as expeditiously as the Member's condition requires, but may not exceed seven (7) ~~within three (3)~~ calendar days after receiving the request for service ~~of the decision~~. [42 CFR 438.10(d)]

4.8.4.3.7.1. [Amendment #4:] Beginning July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), the MCO shall provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request to the MCO. [42 CFR 438.210(d)] Reasons may be communicated via portal (may include existing payer messaging portal), fax, email, mail, or phone. [42 CFR 438.242(b)(8)]

4.8.4.3.8 The MCO shall provide Utilization Management Confidential Data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.8.5. **Advance Directives**

4.8.5.1. The MCO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:20.

4.8.5.2. The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.

4.8.5.3. The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.

4.8.5.4. The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]

4.8.5.5. The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

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4.8.5.6. The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.7. The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.8. The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9. Member Education and Incentives

4.9.1. General Provisions

4.9.1.1. The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by the Department, including the National Diabetes Prevention Program. The MCO shall also participate in other public health initiatives at the direction of the Department.

4.9.1.2. The MCO shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. The MCO shall encourage Members to take an active role in shared decision-making.

4.9.1.3. The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. The Department shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2. Member Health Education

4.9.2.1. The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

4.9.2.2. The MCO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3. Member Cost Transparency

4.9.3.1. The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with

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clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2. The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to permit Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3. The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) of this Agreement.

4.9.4. **Member Incentive Programs**

4.9.4.1. The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this section of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives described in Section 4.15 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.2. For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 [Amendment #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), except as specified in separate guidance.

4.9.4.2.3 The MCO shall submit to the Department for review and approval all Member Incentive Program plan proposals prior to implementation.

4.9.4.3. Within the plan proposal, the MCO shall include adequate assurances, as assessed by the Department, that:

4.9.4.3.1 The program meets the requirements of the Social Security Act; and

4.9.4.3.2 The program meets the criteria determined by the Department as described in Section 4.9.4.5 (Healthy

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Behavior Incentive Programs) and Section 4.9.4.6 (Reference-Based Pricing Incentive Programs) of this Agreement.

4.9.4.4. The MCO 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:

4.9.4.4.1 The number of Members in the program's target population, as determined by the MCO;

4.9.4.4.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.4.4.3 The total value of the incentive payments;

4.9.4.4.4 An analysis of the statistically relevant results of the program; and

4.9.4.4.5 Identification of goals and objectives for the next year informed by the data.

4.9.4.5. Healthy Behavior Incentive Programs

4.9.4.5.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.4.5.1.1. Incorporate incentives for Members who complete a HRA Screening, in compliance with Section 4.10.2 of this Agreement;

4.9.4.5.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.9.4.5.1.3. Address obesity;

4.9.4.5.1.4. Prevent diabetes;

4.9.4.5.1.5. [Amendment #1:] Support nicotine~~smoking~~ cessation;

4.9.4.5.1.6. Increase lead screening rates in one- and two-year old Members; and/or

4.9.4.5.1.7. Other similar types of healthy behavior incentive programs in

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consultation with the collaboration with the Department's Division of Public Health New Hampshire Tobacco Cessation Program, Quitline.

4.9.4.6. Reference-Based Pricing Incentive Programs

4.9.4.6.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO and on its website in compliance with the Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.6.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5. **Collaboration with New Hampshire Tobacco Cessation Programs**

4.9.5.1. [Amendment #1:] The MCO shall enter into a Provider or Subcontractor agreement to cover the cost of nicotine cessation services for youth (13-17 years), and adults without Copayment, Prior Authorization, or annual limits with Department approved nicotine quitline(s). ~~The MCO shall promote and utilize the Department-approved tobacco treatment quitline, 1-800-QUITNOW (1-800-784-8669) to provide:~~

4.9.5.1.1 [Amendment #1:] Intentionally left blank. ~~Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;~~

4.9.5.1.2 [Amendment #1:] Intentionally left blank. ~~Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;~~

4.9.5.1.3 [Amendment #1:] Intentionally left blank. ~~The following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by the Department; and~~

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4.9.5.1.4 [Amendment #1:] Intentionally left blank. ~~Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.~~

4.9.5.2. [Amendment #1:] The MCO shall cover the cost of nicotine cessation, including counseling visits, in addition to the quitline without Copayment, Prior Authorization, or duration/frequency or annual limits. ~~The MCO shall provide tobacco cessation treatment to include, at a minimum~~:

4.9.5.2.1 [Amendment #1:] Intentionally left blank ~~Tobacco cessation coaching/counseling in addition to the quitline~~;

4.9.5.2.2 [Amendment #1:] Intentionally left blank ~~In addition to the quitline, the following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by the Department~~;

4.9.5.2.3 [Amendment #1:] Intentionally left blank ~~In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release; and~~

4.9.5.2.4 [Amendment #1:] Intentionally left blank ~~Covered FDA-approved tobacco cessation prescription medications that qualify for rebates under the Medicaid Prescription Drug Rebate Program, including~~:

4.9.5.2.5 [Amendment #1:] Intentionally left blank ~~Non-nicotine prescription medications; and~~

4.9.5.2.6 [Amendment #1:] Intentionally left blank ~~Inhalers and nasal sprays.~~

4.9.5.3. [Amendment #1:] The MCO shall promote through its website and membership mailings the nicotine cessation quitlines: QuitNow-NH (quitnownh.org and 1-800-QUIT-NOW) for adults, and MYLIFEMYQUIT (nh.mylifemyquit.org and Text 36072) for children 13-17 years old.

4.9.5.3.1 [Amendment #1:] The MCO shall collaborate with the New Hampshire Tobacco Cessation Program (TPCP) within the Department's Division of Public Health

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Services to update and maintain a website presence for QuitNow-NH and resources for nicotine cessation.

4.9.5.3.2 [Amendment #1:] Quarterly, the MCO shall use claims data to identify Members receiving nicotine cessation counseling and mail promotional materials, as indicated by TPCP.

4.9.5.3.3 [Amendment #1:] The MCO shall participate in quitline data sharing with the TPCP by reporting on tobacco cessation activities in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.9.5.4. [Amendment #1:] The MCO shall report on tobacco cessation activities in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10. Primary Care and Prevention Focused Care Model

4.10.1 General Requirements

4.10.1.1. Under the Primary Care and Prevention Focused Care Model of Care, Primary Care services shall be furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant, or nurse practitioner, including alternative provider types as designated by the Department.

4.10.1.2. The MCO shall ensure that the Primary Care and Prevention Care Focused Care Model of Care shall be administered in accordance with this Agreement, including:

4.10.1.2.1 Assurance of comprehensive PCP participation in the Model of Care wholly supported by the MCO;

4.10.1.2.2 Guaranteed access to related services for all Members;

4.10.1.2.3 Delivery of services in a manner that are both clinically and developmentally appropriate, patient-focused, and that consider the Member's, parent's, caregiver's and other networks of support the Member may rely upon, in accordance with this Agreement and all applicable State and federal laws and regulations;

4.10.1.2.4 PCP (and other Providers who share responsibility for primary care of the Member) responsibility for Provider-Delivered Care Coordination as described at Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) of this Agreement consistent with Practice Guidelines and Standards required and stipulated in Section 4.8.2, including a plan for integration of these programs;

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4.10.1.2.5 Member's selection or assignment of a PCP within fifteen (15) calendar days of enrollment with the MCO;

4.10.1.2.6 Completion of the Member welcome call as stipulated at Section 4.4.11 (Welcome Call);

4.10.1.2.7 Member receipt of a Wellness Visit with their PCP, as defined in Section 4.10.3 (Wellness Visits), at least once annually. If the Member is assigned a new PCP, the MCO shall ensure the Member receives a Wellness Visit with the new PCP regardless of when the last Wellness Visit occurred with another Provider;

4.10.1.2.8 Initial and regular reporting to PCPs the names of Members attributed to the PCP's panel within thirty (30) calendar days of PCP assignment or selection, including the date of the attributed Member's last Wellness Visit and HRA Screening, as available, and/or the absence of such visit and screenings if there have been none;

4.10.1.2.9 Demonstration of the authentic engagement between the Member and PCP. At a minimum, as demonstrated through claim encounters initially within ninety (90) days of PCP selection/assignment, and routinely thereafter.

4.10.1.2.10 Provider reimbursement for provision of the following Member services:

4.10.1.2.10.1. Wellness Visits in accordance with Section 4.10.3 (Wellness Visits), including assurance there are no barriers to professional claim billing and payment outside of a Wellness Visit for U.S. Preventive Services Task Force (USPSTF) recommended services that utilize a standardized tool in the screening for obesity, anxiety, depression and suicide risk, unhealthy alcohol use, unhealthy drug use, and falls prevention;

4.10.1.2.10.2. HRA Screening as stipulated in Section 4.10.2 (Health Risk Assessment (HRA) Screening) can occur during a visit for any separate acute service and is not

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solely restricted to a Wellness Visit;

4.10.1.2.10.3. Preventive screenings in accordance with the Practice Guidelines and Standards (Section 4.8.2), including but not limited to the recommendations of the U.S. USPSTF for the provision of primary and secondary care for adult, adolescent, and pediatric populations, rated Level A or B and other preventive screening and services as required by the Department; and

4.10.1.2.10.4. Medically Necessary diagnostic and treatment Covered Services based on the findings or risk factors identified in the annual Wellness Visit, completion of a HRA Screening, or during routine, urgent, or emergent health care visits.

4.10.1.2.10.5. [Amendment #1:] Comprehensive Medication Reviews for Required Priority Population Members, and children and adults meeting Polypharmacy criteria as stipulated in Section 4.2.6.

4.10.1.2.11 Provider and Member incentives for completion of the following:

4.10.1.2.11.1. A Wellness Visit;

4.10.1.2.11.2. A HRA Screening; and

4.10.1.2.11.3. Preventive screenings.

4.10.1.3. Support the PCP to engage Members to complete the HRA Screening in accordance with Section 4.10.2.

4.10.1.4. [Amendment #1:] Intentionally left blankComprehensive Medication Reviews for children and adults meeting Polypharmacy criteria as stipulated in Section 4.2.6.

4.10.1.5. Provider-Delivered Care Coordination utilization of closed-loop referral processes in accordance with Section 4.11.7 (Provider-Delivered Care

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Coordination and Integration with Social Services and Community Care), including:

4.10.1.5.1 PCP initiation and coordination of closed-loop referrals for clinical and non-clinical services the Member needs, including but not limited to Behavioral Health Services and health-related social needs, with the Provider remaining engaged with clinical and non-clinical Provider(s) throughout the course of treatment for the referred service(s);

4.10.1.5.2 PCP adoption and utilization of closed-loop referral processes, and the Department's closed-loop referral system, as it becomes available, to promote efficiency and optimal communication among and between Providers; and

4.10.1.5.3 PCP education and training to ensure that the PCP knows when and how to utilize a closed-loop referral system.

4.10.1.6. The MCO shall ensure the Primary Care and Prevention Focused Model satisfies care and coordination of services as follows: [42.CFR 438.208]

4.10.1.6.1 The MCO shall ensure that each Member has a designated PCP who shall serve as an ongoing source of case appropriate to his or her needs and the Member shall be provided information on how to contact their designated PCP;

4.10.1.6.2 The MCO shall provide Care Management services for times at which a Member does not have an established and designated PCP (e.g., corrections populations, DCYF children and youth);

4.10.1.6.3 The MCO shall also cover Transitions of Care Management (TCM) codes for Participating Providers to perform care transition assistance including coordinating appropriate services between settings of care;

4.10.1.6.4 [Amendment #1:] The MCO shall make best effort to connect each Member to a PCP and to pay network PCPs to review the Member's HRA Screening results with the Member at least once annually or when the Member's circumstances or needs change significantly ~~pay network PCPs to conduct an initial screening of each Member's needs within ninety (90) calendar days of the effective date of enrollment for new Members~~;

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4.10.1.6.5 [Amendment #1:] The MCO shall request documentation from the Participating Provider regarding HRA Screenings ~~and initial screenings~~ of Member needs should the MCO determine that additional entities such as the State, PIHPs and PAHPs are serving the enrollee to prevent duplication of those activities;

4.10.1.6.6 The MCO shall ensure Participating Providers that furnish services to Members maintains and shares, as appropriate, Member health records in accordance with professional standards; and

4.10.1.6.7 The MCO shall ensure that in the process of coordinating care, each Member's privacy is protected in accordance with state and federal privacy requirements in to the extent that they are applicable. [45 CFR parts 160 and 164 subparts A and E]

4.10.1.7. The MCO shall collaborate with the other contracted Medicaid MCOs to offer training for Providers on the Primary Care and Prevention Focused Care Model in an efficient and effective manner that reduces the administrative burden of Providers.

4.10.2 **Health Risk Assessment (HRA) Screening**

4.10.2.1. The HRA Screening process shall identify the need for the Member's Care Coordination and Care Management services and the need for clinical and non-clinical services, including closed-loop referrals to specialists, not limited to Behavioral Health services Providers, and community resources.

4.10.2.2. The MCO shall implement a process to allow professional services billing and payment for Participating Providers who complete and review a Member's HRA Screening, and shall create incentive programs to facilitate the Participating Provider's completion and review of the HRA Screening.

4.10.2.3. [Amendment #1:] The MCO shall support and empower Providers to conduct and review a HRA Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of MCO enrollment and at least annually thereafter for all Members, and when the Member's circumstances or needs change significantly to identify Members who may have unmet health care needs. [42 CFR 438.208(c)(1)]

4.10.2.4. [Amendment #1:] The HRA Screening tool and methodology shall be the same for each MCO~~. The HRA Screening tool~~ and approved ~~shall be developed by the Department and made available for Provider use~~.

4.10.2.4.1 [Amendment #1:] The Provider may utilize an alternate HRA Screening tool that includes the minimum HRA Screening criteria specified by the Department in separate guidance.

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4.10.2.5. [Amendment #2] [Amendment #1:] The MCO shall ~~empower and~~ support and incentivize the PCP to engage Members to complete the HRA screening in an agency office/clinic setting, during a scheduled home visit or medical appointment. The HRA Screening may be conducted in-person or through a HIPAA compliant electronic means, telephonic means, or through completion of the written form by the Member. ~~The MCO shall make best efforts to verify the PCP has made at least three (3) reasonable attempts to contact a Member at the phone number and address most recently reported by the Member.~~ [42 CFR 438.208(b)(3)]

4.10.2.5.1 For Members determined eligible for Community Mental Health services pursuant to He-M 401, the MCO shall encourage the Member's PCP to coordinate completion of the HRA Screening (Section 4.10.2) with the Member's applicable Community Mental Health program (a Community Mental Health Center) or other Community Mental Health Provider, if the Member consents, to enable the Community Mental Health Provider to provide support for effective completion of the Health Risk Assessment Screening by the PCP and the Member.

4.10.2.6. The MCO shall report the number of Members who received a HRA Screening, using claims data, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10.2.7. [Amendment #1:] Intentionally left blankThe MCO shall share with the Department the results of any identification and assessment of Member's needs to prevent duplication of activities as described in separate guidance. [42 CFR 438.208(b)(4)]

4.10.2.7.1 [Amendment #1:] The PCP shall review HRA Screening data and make appropriate referrals to social service agencies or other entities whether the data is collected in-person, digitally or electronically, telephonically, ~~in-person, digitally or electronically, telephonically,~~ or through completion of the written form by the Member.

4.10.2.7.2 The Provider conducting the HRA Screening shall share Member HRA results with the MCO upon request.

4.10.2.8. The MCO shall ensure, through incentives or professional provider reimbursement, that the Participating Provider reviews the HRA Screening results and make appropriate referrals to social service agencies or other entities whether the HRA is collected in person, electronically, telephonically, or through completion of the written form by the Member.

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4.10.2.9. [Amendment #1:] Intentionally left blank.~~The Participating Provider conducting the HRA Screening shall share Member HRA Screening results with the MCO upon request.~~

4.10.2.10. The MCO shall ensure Participating Providers complete and review Member HRA Screenings at least annually as follows:

4.10.2.10.1 By the end of Year 1 (SFY 2025 (June 30, 2025)), the HRA minimum completion rate requirement is twenty percent (20%) of the plan's total membership;

4.10.2.10.2 By the end of Year 2 (SFY 2026 (June 30, 2026)), the HRA minimum completion rate requirement is forty percent (40%) of the plan's total membership;

4.10.2.10.3 By the end of Year 3 (SFY 2027 (June 30, 2027)), the HRA minimum completion rate completion rate requirement is sixty percent (60%) of the plan's total membership; and

4.10.2.10.4 By the end of Year 4 (SFY 2028 (June 30, 2028) and through the end of the contract term, the HRA minimum completion rate requirement is seventy-five percent (75%) of the plan's total membership.

4.10.2.11. [Amendment #1:] The evidence-based HRA Screening tool are described in separate guidance ~~shall identify, at minimum, the following information about Members~~:

4.10.2.11.1 [Amendment #1:] Intentionally left blank ~~Demographics~~;

4.10.2.11.2 [Amendment #1:] Intentionally left blank ~~Chronic and/or acute conditions;~~

4.10.2.11.3 [Amendment #1:] Intentionally left blank ~~Chronic pain;~~

4.10.2.11.4 [Amendment #1:] Intentionally left blank ~~The unique needs of children with developmental delays, Special Health Care Ne eds or involved with the juvenile justice system and child protection agencies (i.e., DCYF);~~

4.10.2.11.5 [Amendment #1:] Intentionally left blank ~~Behavioral Health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.12.10 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.12.20.4 (Comprehensive Assessment and Care Plans), and Section 4.12.26 (Provision of Substance Use Disorder Services);~~

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4.10.2.11.6 [Amendment #1:] Intentionally left blank ~~The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;~~

4.10.2.11.7 [Amendment #1:] Intentionally left blank Nicotine~~Tobacco C~~cessation needs;

4.10.2.11.8 [Amendment #1:] Intentionally left blank ~~Health-related social needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and~~

4.10.3 **[Amendment #1:] Intentionally left blank ~~Other factors or conditions about which the MCO shall need to be aware to arrange available interventions for the Member~~.**

4.10.4 **Wellness Visits**

4.10.4.1. For all Members the MCO shall support the Member to arrange a Wellness Visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs. If the Member changes their PCP, the MCO shall authorize a new Wellness Visit with the new PCP, even if within a calendar year of the last Wellness Visit with the previous PCP.

4.10.4.2. The Wellness Visit conducted by the PCP or other qualified Provider shall include health risk and social determinant of health screening assessments for the purpose of determining a Member's health wellness and development of a plan of care, including evaluations of:

4.10.4.2.1 Both physical and behavioral health, including screening for depression;

4.10.4.2.2 Mood, suicidality; and

4.10.4.2.3 Substance Use Disorder.

4.10.5 **Prior Authorization for Primary Care and Preventive Services**

4.10.5.1. Notwithstanding other provisions of Section 4.8.1.6, Prior Authorizations for any preventive services, as defined in Section 4.8.2.3.2 of this Agreement, and as stipulated to in Practice Guidelines and Standards at Section 4.8.2 shall be prohibited. This prohibition shall include medically appropriate follow-up testing related to the initial test results, as well as any claims or encounters associated with the PCP's coordination and collaboration with Behavioral Health Services to support the Member's participation in preventive services activities.

4.10.6 **Primary Care and Prevention Focused Care Model Implementation Plan**

4.10.6.1. The MCO shall submit a plan for implementing the Primary Care and Prevention Focused Care Model in accordance with Exhibit O: Quality and Oversight Reporting.

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4.11. Care Coordination and Care Management

4.11.1. General Requirements

4.11.1.1. The MCO shall be responsible for ensuring effective management, coordination, and Continuity of Care for all Members, including oversight of Provider-Delivered Care Coordination for the PCPs' attributed Members, and shall develop and maintain policies and procedures to address these responsibilities.

4.11.1.2. The MCO shall submit a plan at time of Readiness Review and implement procedures to facilitate integrated Provider-Delivered Care Coordination and MCO-Delivered Care Management to ensure each Member has an ongoing source of care appropriate to their needs, and includes procedures for confidentiality, consent, or informed consent. [42 CFR 438.208(b)]

4.11.1.3. The MCO shall ensure the services described in this section are provided for all Members who need Care Coordination regardless of their acuity level.

4.11.1.4. The MCO shall implement and monitor Provider-Delivered Care Coordination and MCO-Delivered Care Management, as appropriate, in order to achieve the following goals:

4.11.1.4.1 Improve care of Members;

4.11.1.4.2 Improve health outcomes;

4.11.1.4.3 Increase collaboration among the Member's Providers, including but not limited to Behavioral Health Services Providers;

4.11.1.4.4 Reduce inpatient hospitalizations including readmissions;

4.11.1.4.5 Improve Continuity of Care;

4.11.1.4.6 Improve transition planning;

4.11.1.4.7 Improve medication management;

4.11.1.4.8 Improve U.S. Preventive Services Task Force (USPSTF) recommended Level A and B preventive screenings; as well as State specified screenings

4.11.1.4.9 Reduce utilization of unnecessary Emergency Services;

4.11.1.4.10 Reduce unmet resource needs related to health-related social needs;

4.11.1.4.11 Decrease total costs of care; and

4.11.1.4.12 Increase Member satisfaction with their health care experience.

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4.11.1.5. The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, Behavioral Health Service Providers, and social service resources, and include related documentation in the Member Care Plan.

4.11.1.5.1 The MCO and its Participating Providers shall utilize, leverage and partner with the Department's closed-loop referral system, if available, or 2-1-1 NH if it is not, which is a New Hampshire statewide information and referral service, using closed-loop referral processes to ensure warm transfers are completed and outcomes are reported for all closed-loop referrals.

4.11.1.6. The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from another MCO. [42 CFR 438.208(b)(2)(ii)]

4.11.1.7. The MCO shall also implement procedures to coordinate services the MCO furnishes to the Required Priority Population Member with the services the Member receives in FFS Medicaid, including Medicaid dental services, as applicable. For other Members not included in the Required Priority Population, the PCP shall coordinate these services. [42 CFR 438.208(b)(2)(iii)].

4.11.1.8. The MCO shall provide Care Management support for Required Priority Population Members who utilize services not covered by this Agreement (e.g., Medicaid, commercial, or government health insurance programs). In such cases, the MCO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii-iv). The MCO shall use the Department's closed-loop referral solution, if available, to initiate and support the Required Priority Population Member's access to other services to which the MCO, or its applicable PCP or other Participating Provider is referring the Member.

4.11.2. **MCO-Delivered Care Management for Required Priority Populations**

4.11.2.1. Required Priority Populations are most likely to have Care Management needs that shall be met with the MCO-Delivered Care Management processes described in this Agreement.

4.11.2.2. The following high-risk groups are identified as Required Priority Populations in need of Care Management focus by the MCO:

Contract Provision	Minimum Care Management Timeframe
[Amendment #1:] 4.11.2.2.1 Individuals who have required an inpatient admission for a behavioral health diagnosis and were discharged within the previous twelve (12) months;	[Amendment #1:] Beginning immediately upon MCO Notice of Discharge, then an additional twelve (12) calendar months after the month of discharge
[Amendment #4:] [Amendment #1:] 4.11.2.2.2 Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care ~~and/or those who have elected voluntary supportive services~~;	[Amendment #1:] Beginning immediately upon DCYF agency engagement, then an additional twelve (12) calendar months after the month of discharge
[Amendment #1:] 4.11.2.2.3 Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS);	[Amendment #1:] Beginning immediately upon MCO identification of low birth weight and/or neonatal abstinence syndrome (NAS) diagnoses, then an additional twelve (12) calendar months after the month of discharge
[Amendment #1:] 4.11.2.2.4 Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval[20]	[Amendment #1:] Beginning immediately upon MCO enrollment for 45 days prior to the scheduled release date, then an additional twelve (12) calendar months after the month of incarceration release
[Amendment #1:] 4.11.2.2.5 Other Required Priority Populations identified by the Department with advance notification to the MCO with an effective date for Care Management services within ninety (90) calendar days of written notice from the Department.	[Amendment #1:] As appropriate for new populations identified by the Department
[Amendment #2:] 4.11.2.2.6 Eligible incarcerated youth as defined by CAA section 5121	[Amendment #2:] Beginning 30-days prior to the scheduled release date, then an additional twelve (12) calendar months after the month of incarceration release

4.11.2.2.1 [Amendment #1:] ~~Individuals who have required an inpatient admission for a behavioral health diagnosis~~

[20] Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver available on July 18, 2023 at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request.pdf.

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and were discharged within the previous twelve (12) months;

4.11.2.2.2 [Amendment #1:] Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services;

4.11.2.2.3 [Amendment #1:] Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS);

4.11.2.2.4 [Amendment #1:] Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval; and

4.11.2.2.5 [Amendment #1:] Other Required Priority Populations identified by the Department with advance notification to the MCO with an effective date for Care Management services within ninety (90) calendar days of written notice from the Department.

4.11.2.3. [Amendment #1:] The MCO may identify other Members who may benefit from the plan's Care Management services as needed for Members in accordance with the clinical care needs of the Member; however, MCO-Delivered Care Management requirements specified in this Agreement apply only to the Required Priority Populations identified by the Department, which may be expanded from time to time with advance notification to the MCO.

4.11.2.4. [Amendment #2:] The MCO shall support reporting for Required Priority Populations as specified by Exhibit O: Quality and Oversight Reporting Requirements of this Agreement.

4.11.3. **Comprehensive Assessment**

4.11.3.1. [Amendment #1:] The MCO shall implement mechanisms to minimally conduct a Comprehensive Assessment for Required Priority Populations to identify whether a Member has Special Health Care Needs and any ongoing special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.208(c)(2)]

4.11.3.1.1 [Amendment #1:] The MCO shall, conduct an initial Comprehensive Assessment screening during a welcome call to assess care needs and to coordinate services for all existing and newly enrolled Members within ninety (90) calendar days of the Member's effective date of MCO enrollment for all new Members,

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including subsequent attempts if the initial attempt to contact the Member is unsuccessful. [42 CFR 438.208(b)(3) and (c)]

4.11.3.2. The Comprehensive Assessment shall identify a Member's health condition that requires a course of treatment that isok either episodic, which is limited in duration or significance to a particular medical episode, or requires ongoing Provider-Delivered Care Coordination or MCO-Delivered Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder).

4.11.3.3. [Amendment #1:] The Comprehensive Assessment shall be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that shall inform whether the Priority Population Member or other Member should receive Care Management, and shall inform the Member's ~~ongoing Care Plan and~~ treatment plan, as well as the Required Priority Population Member's Care Plan managed by the MCO. The MCO shall incorporate into the Comprehensive Assessment information obtained from Providers ~~as a result of Provider referral, or the Wellness Visit~~.

4.11.3.4. [Amendment #1:] ~~In addition to any initial Comprehensive Assessment cited at Section 4.11.3.1.1, t~~The MCO shall complete a Comprehensive Assessment within thirty (30) calendar days of identifying a Priority Population Member at the time of a welcome call or at any time a Member is identified as being part of a one or more Required Priority Population. ~~as being part of one or more Required Priority Population as identified~~ Methods for identifying Required Priority Population Members may include ~~through~~ Medicaid enrollment records, HRA Screening, risk scoring and stratification or other means at the MCO's discretion, or means as determined by the Department.

4.11.3.5. The MCO shall not withhold any Medically Necessary Covered Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.11.3.6. The MCO shall conduct the Comprehensive Assessment in a location of the Member's, parent's or guardian's choosing, as applicable, and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as family members, paid and natural supports as agreed upon and appropriate to the Member/Member's parent, if a minor, or guardian to the maximum extent practicable.

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4.11.3.7. Additionally, participation in the Comprehensive Assessment shall be extended to the Member's Care Team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs, Special Medical Services, and 1915(i) case managers as practicable, with Member consent to the extent required by State and federal law.

4.11.3.8. The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

4.11.3.8.1 Members' immediate care needs;

4.11.3.8.2 Demographics;

4.11.3.8.3 Education;

4.11.3.8.4 Housing;

4.11.3.8.5 Employment and entitlements;

4.11.3.8.6 Legal involvement;

4.11.3.8.7 Risk assessment, including suicide risk;

4.11.3.8.8 Other State or local community and family support services currently used;

4.11.3.8.9 Medical and other health conditions;

4.11.3.8.10 Physical, I/DDs;

4.11.3.8.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living (IADL)) including cognitive functioning;

4.11.3.8.12 Medications;

4.11.3.8.13 Available informal, caregiver, or social supports, including peer supports;

4.11.3.8.14 Current and past mental health and substance use status and/or disorders;

4.11.3.8.15 Health-related social needs; and

4.11.3.8.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).

4.11.3.9. The MCO shall provide to the Department a copy of the Comprehensive Assessment tool and all policies and procedures related to conducting the Comprehensive Assessment for the Department's review as part of Readiness Review and annually thereafter.

4.11.3.10. The MCO shall conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing Care Management:

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4.11.3.10.1 At least annually;

4.11.3.10.2 When the Member's circumstances or needs change significantly;

4.11.3.10.3 At the Member's request; and/or

4.11.3.10.4 Upon the Department's request.

4.11.3.11. The MCO shall share the results of the Comprehensive Assessment in writing with the Member's Care Team within 14 calendar days of completion of the assessment to inform care and treatment planning, with Member consent to the extent required by State and federal law.

4.11.3.12. The MCO shall report to the Department the following in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.11.3.12.1 Assessments conducted as a percentage (%) of total Members and by Required Priority Population category;

4.11.3.12.2 Assessments completed by a Subcontractor entity, such as but not limited to CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.11.3.12.3 Timeliness of assessments;

4.11.3.12.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other members of the local community based care team; and

4.11.3.12.5 Quarterly report of unmet resource needs, aggregated by county, based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.11.4. **Member Care Management Engagement**

4.11.4.1. [Amendment #2:] The MCO shall conduct Care Management in accordance with this Agreement and as specified in separate guidance which shall include assignment a designated Care Manager for every Required Priority Population Member.

4.11.4.2. [Amendment #4:] Intentionally left blank. ~~For any Member identified as part of a Required Priority Population relative to behavioral health, as described in this Agreement, and subsequently identified by the MCO as not needing Care Management, the MCO shall provide documentation to the Member's PCP and behavioral health provider(s), if applicable, of this decision, and to the Department. If, based on Member utilization data or consultation with the behavioral health provider, the Department notifies the MCO that the Member's~~

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~~utilization history is of continuing concern to the Department, such that Care Management is still warranted, the Department will notify the MCO and the MCO shall provide Care Management and designate a Care Manager for the Member.~~

4.11.4.3. Members selected for MCO-Delivered Care Management shall be informed of:

4.11.4.3.1 The nature of the Care Management engagement relationship;

4.11.4.3.2 Circumstances under which information shall be disclosed to third parties, consistent with State and federal law;

4.11.4.3.3 The availability of a grievance and appeals process;

4.11.4.3.4 The rationale for implementing Care Management services; and

4.11.4.3.5 The processes for opting out of and terminating Care Management services.

4.11.4.4. The MCO's Care Management responsibilities shall include, at a minimum:

4.11.4.4.1 Coordination of physical, mental health, Substance Use Disorder and social services using Provider engagement approaches not inconsistent with those described in this Agreement for certain Department identified Required Priority Populations and Behavioral Health Providers, including but not limited to Community Mental Health Programs and Certified Community Behavioral Health Centers, and other Providers providing Behavioral Health Services;

4.11.4.4.2 [Amendment #1:] Comprehensive medication review results and q~~Q~~uarterly medication reconciliation;

4.11.4.4.3 Monthly telephonic contact with the Member;

4.11.4.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the Care Plan for dissemination to care team participants;

4.11.4.4.5 Referral follow-up monthly;

4.11.4.4.6 Peer support;

4.11.4.4.7 Support for unmet resource needs;

4.11.4.4.8 Training on disease self-management, as relevant; and

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4.11.4.4.9 Transitional Care Management as defined in Section 4.11.6 (Transitional Care Management).

4.11.4.5. [Amendment #1:] The MCO shall convene an initial Care Team for each Required Priority Population Member receiving MCO-Delivered Care Management where necessary to improve health outcomes for the Member, dependent on a Member's needs ~~including~~, including but not limited to, the Member, caretaker(s) and guardian(s), PCP, behavioral health Provider(s), specialist(s), targeted case managers, children's behavioral health system coordinators, Critical Time Intervention coaches, Supportive Housing case~~ing~~ managers, transitional case managers, school personnel, nutritionist(s), and/or pharmacist(s) based on applicable need to participate to effectively support achievement of improved health outcomes for the Member.

4.11.4.6. The ongoing Care Team shall be chosen or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.11.4.7. The MCO shall identify the information necessary to support improved health outcomes for the Member to be shared among all Care Team participants concerned with a Member's care to achieve safer, more effective health care delivery and improved health outcomes for the Member, including how the Provider-Delivered Care Coordination and MCO-Delivered Care Management programs interface with the Member's PCP, behavioral health providers for mental illness, SMI, SPMI, SED, I/DD, and Substance Use Disorder, and other applicable specialist Providers and existing community resources and supports. The MCO shall communicate this information, with the Member or their parent(s)' or guardian(s)' consent in compliance with state and federal laws and regulations.

4.11.4.8. [Amendment #1:] The MCO shall maintain a Care Plan for the Required Priority Population Members and shall work in collaboration with the Member's Care Team ~~to identify responsibilities for the Member's Care Plan which is optimally maintained by the PCP, in collaboration with the Care Team participants~~ within thirty (30) calendar days of the completed Comprehensive Assessment to develop a Care Plan in accordance with [42 CFR 438.208].~~, for each Priority Population Member identified through a Comprehensive Assessment or other means as in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)]~~

4.11.4.8.1 The MCO shall ensure that each Provider furnishing services to Members maintains and shares Member health records in accordance with professional standards. [42 CFR 438.208(b)(5)]

4.11.4.8.2 The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with

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confidentiality requirements in 45 CFR 160 and 164, this Agreement, and all other applicable laws and regulations. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164]

4.11.4.8.3 The MCO shall develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.

4.11.4.8.4 The MCO shall contribute to the Member's Care Plan as follows:

4.11.4.8.4.1. At least quarterly;

4.11.4.8.4.2. When a Member's circumstances or needs change significantly;

4.11.4.8.4.3. At the Member's request;

4.11.4.8.4.4. When a re-assessment occurs; and

4.11.4.8.4.5. Upon the Department's request.

4.11.4.8.5 The MCO shall submit coordinating Care Plan processes to the Department for review as part of the Readiness Review process and annually thereafter.

4.11.4.9. The MCO shall track the Member's progress through routine Care Team conferences, the frequency to be determined by the MCO based on the Member's level of need.

4.11.4.10. The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the Care Team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring. Policies and procedures for discharge shall include a Member notification process.

4.11.4.11. For Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.11.5. **MCO Care Managers**

4.11.5.1. The MCO shall formally designate a Care Manager that is primarily responsible for MCO-Delivered Care Management for each Required Priority Population Member, including regular contact with the Member's PCP who is

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responsible for Provider-Delivered Care Coordination as defined in this Agreement.

4.11.5.2. The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.11.5.3. Care Managers shall have qualifications and competency in the following areas:

4.11.5.3.1 All aspects of person-centered needs assessments and Care Planning;

4.11.5.3.2 Motivational interviewing and self-management;

4.11.5.3.3 Trauma-informed care;

4.11.5.3.4 Cultural and linguistic competency;

4.11.5.3.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and

4.11.5.3.6 Adverse childhood experiences and trauma.

4.11.5.4. Care Managers shall be trained in the following:

4.11.5.4.1 Disease self-management;

4.11.5.4.2 Person-centered needs assessment and Care Planning including coordination of care needs;

4.11.5.4.3 Integrated and coordinated physical and behavioral health, including as they intersect with and are served within the State's Community Mental Health system, Substance Use Disorder system, and Children's Behavioral Health system;

4.11.5.4.4 The State's Behavioral Health Crisis Response system and available resources (for Care Managers with assigned Members with behavioral health needs);

4.11.5.4.5 Cultural and linguistic competency;

4.11.5.4.6 Family support; and

4.11.5.4.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.

4.11.5.5. 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.

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4.11.5.6. The MCO shall provide real-time, high-touch, Care Management for Required Priority Populations and consistent follow up with Providers and Members to assure that Members are making progress with their Care Plans.

4.11.5.7. The MCO shall design an effective Care Management structure for the Required Priority Population Members.

4.11.5.7.1 At a minimum by the measurement period ending June 30, 2026 (SFY 2026), the MCO shall have no less than fifty percent (50%) of each Required Priority Population in MCO-Delivered Care Management.

4.11.5.8. The MCO shall, as described in Section 4.11.6 (Transitional Care Management), demonstrate that it has active access to an Admission, Discharge, Transfer (ADT) data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital or DRF in real-time or near real-time.

4.11.5.8.1 The MCO shall ensure that ADT data from applicable hospitals be made available to the Member's PCP, behavioral health Providers, Care Team, and applicable community-based agencies within twelve (12) hours of the admission, discharge, or transfer.

4.11.6. **Transitional Care Management**

4.11.6.1. For all Members, the MCO shall be responsible, in collaboration with the Member's Care Team, as applicable, which may include the Member's PCP, behavioral health provider(s), specialist(s), targeted case managers, children's behavioral health system service coordinators, Critical Time Intervention coaches, Supportive Housing case managers, and transitional case managers, school personnel as needed, pharmacists, and others as appropriate, for managing transitions of care for all Members moving from one (1) clinical setting to another, including step-up or step-down treatment programs for Members in need of continued mental health and Substance Use Disorder services, to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

4.11.6.2. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management for all Members, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

4.11.6.3. The MCO shall develop policies and procedures for the Department's review, as part of Readiness Review and annually thereafter, which describe how transitions of care between settings shall be effectively managed including data systems that trigger notification that a Member is in transition.

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4.11.6.4. The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(12)]

4.11.6.5. The MCO shall have a documented process to, at a minimum:

4.11.6.5.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.11.6.5.2 Support continuity of care for Members when they move from home to foster care placement; foster care to independent living; return from foster care placement to community; change in legal status from foster care to adoption; or when the Member moves from one level of care to another within the State's behavioral health system for Community Mental Health, Substance Use Disorders, or children's behavioral health;

4.11.6.5.3 [Amendment #1:] Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's Care Plan when a Member of the Required Priority Population is hospitalized;

4.11.6.5.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.12.21 (Agreements for New Hampshire State-Owned Hospital Agreement(s) and Other State Determined IMDs for Mental Illness), and upon discharge from an ED due to a mental illness or substance use disorder; and

4.11.6.5.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.11.6.6. The MCO shall have an established process, inclusive of but not limited to use of the Department's event notification system and closed-loop referral solution, if available, to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs.

4.11.6.6.1 [Amendment #1:] The MCO shall interface with the Department's closed loop referral solution to support Members. The integration shall transfer information and data as necessary to facilitate Member referrals to participating closed loop referral providers.

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4.11.6.7. The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.11.6.8. The MCO shall demonstrate, at a minimum, it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real-time or near real-time.

4.11.6.9. The MCO shall ensure that ADT data from applicable hospitals be made available to PCPs, and behavioral health Providers within twelve (12) hours of the admission, discharge, or transfer.

4.11.6.10. The MCO shall ensure that Transitional Care Management includes, at a minimum:

4.11.6.10.1 Care Management or other services to ensure the Member's Care Plan continues;

4.11.6.10.2 Facilitating clinical hand-offs;

4.11.6.10.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

4.11.6.10.4 Communicating with the Member's PCP about discharge plans and any changes to the Care Plan;

4.11.6.10.5 Conducting medication reconciliation within forty-eight (48) business hours of discharge;

4.11.6.10.6 Ensuring that a Care Manager is assigned to manage the transition, and that the Care Manager collaborates with the Member's applicable Community Mental Health system, Substance Use Disorder system, or Children's Behavioral Health system providers to support the Member's effective transition and continuous access to needed services throughout the transitional period;

4.11.6.10.7 Follow-up by the assigned Care Manager, or otherwise designated member of the Member's care management team, within forty-eight (48) business hours of discharge of the Member;

4.11.6.10.8 Determining when a follow up visit should be conducted in a Member's home;

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4.11.6.10.9 Supporting Members to keep outpatient appointments; and

4.11.6.10.10 [Amendment #1:] A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care within 24 hours of enrollment with the MCO~~who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered~~.

4.11.6.11. The MCO shall assist with coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information.

4.11.6.12. The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.11.6.12.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.11.6.12.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge);

4.11.6.12.3 The hospital's evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.11.6.12.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented.

4.11.7. **Provider-Delivered Care Coordination and Integration with Social Services and Community Care**

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4.11.7.1. The MCO shall implement and provide administrative support of a Provider-Delivered Care Coordination Program that includes reimbursement and other incentives to enable Participating Providers to coordinate health-related and community support services for Members.

4.11.7.2. The MCO shall provide program administrative support that includes, at a minimum:

4.11.7.2.1 Secure transmission of data and other information to Providers about their attributed Members' service utilization and care coordination needs;

4.11.7.2.2 Provider assistance with securing:

4.11.7.2.2.1. Health-related services and community support services, including but not limited to housing, that can improve health and family well-being, including assistance filling out and submitting applications; and

4.11.7.2.2.2. Access to medical-legal partnership for legal issues adversely affecting health, subject to the availability and capacity of a medical-legal assistance Provider.

4.11.7.3. Provider education and training, including:

4.11.7.3.1.1. How to access information about community support services, and housing for Members; and

4.11.7.3.1.2. How to facilitate Member closed-loop referrals utilizing the Department's event notification system and closed-loop referral solution, if available, or another closed-loop referral solution.

4.11.7.3.2 [Amendment #1:] Incentivizing the Provider's use of closed-loop referrals for effective care coordination and reporting on related incentives in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.11.7.4. The MCO shall assist Providers to actively link Members with other State, local, and community programs that may provide or assist Members with health and social services including, but not limited to [42 CFR 438.208(b)(2)(iv)]:

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4.11.7.4.1 Juvenile Justice and Adult Community Corrections;

4.11.7.4.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

4.11.7.4.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.11.7.4.4 Public Health Agencies;

4.11.7.4.5 Schools;

4.11.7.4.6 The court system;

4.11.7.4.7 ServiceLink Resource Network;

4.11.7.4.8 2-1-1 NH;

4.11.7.4.9 Housing; and

4.11.7.4.10 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.11.7.5. The MCO shall report on the number of referrals for social services and community care provided to Required Priority Population Members by Member type, consistent with the format and content requirements in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12. Behavioral Health

4.12.1 General Coordination Requirements

4.12.1.1. This section describes the delivery and coordination of Behavioral Health Services and supports for mental health, Serious Mental Illness, Substance Use Disorders, and Serious Emotional Disturbances, delivered to children, youth and transition-aged youth/young adults, and adults.

4.12.1.2. The MCO shall ensure Behavioral Health Services are delivered in a manner that is both clinically and developmentally appropriate, and that considers the Member, parents, caregivers, and other networks of support the Member may rely upon.

4.12.1.3. The delivery of service shall be Member-centered and align with the principles of system of care, recovery, and resiliency.

4.12.1.4. The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal laws and regulations.

4.12.1.5. The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services, as authorized under the State's Medicaid State Plans and in accordance with the applicable NH Administrative

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Rules identified in this Agreement specific to Behavioral Health Services; ensuring continuity and coordination of care between covered physical health and Behavioral Health Services Providers; and requiring collaboration between physical health and Behavioral Health Providers.

4.12.1.6. The continuum of Behavioral Health Services shall include the following categories of Providers approved by the Department for providing one or more types of services under the State Medicaid Plan, certain Administrative Rules, and under contracts with the Department when necessary to ensure Member access to higher levels of care for Serious Mental Illness, Substance Use Disorder, Serious Emotional Disturbance, and I/DD:

4.12.1.6.1 **Mental Health Services**, including but not limited to psychotherapy, psychological evaluation and testing, authorized in the Medicaid State Plan under Attachment 3.1-A for Medical, Remedial Care and Services. These services shall be provided by appropriately licensed and certified Providers who are not providing the service on behalf of or under agreement with a Community Mental Health Program (also known as Community Mental Health Center) or a Community Mental Health Provider. The MCO shall not authorize payment of these services under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members who are currently eligible for that level of care under He-M 401 and which are only a covered service if provided by Community Mental Health Programs or Community Mental Health Providers.

4.12.1.6.2 **Community Mental Health Services** (CMH Services), authorized in the Medicaid State Plan under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members with current He-M 401 eligibility and which are provided by:

4.12.1.6.2.1. **Community Mental Health Programs** (CMH Programs), also known as Community Mental Health Centers (CMHC) that are currently approved by the Department pursuant to He-M 403; there are ten such programs in NH; or by

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4.12.1.6.2.2. **Community Mental Health Providers** (CMH Providers) that have been previously approved by the Commissioner of the Department of Health and Human Services to provide Community Mental Health Services identified in He-M 426.07-He-M 426.17 for which they have received approval to provide pursuant to He-M 426.04 and remain in compliance with the requirements specified in He-M 426.04.

4.12.1.6.3 **Substance Use Disorder Services** authorized in accordance with the Medicaid State Plan, He-W 513, and where applicable, He-W 300 for Opioid Treatment Programs (OTP).

4.12.2 **Behavioral Health Subcontracts**

4.12.2.1. If the MCO enters into a Subcontractor relationship with a behavioral health (Mental Health, Community Mental Health or Substance Use Disorder Provider) Subcontractor to provide or manage Behavioral Health Services, the MCO shall provide a copy of the agreement between the MCO and the Subcontractor to the Department for review and approval, including but not limited to any agreements with CMH Providers as required in Section 4.12.20 (Community Mental Health Services).

4.12.2.2. Such subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

4.12.2.3. The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to all requirements and guidelines, as outlined in Section 3.10 (Subcontractors).

4.12.3 **Promotion of Integrated Care**

4.12.3.1. The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

4.12.3.2. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall include in its Behavioral Health Strategy Plan

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and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.12.4 **Approach to Behavioral Health Services**

4.12.4.1. The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA[21] and reflect a focus on Recovery and resiliency.[22]

4.12.4.2. The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s).

4.12.4.3. The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

4.12.4.4. In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.12.5 **Behavioral Health Strategy Plan and Report**

4.12.5.1. The MCO shall submit to the Department an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the initial Plan shall address but not be limited to how the MCO shall:

4.12.5.1.1 Assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare;

4.12.5.1.2 Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.12.5.1.3 Assure the promotion of Integrated Care;

4.12.5.1.4 Reduce Psychiatric Boarding described in Section 4.12.20.16 (Psychiatric Boarding);

4.12.5.1.5 Reduce Behavioral Health Readmissions described in Section 4.12.11 (Reduction in Behavioral Health Readmissions and Emergency Department Utilization);

[21] Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at https://www.samhsa.gov/nctic/trauma-interventions.
[22] Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at https://www.samhsa.gov/recovery.

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4.12.5.1.6 Reduce Behavioral Health related emergency department utilization as described in Section 4.12.11 (Reduction in Behavioral Health Readmissions and Emergency Department Utilization);

4.12.5.1.7 Support the NH 10-Year Mental Health Plan23;

4.12.5.1.8 Assure the appropriateness of psychopharmacological medication;

4.12.5.1.9 Assure access to appropriate services;

4.12.5.1.10 Implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and

4.12.5.1.11 Other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.5.2. On an annual basis and in accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which shall include an effectiveness analysis of the initial Plan's program, policies and procedures.

4.12.5.2.1 The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination (i.e., enhanced Care Coordination and Care Management to minimize inpatient readmissions, emergency department utilization, and psychiatric boarding), and collaboration for physical health and Behavioral Health Services.

4.12.6 **Collaboration with the Department**

4.12.6.1. At the discretion of the Department, the MCO shall provide mental health and Substance Use Disorder updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.6.2. To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and the Department at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

[23] New Hampshire Department of Health and Human Services, New Hampshire 10-Year Mental Health Plan (January 2019), available on July 20, 2023 at https://www.dhhs.nh.gov/programs-services/health-care/behavioral-health/10-year-mental-health-plan#:~:text=The%2010-Year%20Mental%20Health%20Plan%20is%20the%20result,health%20needs%20of%20people%20across%20their%20life%20span

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4.12.6.3. Quarterly meetings shall also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O: Quality and Oversight Reporting Requirements. Progress and data reports shall be produced and exchanged between the MCO and the Department two (2) weeks prior to each quarterly meeting.

4.12.6.3.1 At each meeting, the MCO shall update the Department on the following topics:

4.12.6.3.1.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.12.6.3.1.2. Utilization of ACT services and any waitlists for ACT services;

4.12.6.3.1.3. Current EBSE rates;

4.12.6.3.1.4. Current compliance with New Hampshire Hospital discharge performance standards;

4.12.6.3.1.5. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.12.6.3.1.6. Updates regarding services identified in Section 4.12 (Behavioral Health);

4.12.6.3.1.7. Updates on Mental Health and Substance Use Disorder PIPs; and

4.12.6.3.1.8. Other topics requested by the Department.

4.12.6.4. For all Members, the MCO shall work in collaboration with the Department and the NH Suicide Prevention Council to promote suicide prevention awareness programs, including the Zero Suicide program.

4.12.6.5. The MCO shall submit to the Department, as specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, its implementation plan for incorporating the "Zero Suicide" program into its operations; the plan shall include, in addition to any other requirements specified in Exhibit O: Quality and Oversight Reporting Requirements related to the plan, how the MCO shall:

4.12.6.5.1 Incorporate efforts to implement standardized provider screenings and other preventative measures; and

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4.12.6.5.2 Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines and Standards).

4.12.7 **Primary Care Provider Screening for Behavioral Health Needs**

4.12.7.1. The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

4.12.7.2. At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary.

4.12.7.3. The MCO shall encourage PCPs and other Providers to use a screening tool approved by the Department, as well as other mechanisms to facilitate early identification of behavioral health needs.

4.12.7.4. The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

4.12.7.4.1 Demographic,

4.12.7.4.2 Medical,

4.12.7.4.3 Substance Use Disorder,

4.12.7.4.4 Housing,

4.12.7.4.5 Family & support services,

4.12.7.4.6 Education,

4.12.7.4.7 Employment and entitlement,

4.12.7.4.8 Legal, and

4.12.7.4.9 Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.12.7.5. The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

4.12.7.5.1 Depression screening (e.g., PHQ 2 & 9); and

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4.12.7.5.2 Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.12.8 **Referrals**

4.12.8.1. [Amendment #2:] The MCO shall ensure through its initial screening of new Members, Comprehensive Screening for Priority Population Members, ~~HRA Screening (Section 4.10.2) and~~ risk scoring and stratification, or other means at the MCO's discretion that Members with a potential need for Behavioral Health Services, particularly Required Priority Population Members as described in Section 4.11.2 (MCO-Delivered Care Management for Required Priority Populations) are identified by the MCO and appropriately and timely referred to a regionally available CCBHC or other behavioral health Providers if co-located care is not available.

4.12.8.2. [Amendment #2:] This shall include education about Behavioral Health Services, including the availability of CCBHCs, the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s).

4.12.8.3. [Amendment #2:] The MCO shall develop a referral process to be used by Participating Providers, including what information shall be exchanged and when to share this information, as well as notification to the Member's Care Manager. The referral process shall include information about regionally available CCBHCs, including warm hand-off referrals, at the time of a discharge from inpatient, institutional, or substance use disorder residential treatment.

4.12.8.4. The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know when and how to refer Members who need specialty Behavioral Health Services.

4.12.8.5. The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health needs when Integrated Care is not available.

4.12.8.6. The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider.

4.12.8.7. The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.12.9 **Prior Authorization for Behavioral Health Services**

4.12.9.1. As of September 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 517 for behavioral health drugs, including use of the universal online Prior Authorization form provided by the Department for drugs used to treat mental illness.

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4.12.9.2. The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.12.10 **Comprehensive Assessment and Care Plans for Behavioral Health Needs**

4.12.10.1. The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a Care Plan.

4.12.10.2. [Amendment #1:] For Required Priority Population Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by a~~n~~ Care Team~~integrated Provider team~~, the MCO shall maintain a Care Plan and ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and Care Plan development process as well as the ongoing provision of services.

4.12.11 **Reduction in Behavioral Health Readmissions and Emergency Department Utilization**

4.12.11.1. Within the MCO's annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O: Quality and Oversight Reporting Requirements, subject to approval by the Department, the MCO shall develop and detail its plan to reduce readmissions and emergency department utilization attributed to a Member's behavioral health. The plan shall include but is not limited to:

4.12.11.1.1 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs, and other CMH Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day, ninety (90)-day and one hundred and eighty (180)-day readmission.

4.12.11.1.2 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day readmission rates to acute care hospitals attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies

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within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.3 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day repeated ED utilization rates attributed to mental illness, to review Member specific data with each of the CMH Programs, and other CMH Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.4 The MCO's approach to monitoring Members' repeated ED utilization rates within thirty (30)-days and ninety (90)-days attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.5 The MCO's approach to ensuring Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Behavioral Health Services after discharge from inpatient or ED care due to a Behavioral Health reason, with sufficient frequency and amounts, to support the Member's progress on achieving their Behavioral Health goals.

4.12.11.1.6 For Members with readmissions to any inpatient psychiatric setting within thirty (30) days and one hundred and eighty (180) days, the MCO shall report on the CMH and related service utilization that directly proceeded readmission in accordance with Exhibit O: Quality and Oversight Reporting Requirements. This data shall be shared with the Member's CMH Program/CMH Provider, if applicable, and the Department in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.12.12 **Written Consent for Release of Behavioral Health Information**

4.12.12.1. Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider

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request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both, and primary care.

4.12.12.2. The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file.

4.12.12.3. The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.13 **Coordination Among Behavioral Health Providers**

4.12.13.1. The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.12.13.1.1 Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.12.13.1.2 Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.12.13.1.3 Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.12.13.1.4 Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

4.12.13.1.5 Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.12.14 **Member Service Line**

4.12.14.1. As further outlined in Section 4.4.10 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

4.12.14.2. The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a “warm transfer”).

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4.12.14.3. If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.12.15 **Provision of Services Required by Courts**

4.12.15.1. The MCO shall pay for all NH Medicaid State Plan services that are within the Managed Care Program including, but not limited to, assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care only when consistent with Medical Necessity for the service.

4.12.16 **Behavioral Health Member Experience of Care Survey**

4.12.16.1. The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

4.12.16.2. The survey shall be designed by the Department and the MCO's results shall be reported in accordance with Exhibit O: Quality and Oversight Reporting Requirements. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.12.17 **Behavioral Health Emergency Services**

4.12.17.1. The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services.

4.12.17.2. Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program.

4.12.17.2.1 [Amendment #1:] Intentionally left blank. ~~Mobile crisis services may be provided by CMH Programs outside of their designated CMH Region to ensure accessibility to Members in crisis 24 hours a day / 7 days a week and within the Geographic Access Standard requirement. Mobile crisis services provided outside of the applicable CMH region are also included.~~

4.12.17.2.2 CMH Program-delivered emergency services that are not delivered by mobile crisis teams, such as for use in determining whether involuntary emergency admission is required, and applying an existing client's crisis safety plan in an office setting, are also included in the meaning of emergency services, and shall be provided within the CMH Program's applicable CMH region only.

4.12.17.2.3 Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention and who have access to

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a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

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4.12.18 **Behavioral Health Training Plan**

4.12.18.1. [Amendment #2:] In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health service and accessibility capacity for Members within the state and to support the efforts of its Behavioral Health provider network to hire, retain and train qualified staff including, but not limited to, CCBHCs, CMH Programs, other Community Mental Health Providers of services covered under He-M 426, Substance Use Disorder harm reduction, treatment and recovery providers, and other providers of behavioral health services in the MCO's network that provide services under the Medicaid State Plan. The MCO shall ensure that any training provided to employees or Subcontractors of a CCBHC do not violate any specific training restrictions within the SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria, updated March 2023 and any subsequent revisions.[24]

4.12.18.2. The MCO shall coordinate its behavioral health training plan's training offerings with the Department to reduce duplication of training efforts, and shall submit the behavioral health training plan to the Department prior to program start, and annually thereafter, inclusive of the training schedule and target Provider audiences.

4.12.18.3. As part of the behavioral health training plan, the MCO shall also incorporate strategies to engage Providers in accessing the training opportunities, including explaining the benefits of participating in the training, how it may increase or improve provider competence, and how the knowledge gained will lead to improved quality of care. The MCO's approach shall include opportunities for skill-enhancement through its training opportunities and consultation, through either the MCO or other consultants with expertise in the subject of the training.

4.12.18.4. The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.12.18.4.1 Trauma Focused Cognitive Behavioral Therapy;

4.12.18.4.2 Trauma Informed Care;

4.12.18.4.3 Motivational Interviewing;

4.12.18.4.4 Interventions for Nicotine Education and Treatment;

4.12.18.4.5 Dialectical Behavioral Therapy (DBT);

4.12.18.4.6 Cognitive Behavioral Therapy;

4.12.18.4.7 Client Centered Treatment Planning;

4.12.18.4.8 Family Psychoeducation;

[24] [Amendment #2:] SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria available on November 21, 2024 at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

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4.12.18.4.9 Crisis Intervention;

4.12.18.4.10 SBIRT for PCPs;

4.12.18.4.11 Depression Screening for PCPs;

4.12.18.4.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.12.18.4.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

4.12.18.5. The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.12.18.5.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

4.12.18.5.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.12.18.5.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.12.18.5.4 Cross training to ensure that Mental Health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive Mental Health training;

4.12.18.5.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.12.18.5.6 Clinical care integration models to Participating Providers; and

4.12.18.5.7 Community-based resources to address health-related social needs.

4.12.18.6. The MCO shall offer a minimum of two (2) hours of training each Agreement year to all contracted CMH Program staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the Department's objective of reducing the number of suicides in NH.

4.12.18.7. The MCO shall provide, on at least an annual basis, training on appropriate billing practices to Participating Providers. The Department reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

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4.12.18.8. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.12.19 **Parity**

4.12.19.1. The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.12.19.2. Semi-Annual Report on Parity

4.12.19.2.1 The MCO shall complete the Department's Parity Compliance Report which shall include, at a minimum:

4.12.19.2.1.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCO pursuant to the Department's criteria;

4.12.19.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.12.19.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.12.19.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.12.19.2.1.5. Any other requirements identified in Exhibit O: Quality

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and Oversight Reporting Requirements. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.12.19.2.2 The MCO shall review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities.

4.12.19.2.3 The MCO shall annually submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

4.12.19.2.4 If the MCO determines that any administrative, clinical, or utilization practices were not in compliance with relevant requirements of the federal Mental Health Parity Law or guidance issued by State and federal entities during the calendar year, the certification shall state that not all practices were in compliance with federal Mental Health Parity Law or any guidance issued by state or federal entities and shall include a list of the practices not in compliance and the steps the MCO has taken to bring these practices into compliance.

4.12.19.2.5 A Member enrolled in any MCO may file a complaint with the Department at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance.

4.12.19.2.6 As described in Section 4.4 (Member Services), the MCO shall describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.12.19.3. Prohibition on Lifetime or Annual Dollar Limits

4.12.19.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

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4.12.19.4. Restrictions on Treatment Limitations

4.12.19.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.12.19.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.12.19.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO shall provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.12.19.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for Community Mental Health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.12.20 **Community Mental Health Services**

4.12.20.1. General Requirements

4.12.20.1.1 The MCO shall be required to enter into a Department approved capitation model of contracting with every CMH Program that is currently approved by the Department pursuant to NH Code of Administrative Rules, Chapter He-M 403, which is essential to

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supporting Member access to the full continuum of Community Mental Health Services under NH Code of Administrative Rules, Chapter He-M 426 in the MCM program. The MCOs shall utilize a Department provided standard contract for this purpose to ensure continuity of services and care across the Community Mental Health Services systems for Members.

4.12.20.1.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by the Department no later than ninety (90) calendar days after the MCM program's Agreement execution.

4.12.20.1.3 For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in September 2024.

4.12.20.1.4 The MCO shall be subject to payment requirements described in Section 4.16 (Provider Payments).

4.12.20.1.5 The MCO shall comply with key administrative functions and processes for CMH Services delivered by CMH Programs (CMHCs), which may include, but are not limited to:

4.12.20.1.5.1. Timely processing of CMH Services Member eligibility lists, which shall be provided to the MCO by the CMH Programs and shall indicate the Member's eligibility for CMH Services pursuant to the eligibility categories under NH Code of Administrative Rules, Chapter He-M 401. The MCO shall validate the eligibility lists through a process developed in collaboration with the CMH Programs and approved by the Department;

4.12.20.1.5.2. Determining whether Members are eligible for the DHHS-required CMH Services Capitation Payments to CMH Programs, or whether the CMH Program should be paid on a

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FFS basis for the service the Member received;

4.12.20.1.5.3. Providing detailed MCO data submissions to DHHS and the CMH Program for purposes of reconciling payments and performance pursuant to the MCO-CMH Program Contract, and for CMH Services provided by a CMH Provider not under subcontract with a CMH Program for the applicable service for purposes of reconciling payments and performance (e.g., 835 file);

4.12.20.1.5.4. Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs by CMH Region, as defined in NH Code of Administrative Rules, Chapter He-M 425, and with CMH Providers not under subcontract with a CMH Program, to ensure Members have access to Substance Use Disorder treatment services they may need from other providers, if not provided by the CMH Program or the CMH Provider under NH Code of Administrative Rules, Chapter He-M 426; and

4.12.20.1.5.5. Monitoring of CMH Program performance through quality metrics and oversight procedures

4.12.20.1.5.6. Ensuring compliance with this Agreement, where applicable, and all applicable State and federal laws, rules and regulations.

4.12.20.1.5.7. Overseeing, enforcing, and remedying contract disputes

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between the MCO and CMH Program.

4.12.20.1.5.8. All additional capabilities set forth by DHHS during the Readiness Review process.

4.12.20.1.6 [Amendment #2:] In the event a CMH Program is designated by the Department as a Certified Community Behavioral Health Clinic, the MCO shall enter into a different contractual relationship and payment model for the payment and delivery of the full continuum of Community Mental Health Services delivered by the agency, Mental Health Services available at lower levels of care, and applicable Substance Use Disorder services as described in Section 4.16 (Provider Payments).

4.12.20.2. MCO Agreements and Payment for Community Mental Health Services – CMH Providers

4.12.20.2.1 Consistent with 4.14, Network Requirements, the MCO shall maintain and monitor a network of CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who are eligible for such services in accordance with He-M 401.

4.12.20.2.2 The MCO shall provide for monitoring of CMH Provider performance through quality metrics and oversight procedures detailed in the MCO's provider or network agreement with each CMH Provider.

4.12.20.2.3 The MCO shall ensure that its agreements with CMH Providers meet the following requirements:

4.12.20.2.3.1. Comply with the requirements of this Agreement and all applicable State and federal laws, rules and regulations;

4.12.20.2.3.2. Define the role of the MCO versus the CMH Provider;

4.12.20.2.3.3. Include procedures for communication and coordination between the MCO and the CMH Provider, other Providers serving the same Member, CMH Programs as may be required by

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He-M 426 for CMH Provider provided services and the need to collaborate with the applicable CMH Program, and the Department;

4.12.20.2.3.4. Include provisions for data sharing on Members;

4.12.20.2.3.5. Include data reporting between the CMH Provider and the MCO and the Department; and

4.12.20.2.3.6. Include provisions for oversight, enforcement, and remedies for contract disputes.

4.12.20.2.4 The MCO shall ensure that Community Mental Health Services provided by CMH Providers are provided in accordance with the Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426.

4.12.20.2.5 This includes, but is not limited to, ensuring that Community Mental Health Services for which the CMH Provider is currently approved by the Department to provide, are appropriately provided to eligible Members.

4.12.20.2.5.1. [Amendment #2:] [Amendment #1:] Upon the termination of a Member's eligibility with the MCO, the MCO shall end date the Member's ~~CMH Program~~ behavioral health certification eligibility span in the next Behavioral Health Certification Data transmission provided to the Department.

4.12.20.2.6 For all Community Mental Health Services provided by a CMH Provider, the CMH Provider shall comply with He-M 426.04, including but not limited to, ensuring that all Members receiving CMH Services from the CMH Provider have been identified as currently eligible Members to receive CMH Services by a CMH Program, pursuant to He-M 401, and that the CMH Provider has a method for collaborative service planning and service delivery with the regional CMH Program, including joint development and approval of an Individual Service Plan for each Member.

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4.12.20.2.7 [Amendment #3:] Beginning January 1, 2026, the MCO shall provide each CMH Program with a monthly electronic 835 file for reconciling CMH program payments and services.

4.12.20.3. Community Mental Health Services Continuum

4.12.20.3.1 Eligible Members shall be offered the provisions of supports for illness self-management and recovery;

4.12.20.3.2 Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.

4.12.20.3.3 The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.12.20.3.4 As described in He-M 400, only Members who are currently eligible for Community Mental Health Services are eligible to receive Community Mental Health Services. Eligibility shall be determined by a CMH Program pursuant to He-M 401, due to a:

4.12.20.3.4.1. Severe or persistent mental illness (SPMI) for an adult;

4.12.20.3.4.2. SMI for an adult;

4.12.20.3.4.3. SPMI or SMI with low service utilization for an adult;

4.12.20.3.4.4. SED for a child; or

4.12.20.3.4.5. SED and interagency involvement for a child.

4.12.20.3.5 Any MCO quality monitoring or audits of the performance of the CMH Programs or of CMH Providers shall be available to the Department upon request.

4.12.20.3.6 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO shall meet with CMH Programs, CMH Providers, and the Department at least quarterly to coordinate data collection and ensure data sharing.

4.12.20.3.7 At a minimum, this shall include sharing of quality assurance activities conducted by the MCO and the Department and a review of quality improvement plans, data reports, Care Coordination activities, and

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outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.12.20.3.8 The MCO shall work in collaboration with the Department, CMH Programs and CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.12.20.4. Comprehensive Assessment and Care Plans

4.12.20.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of the Department administered quality service reviews for adults, that Community Mental Health Services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans.

4.12.20.4.2 [Amendment #1:] The MCO shall ensure that initial and updated Care Plans maintained by CMH Programs are based on a Comprehensive Assessment conducted and completed by a CMH Program using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

4.12.20.4.3 If the MCO, or a CMH Program acting on behalf of the MCO, elects to permit clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO shall notify and receive approval of the specific tool from the Department.

4.12.20.4.4 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by the Department within one hundred and twenty (120) calendar days of implementation by the Department of a web-based training and certification system.

4.12.20.4.5 The MCO shall require that CMH Program's certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by the Department for any newly evaluated Member and for

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an existing Member no later than at the Member's first eligibility renewal determination for CMH Services, following certification.

4.12.20.5. Assertive Community Treatment (ACT)

4.12.20.5.1 The MCO shall work in collaboration with DHHS, CMH Programs, and CMH Providers to ensure that Members identified as needing ACT services are provided ACT services pursuant to He-M 426.16, and in sufficient quantity to ensure applicable Members have appropriate access to these service.

4.12.20.5.2 In collaboration with the Department, the MCO shall support CMH Programs and CMH Providers, if applicable, to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with the Department to achieve full implementation of ACT.

4.12.20.5.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services.

4.12.20.6. Mental Health Performance Improvement Project

4.12.20.6.1 As outlined in Section 4.13.3.8 (Performance Improvement Projects), the MCO shall focus on the Department's objectives outlined in the NH MCM Quality Strategy.

4.12.20.7. Services for the Homeless

4.12.20.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

4.12.20.7.2 In its contract with CMH Programs, the MCO shall describe how it shall provide appropriate oversight of CMH Program responsibilities, including:

4.12.20.7.2.1. Identifying housing options for Members at risk of experiencing homelessness;

4.12.20.7.2.2. Assisting Members in filing applications for housing and

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gathering necessary documentation;

4.12.20.7.2.3. Coordinating the provision of supportive housing; and

4.12.20.7.2.4. Coordinating housing-related services amongst CMH Programs, the MCO and NH's Housing Bridge Subsidy Program.

4.12.20.7.3 The contract with CMH Programs shall require quarterly assessments and documentation of housing status and homelessness for all Members.

4.12.20.7.4 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) within twenty-four (24) hours upon release.

4.12.20.8. Supported Employment

4.12.20.8.1 In coordination with CMH Programs and CMH Providers, if applicable, the MCO shall actively promote an Evidence Based Supported Employment (EBSE) or an Individual Placement and Support Model of Supported Employment (IPS-SE) to eligible Members, whichever is the Department approved model pursuant to He-M 426.

4.12.20.8.2 The MCO shall obtain fidelity review reports from the Department to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program and CMH Provider, if providing supported employment services.

4.12.20.8.3 In collaboration with DHHS, the MCO shall support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the applicable model's Quality Improvement Plan on file with DHHS to achieve full implementation of the model.

4.12.20.8.4 Based on data provided by the Department, the MCO shall support DHHS's goals to ensure that at least nineteen percent (19%) of adult CMH eligible Members are engaged in a Department approved supported employment model of supported employment services and that employment status is

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updated by the CMH Program and CMH Provider, if applicable on a quarterly basis.

4.12.20.8.5 The MCO shall report the Supported Employment participation rate to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements and provide updates as requested by DHHS during regular behavioral health meetings between the MCO and the Department.

4.12.20.9. Illness Management and Recovery (IMR)

4.12.20.9.1 In coordination with CMH Programs and CMH Providers, if applicable, the MCO shall actively promote the delivery of, and increased penetration rates of, Illness Management and Recovery to Members with SMI and SPMI.

4.12.20.9.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and the Department.

4.12.20.10. Dialectical Behavioral Therapy (DBT)

4.12.20.10.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder.

4.12.20.10.2 The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by the Department during regular behavioral health meetings between the MCO and DHHS.

4.12.20.11. Peer Support Services (PSS)

4.12.20.11.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of PSS provided by Peer Support Specialists who are employees of CMH Programs.

4.12.20.11.2 The MCOs, in coordination with CMH Programs, the Department and Peer Support Agencies authorized by the Department under He-M 402, shall actively promote in a variety of settings, such as New Hampshire Hospital, primary care clinics, EDs, CMH Programs, and CMH Provider sites, the delivery of peer support services provided by Peer Support Agencies under He-M 402.

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4.12.20.11.3 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and DHHS on its efforts to promote Peer Support Services delivered in CMH Program and those provided by Peer Support Agencies under He-M 402.

4.12.20.12. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

4.12.20.12.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems25 for children and youth Members experiencing anxiety, depression, trauma and conduct issues.

4.12.20.12.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.13. First Episode Psychosis

4.12.20.13.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis.

4.12.20.13.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.14. Child Parent Psychotherapy

4.12.20.14.1 In coordination with CMH Programs, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children.

4.12.20.14.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.15. Changes in Healthy Behavior

4.12.20.15.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities.

4.12.20.15.2 [Amendment #1:] Efforts can encompass interventions (e.g., ~~tobacco~~nicotine cessation, "InShape") or other efforts designed to improve health.

[25] Available at: http://www.practicewise.com/portals/0/match_public/index.html.

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4.12.20.15.3 The MCO shall gather smoking status data on all Members and report to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.20.15.4 The MCO shall support CMH Programs to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.12.20.16. Psychiatric Boarding

4.12.20.16.1 The MCO shall provide assistance and support to Members, directly or through the Member's care team, to reduce the frequency and duration of the Member's wait for psychiatric services needed on an acute or crisis basis, regardless of the facility type best-suited to meet the Member's immediate care and treatment needs. The MCO's assistance shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or other State determined facility or IMDs for mental illness or Substance Use Disorder services.

4.12.20.16.2 At the request of the Department, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.12.20.16.3 The MCO shall pay no less than the rate paid by NH Medicaid FFS program for all inpatient and outpatient service categories for billable services related to psychiatric boarding.

4.12.20.16.4 The MCO's capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital or other State determined IMDs for mental illness or Substance Use Disorder services.

4.12.20.16.5 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.20.16.6 At minimum, the Plan shall address how:

4.12.20.16.6.1. The MCO identifies when its Members are in the ED awaiting psychiatric placement or in a

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hospital setting awaiting an inpatient psychiatric bed;

4.12.20.16.6.2. Policies for ensuring a prompt crisis team consultation and face-to-face evaluation;

4.12.20.16.6.3. Strategies for identifying placement options or alternatives to hospitalization; and

4.12.20.16.6.4. Coordination with the CMH Programs and CMH Providers, as applicable, serving Members.

4.12.20.16.7 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.12.20.17. Services [Amendment #2:] Certified Community Behavioral Health (CCBHC)

4.12.20.17.1 [Amendment #2:] Effective for dates of services on or after January 1, 2025, New Hampshire has been awarded a SAMHSA demonstration for CCBHCs. CCBHCs are comprehensive centers for behavioral health needs for all populations, and CCBHCs are required to serve anyone who requests care for mental health or substance use. Under the CCBHC model, CCBHCs are reimbursed through a cost based prospective payment methodology for CCBHC services.

4.12.20.17.2 [Amendment #2:] The MCO shall implement the CCBHC model in accordance with SAMHSA demonstration certification criteria and guidance specified by the Department, and shall support the CCBHCs in implementing the CCBHC model of care for Members.

4.12.20.17.3 [Amendment #2:] The MCO shall work with CCBHCs on quality improvement of required and optional CCBHC measures included in New Hampshire's demonstration. The MCO shall submit narrative

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reports describing their plan and activities supporting CCBHC quality improvement in accordance with Exhibit O: Quality and Oversight Reporting Requirements of this Agreement.

4.12.21 **Agreements for New Hampshire State-Owned Hospital Agreement(s) and Other State Determined IMDs for Mental Illness**

4.12.21.1. [Amendment #3:] The MCO shall utilize the Department's model contract for State-owned New Hampshire Hospital and ~~Hampstead Hospital~~ Covered Services.

4.12.21.2. This collaborative agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program and CMH Provider, as applicable, to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and State-Owned Hospitals and other State determined IMDs for mental illness.

4.12.21.3. The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to State-Owned Hospitals and other State determined IMDs for mental illness.

4.12.21.4. Prior to admission to State-Owned Hospitals or other State determined IMDs for mental illness, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist.

4.12.21.5. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to State-Owned Hospitals and determine whether all available less restrictive alternative services and supports are unsuitable.

4.12.22 **Discharge Planning**

4.12.22.1. The MCO shall ensure that upon discharge from a State-Owned Hospital, inpatient psychiatric facility, or other State determined IMDs for mental illness, the Member has immediate access to an appropriate living situation rather than a homeless shelter.

4.12.22.2. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

4.12.22.3. At the Department's option, the MCO shall designate an off-site liaison with privileges to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to State-Owned Hospitals or other State determined IMDs for mental illness.

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4.12.22.4. In the event the Member is attributed to a CMH Program upon their admission or discharge, the MCO's liaison shall assist and collaborate with the applicable CMH Program to expedite discharge and engagement in ongoing CMH Services provided by the CMH Program or CMH Provider, as may be applicable, which may include the Member's participation in Critical Time Intervention, Supportive Housing Services, or other Department approved evidence based practices covered as an In Lieu of Service, a 1915(i) service, or under a Department approved contract for Transitional Housing Services.

4.12.22.5. In the event the Member is not attributed to a CMH Program upon admission or discharge, the MCO's shall actively participate in State-Owned Hospital and other State determined IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

4.12.22.6. The MCO shall actively participate, and assist State-Owned Hospitals and other State determined IMDs for mental illness staff in the development of a written discharge plan within twenty-four (24) hours of admission.

4.12.22.7. [Amendment #2] The MCO shall ensure that the final ~~State-Owned Hospitals or other State determined IMDs for mental illness~~ discharge instruction sheet ~~shall~~ be provided to the Member and the Member's authorized representative prior to discharge, or the next business day after the discharge, for at least ninety-eight percent (98%) of Members discharged from State-Owned Hospitals or other State determined IMDs for mental illness.

4.12.22.8. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.12.22.9. For ACT team service recipients, the MCO shall ensure that the discharge progress note is provided to the CMH Program or CMH Provider, if applicable, within twenty-four (24) hours of Member discharge.

4.12.22.10. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.12.22.11. The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from State-Owned Hospitals and other State determined IMDs for mental illness in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.12.22.12. The performance metric shall be that one hundred percent (100%) of Members discharged shall have been attempted to be contacted within three (3) business days.

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4.12.22.12.1 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member within twenty-four (24) hours.

4.12.22.12.2 The MCO shall ensure an appointment with a CMH Program or CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member.

4.12.22.13. Such appointment shall occur within seven (7) calendar days after discharge.

4.12.22.14. Members receiving ACT team services shall be seen within twenty-four (24) hours of discharge by the applicable CMH Program or CMH Provider.

4.12.22.15. For Members discharged from psychiatric hospitalization who are not currently attributable to a CMH Program, the Member shall have an intake appointment that is scheduled to occur with the CMH Program assigned to the CMH Region in which the Member resides within seven (7) calendar days after discharge.

4.12.22.16. The MCO shall work with DHHS and the applicable CMH Program and CMH Provider to review cases of Members that New Hampshire Hospital and other State determined IMDs for mental illness have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

4.12.23 **Administrative Days and Post Stabilization Care Services**

4.12.23.1. The MCO shall perform Member in-reach activities within State-Owned Hospitals and other State determined IMDs for mental illness and other State determined IMDs for mental illness designed to accomplish transitions to the community in collaboration with the CMH Program applicable to the CMH Region to which the Member's town of residence is attributed. These activities shall include, but not be limited to:

4.12.23.1.1 The MCO's use of the Department's event notification system and closed-loop referral solution, if available, to facilitate sharing of clinical, care, transition to other levels of care, discharge planning, CMH eligibility assessment, and final discharge information;

4.12.23.1.2 The MCO's and CMH Program's meaningful and effective collaboration with applicable members of the IMD's care team assigned to the Member to ensure that the MCO and CMH Program are appropriately informed of the Member's ongoing care needs post-discharge.

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4.12.23.1.3 In the event the Member declines to consent to the CMH Program's involvement in discharge planning and the CMH Program becoming their post-discharge ongoing provider of CMH Services, the MCO shall follow this same approach to in-reach activities utilizing the Member's CMH Provider, if applicable, or other Mental Health Services provider of covered services at levels lower than CMH Services. In such cases, the MCO shall directly, or through the other CMH Provider or Mental Health services, connect, in sufficient frequency and effective duration, with the Member post-discharge to ensure the Member's access to the post-discharge services is sufficient to support the Member's continued progress toward achieving the behavioral health related goals.

4.12.24 **Substance Use Disorder**

4.12.24.1. The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including but not limited to, Chapter 420-J, Section J:15 through Section J:19 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.12.24.2. In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.12.24.3. The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.12.25 **Contracting for Substance Use Disorder**

4.12.25.1. The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.[26]

4.12.25.2. The contract between the MCO and the Substance Use Disorder programs and Participating Providers shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.10.2 (Contracts with Subcontractors).

4.12.25.3. The contract shall, at minimum, address the following:

4.12.25.3.1 The scope of services to be covered;

[26] Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html.

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4.12.25.3.2 Compliance with the requirements of this Agreement and applicable State and federal law;

4.12.25.3.3 The role of the MCO versus the Substance Use Disorder program and/or Provider;

4.12.25.3.4 Procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider;

4.12.25.3.5 Other Providers serving the same Member, and DHHS as applicable;

4.12.25.3.6 The approach to payment, including payment for MAT services;

4.12.25.3.7 Data sharing on Members;

4.12.25.3.8 Data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and

4.12.25.3.9 Oversight, enforcement, and remedies for contract disputes.

4.12.25.4. The contract shall provide for monitoring of Substance Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.12.25.5. When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the State through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract.

4.12.25.6. Intentionally left blank.

4.12.25.7. When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.12.26 **Provision of Substance Use Disorder Services**

4.12.26.1. The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513, this includes but is not limited to all of the MCO's Substance Use Disorder service providers' compliance with the Covered Services provisions in He-W 513.0 applicable to their provider type, to Opioid Treatment Programs, other Substance Use Disorder Treatment, and Recovery Services providers. This includes, but is not limited to:

4.12.26.1.1 Ensuring that the full continuum of care is appropriately provided to eligible Members including, but not limited to the provision of treatment and services that meet the Member's assessed ASAM level of care needs, and subject to the following

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additional conditions associated with certain providers of Substance Use Disorder services:

4.12.26.1.1.1. For those providers for whom the MCO is contracted with under a Department-approved directed payment model, such as Community Mental Health Programs, or a prospective payment system model, such as Certified Community Behavioral Health Clinics, the MCO's obligation to ensure the provision of the continuum of care shall be achieved through the MCO's review of services provided to Members, audits of clinical records no less than annually, and through its collaboration between those providers and the balance of the Member's care team, as appropriate;

4.12.26.1.1.2. Ensuring that eligible Members are provided with recovery support services; and

4.12.26.1.1.3. Ensuring that eligible Members are provided with coordinated care by the current treatment program provider and the provider(s) to whom the Member is being referred for ongoing treatment and services when entering or leaving a treatment program.

4.12.26.1.2 For those providers for whom the MCO is contracted with under a Department-approved directed payment model, such as Community Mental Health Programs, or a prospective payment system model, such as Certified Community Behavioral Health Clinics, the MCO's obligation to ensure the provision of coordinated care shall be achieved through the MCO's direct involvement that facilitates connection between the providers, or at minimum confirms that the connection has been made between the providers.

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4.12.26.1.3 In the event the MCO cannot ensure or otherwise confirm that the Member has been connected to subsequent treatment or other services identified as necessary for the Member, within a time period that is sufficient to support effective continuity of care, including authorization of pharmacotherapy, the MCO shall contact the Member directly to facilitate connection to such services.

4.12.26.2. The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513, through mechanisms including but not limited to claims utilization review, record audits, reauthorizations when applicable, and provider enrollment qualifications and certification audits.

4.12.26.2.1 The MCO shall conduct reviews and audits of clinical records and claims for Members receiving Substance Use Disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP), as described in separate guidance.

4.12.26.2.2 For Providers of Substance Use Disorder services that are delivered through CMH Programs under a Department approved APM, and Certified Community Behavioral Health Clinic under a Department approved PPS, this shall be limited to analysis of utilization patterns, provider and Department released quality reviews, and MCO conducted audits as required by the Department in this Agreement.

4.12.26.3. The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes, including, but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.12.26.4. The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.12.26.5. This includes, but is not limited to:

4.12.26.5.1 Ensuring that Members at-risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and

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4.12.26.5.2 Providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether a Peer Recovery Support Service (PRSS) is an aspect of an additional service provided to the Member.

4.12.26.6. The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.

4.12.26.7. The provision of services to recipients enrolled in an MCO shall not be subject to more stringent service coverage limits than specified under this Agreement or State Medicaid policies.

4.12.27 **Substance Use Disorder Clinical Evaluations and Treatment Plans**

4.12.27.1. The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

4.12.27.2. A clinical evaluation is a biopsychosocial evaluation completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.

4.12.27.3. The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013 or as revised by ASAM.

4.12.27.4. The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission.

4.12.27.5. For a Member being transferred from or otherwise referred by another Provider, the Provider shall use the clinical evaluation completed by a licensed behavioral health professional from the referring agency, which may be amended by the receiving Provider.

4.12.27.6. [Amendment #2:] The Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation (or three (3) sessions, if the Member is meeting with an outpatient treatment provider no more than once per week), that addresses problems in all ASAM ~~2013~~ domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).

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4.12.27.7. The treatment plan shall include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.12.27.8. [Amendment #2:] Treatment plans shall be updated based on any changes in any ASAM domain and at minimal intervals as described by ASAM ~~(2013)~~ for each level of care.

4.12.27.9. Treatment plan updates shall include:

4.12.27.9.1 Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.12.27.9.2 Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives, as appropriate;

4.12.27.9.3 The Provider's assessment of whether or not the Member needs to move to a different level of care based on ASAM continuing care, transfer and discharge criteria; and

4.12.27.9.4 The signature of the Member and the Provider agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.12.28 **Substance Use Disorder Performance Improvement Project**

4.12.28.1. In compliance with the requirements outlined in Section 4.13.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum, conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.12.29 **Reporting**

4.12.29.1. The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O: Quality and Oversight Reporting Requirements including, but not limited to, measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment retention, safety monitoring, and service utilization.

4.12.29.2. The MCO shall provide, in accordance with Exhibit O: Quality and Oversight Reporting Requirements, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns.

4.12.29.3. The MCO shall conduct reviews and audits of clinical records and claims for Members receiving Substance Use Disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).

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4.12.29.4. The MCO shall utilize audit tool(s) provided by or approved by DHHS, collected via one or more mediums made available or approved by DHHS, to assess the activities of Substance Use Disorder Providers and Opioid Treatment Programs (OTPs), to ensure compliance with the He-W 513 rules, He-A 304 rules, and the MCO Contract, and this Agreement. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.12.29.4.1 The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorders conducted by the MCO or on behalf of the MCO.

4.12.29.4.2 The MCO shall report on SUD Provider compliance with service provisions outlined in the SUD audit tool in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.29.5. [Amendment #2:] On a ~~monthly~~quarterly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members.

4.12.29.6. The MCO shall also provide annual training to Participating Providers.

4.12.30 **Services for Members Who are Homeless or At-Risk of Homelessness**

4.12.30.1. In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.12.20.7 (Services for the Homeless).

4.12.31 **Peer Recovery Support Services**

4.12.31.1. In coordination with Peer Recovery Programs and Peer Recovery Coaches, as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.12.32 **Naloxone Availability**

4.12.32.1. The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.12.33 **Prescription Drug Monitoring Program**

4.12.33.1. The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

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4.12.33.2. The Provider agreements shall require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

4.12.33.3. The MCO 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.

4.12.34 **Response After Overdose**

4.12.34.1. Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital.

4.12.34.2. Whenever a Member discharges themselves against medical advice, the MCO shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.12.34.3. Limitations on Prior Authorization Requirements

4.12.34.3.1 To the extent permitted under State and federal law, the MCO shall cover MAT.

4.12.34.3.2 Methadone received at a methadone clinic shall not require Prior Authorization.

4.12.34.3.3 Methadone used to treat pain shall require Prior Authorization.

4.12.34.3.3.1. Any Prior Authorization for office based MAT shall comply with RSA 420-J:17 and RSA 420-J:18.

4.12.34.3.4 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per treated Member.

4.12.34.3.5 In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.12.34.3.6 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.12.34.3.7 The MCO may require prior authorization for SUD treatments, excluding MAT services.

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4.12.34.3.8 The MCO shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

4.12.34.3.9 Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

4.12.34.3.10 [Amendment #2:] The MCO may require prior authorization for covered services only if the MCO has a medical clinician or licensed alcohol and drug counselor available on a 24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care, and the MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than 6 hours of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria, as ~~defined in~~ specified in Section 2.1.9.1 of this Agreement~~RSA 420-J:15, I~~.

4.12.34.3.11 The Department may grant exceptions to this provision in instances where it is necessary to prevent Fraud, Waste or Abuse.

4.12.34.3.12 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.4 (Pharmacy Clinical Policies and Prior Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.12.34.4. Opioid Prescribing Requirements

4.12.34.4.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members.

4.12.34.4.2 As required under the NH Board Administrative Rule MED 502 Opioid Prescribing, the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.12.34.4.2.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

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4.12.34.4.2.2. Random and periodic UDS; and

4.12.34.4.2.3. Utilizing written, informed consent.

4.12.34.4.3 The MCO shall ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED or more per day for longer than ninety (90) calendar days.

4.12.34.4.3.1. If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.12.34.5. Neonatal Abstinence Syndrome

4.12.34.5.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2.

4.12.34.5.2 Substance Use Disorder Care Management features shall include, but not be limited to:

4.12.34.5.2.1. Conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose).

4.12.34.5.2.2. Ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services.

4.12.34.5.2.3. Scheduling Substance Use Disorder treatment appointments and following up to

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ensure appointments are attended.

4.12.34.5.2.4. Coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies.

4.12.34.5.2.5. The MCO shall make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.12.34.5.3 The MCO shall work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed.

4.12.34.5.4 The MCO shall work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care.

4.12.34.5.4.1. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.12.34.5.5 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment protocol for infants at risk of NAS.

4.12.34.5.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.12.34.5.6.1. Opportunities for the primary care giver(s) to room-in;

4.12.34.5.6.2. Transportation and childcare for the primary care giver(s);

4.12.34.5.6.3. Priority given to non-pharmaceutical approaches

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(e.g., quiet environment, swaddling);

4.12.34.5.6.4. Education for primary care giver(s) on caring for newborns;

4.12.34.5.6.5. Coordination with social service agencies proving supports, including coordinated case meetings and appropriate developmental services for the infant;

4.12.34.5.6.6. Information on family planning options; and

4.12.34.5.6.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.12.34.5.7 The MCO shall work with the Department and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network's (NNEPQIN) standards.

4.12.34.6. Discharge Planning After Substance Use Disorder Event

4.12.34.6.1 In all cases where the MCO is notified or otherwise learns that a Member has had an ED visit or is hospitalized for an overdose or Substance Use Disorder, the MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan.

4.12.34.6.2 The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged.

4.12.34.6.3 The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.12.34.6.3.1. If a Member lacks a reasonable means of communicating with a

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plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.12.34.6.4 The MCO shall ensure that any referrals necessary to connect the Member to post-discharge treatment Provider(s) are made as closed-loop referrals prior to the Member's discharge, including those that may be necessary for an ASAM evaluation.

4.12.34.6.5 The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

4.12.34.6.6 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.12.34.6.7 At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.12.34.6.8 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member within twenty-four (24) hours.

4.12.34.6.9 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.12.34.6.10 [Amendment #1:] In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been treated in an EDseen for more than three (3) overdose events within a thirty (30) calendar day period or those when the ED discharged Member with a behavioral health diagnosis hasthat have had a

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difficulty engaging in treatment services following referral and Care Management~~Coordination~~ provided by the MCO.

4.12.34.6.11 The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.13 Quality Management

4.13.1 General Provisions

4.13.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.13.1.2. The MCO shall work in collaboration with the Department, Members and Providers to actively improve the quality of care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement.

4.13.1.3. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.13.1.4. The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.13.1.5. The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.13.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.13.1.5.2 Foster data-driven decision-making;

4.13.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.13.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.13.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

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4.13.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.13.2 **Health Plan Accreditation**

4.13.2.1. The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module.

4.13.2.2. If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.13.2.3. If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date.

4.13.2.4. To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.13.2.4.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify the Department of the initiation of the process to obtain NCQA Health Plan Accreditation; and

4.13.2.4.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, the MCO shall notify the Department of the date of the scheduled on-site review.

4.13.2.5. The MCO shall inform the Department of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation.

4.13.2.6. The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to the Department, including [42 CFR 438.332(a)]:

4.13.2.6.1 Accreditation status, survey type, and level (as applicable);

4.13.2.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.13.2.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1-3)]

4.13.2.7. 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

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protocols and that the Department shall consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.13.2.8. An MCO going through an NCQA renewal survey shall complete the full Accreditation review of all NCQA Accreditation Standards.

4.13.2.9. During the renewal survey, the MCO shall:

4.13.2.9.1 Request from NCQA the full review of all NCQA Accreditation Standards and cannot participate in the NCQA renewal survey option that allows attestation for certain requirements; and

4.13.2.9.2 Submit to the Department a written confirmation from NCQA stating that the renewal survey for the MCO will be for all NCQA Accreditation Standards without attestation.

4.13.3 **Quality Assessment and Performance Improvement Program**

4.13.3.1. The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.13.3.2. The MCO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to the Department for its review annually.

4.13.3.3. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the QAPI Plan shall contain at a minimum, the following elements:

4.13.3.3.1 A description of the MCO's organization-wide QAPI program structure;

4.13.3.3.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.13.3.3.2.1. Department-required PIPs;

4.13.3.3.2.2. Department-required quality performance data;

4.13.3.3.2.3. Department-required quality reports; and

4.13.3.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.13.3.3.2.5. Mechanisms to detect both underutilization and

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overutilization of services; [42 CFR 438.330(b)(3)]

4.13.3.3.2.6. 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

4.13.3.3.2.7. 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)]

4.13.3.4. The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.13.3.5. The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.13.3.5.1 Is organization-wide, with clear lines of accountability within the organization;

4.13.3.5.2 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;

4.13.3.5.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.13.3.5.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

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4.13.3.6. If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by 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 MCO's QAPI Plan submitted to the Department annually.

4.13.3.7. 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.

4.13.3.8. Performance Improvement Projects

4.13.3.8.1 The MCO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.13.3.8.2 Throughout the contract period, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

4.13.3.8.2.1. At least one (1) clinical PIP shall have a focus on the Department's objectives outlined in the NH MCM Quality Strategy;

4.13.3.8.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.12.24 (Substance Use Disorder);

4.13.3.8.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by the Department;

4.13.3.8.2.4. If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the

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seventy-fifth (75th) percentile; and

4.13.3.8.2.5. Should no quality measure have a lower than seventy-fifth (75th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.13.3.8.3 Throughout the five-year contract term, the MCO shall conduct at least one (1) non-clinical PIP, which shall be related to one (1) of the following topic areas and approved by the Department:

4.13.3.8.3.1. Addressing health-related social needs; and

4.13.3.8.3.2. Integrating physical and behavioral health.

4.13.3.8.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

4.13.3.8.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.13.3.8.5.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.13.3.8.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.13.3.8.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.13.3.8.5.4. Planning and initiation of activities for increasing or

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sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.13.3.8.6 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.

4.13.3.8.7 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO 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 MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.13.3.8.8 At the sole discretion of the Department, the PIPs may be delayed in the event of a public health emergency.

4.13.4 **Member Experience of Care Survey**

4.13.4.1. The MCO shall be responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.13.4.1.1 CAHPS Health Plan Survey 5.1H, Adult Version or later version as specified by the Department;

4.13.4.1.2 CAHPS Health Plan Survey 5.1H, Child Version with Children with Chronic Conditions Supplement or later version as specified by the Department.

4.13.4.2. Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by the Department and indicated in Exhibit O: Quality and Oversight Reporting Requirements. Supplemental questions, including the number, are subject to NCQA approval each October preceding the survey fielding timeframe.

4.13.4.3. The MCO shall obtain the Department approval of instruments prior to fielding the CAHPS surveys.

4.13.5 **Quality and Administrative Reporting Deliverables**

4.13.5.1. Required quality and administrative reporting deliverables appear in this Agreement and/or in Exhibit O: Quality and Oversight Reporting Requirements. For ease of reference, the Department shall list quality deliverables in Exhibit O: Quality and Oversight Reporting Requirements where possible. When a reporting requirement is included in the Agreement, but not Exhibit O, or vice versa, the MCO shall still fulfill the requirement. These deliverables include:

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4.13.5.1.1 Quality measures;

4.13.5.1.2 Narrative Reports;

4.13.5.1.3 Plans; and

4.13.5.1.4 Templates.

4.13.5.2. The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with the submission frequency established in 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)]:

4.13.5.2.1 Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)] to include;

4.13.5.2.1.1. CMS Child Core Set of Health Care Quality deliverables for Medicaid and CHIP, as specified by the Department;

4.13.5.2.1.2. Deliverables included in any future CMS Universal Foundation Measure list;

4.13.5.2.1.3. CMS Adult Core Set of Health Care Quality Measures deliverables for Medicaid, as specified by the Department;

4.13.5.2.1.4. Deliverables indicated by the Department as a requirement for fulfilling CMS waiver requirements; and

4.13.5.2.1.5. Deliverables indicated by the Department as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.13.5.2.2 NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA.

4.13.5.2.2.1. The MCO shall include supplemental Confidential Data in HEDIS measures identified in Exhibit O: Quality and Oversight Reporting Requirements for NCQA Accreditation and

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reporting through the Interactive Confidential Data Submission System.

4.13.5.2.2.2. The MCO shall report Member level Confidential Data for audited HEDIS measures as identified in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.2.3 All available CAHPS measures and sections and additional supplemental questions defined by the Department;

4.13.5.2.4 Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts; and

4.13.5.2.5 Select measures specified by the Department as priority measures for use in assessing and addressing local challenges to high-quality care and access;

4.13.5.3. Where the Department, NCQA, CMS or other key stakeholders require the use of electronic clinical data in deliverable calculation, the MCO shall obtain this data as stipulated in measure specifications and by the measure stewards.

4.13.5.4. If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to the Department.

4.13.5.5. 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 MCO quality measure reporting requirements shall be communicated to MCOs and documented within a format similar to Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.6. The MCO shall report all quality deliverables in accordance with Exhibit O: Quality and Oversight Reporting Requirements, regardless of whether the MCO has achieved accreditation from NCQA.

4.13.5.7. The MCO shall submit all quality deliverables in the formats and schedule in Exhibit O: Quality and Oversight Reporting Requirements or otherwise identified by the Department.

4.13.5.8. The MCO shall work with the Department to ensure their understanding of Department deliverable specifications, deliverable submission processes, and deliverable review processes. This includes, as determined by the Department:

4.13.5.8.1 The MCO shall gain access to and utilize the NH Medicaid Quality Information System, to include participation in any Department-required training deemed necessary;

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4.13.5.8.2 The MCO shall gain access to and utilize the Department SharePoint site utilized for deliverables other than measures, to include any deliverables which contain confidential data;

4.13.5.8.3 The MCO shall attend all meetings with relevant MCO subject matter experts to discuss specifications for deliverables indicated in Exhibit O: Quality and Oversight Reporting Requirements; and

4.13.5.8.4 The MCO shall communicate and distribute all specifications and templates provided by the Department for deliverables in Exhibit O: Quality and Oversight Reporting Requirements, to all MCO subject matter experts involved in the production of deliverables in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.9. The Department shall provide the MCO, with a ninety (90) calendar day notice, any additions or modifications to the deliverables and quality deliverable specifications.

4.13.5.10. At such time as the Department provides access to Medicare Confidential Data sets to the MCO, the MCO 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 MCO shall:

4.13.5.10.1 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;

4.13.5.10.2 Include Medicare Confidential Data in the Department quality reporting; and

4.13.5.10.3 Sign Confidential Data use Agreements and submit Confidential Data management plans, as required by the Department and CMS.

4.13.5.10.4 For failure to submit required reports and quality Confidential Data to the Department, NCQA, the EQRO, and/or other Department-identified entities, the MCO shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

4.13.6 **Evaluation**

4.13.6.1. The Department shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O:

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Quality and Oversight Reporting Requirements, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.13.6.1.1 Performance on required quality measures; and

4.13.6.1.2 The MCO's QAPI Plan.

4.13.6.2. Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.13.6.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.13.6.2.2 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;

4.13.6.2.3 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;

4.13.6.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.13.6.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.13.6.3. The annual evaluation report, developed in accordance with Exhibit O: Quality and Oversight Reporting Requirements, shall be reviewed and approved by the MCO's governing body and submitted to the Department for review [42 CFR 438.330(e)(2)].

4.13.6.4. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as for posting on the web.

4.13.6.5. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of Quality Management activity are documented and reported on a semi-annual basis to the Department and reviewed by the appropriate individuals within the organization.

4.13.7 **Accountability for Quality Improvement**

4.13.7.1. External Quality Review

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4.13.7.1.1 The MCO shall collaborate and cooperate fully with the Department's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.13.7.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

4.13.7.1.3 To facilitate this process, the MCO shall supply information, including but not limited to:

4.13.7.1.3.1. Claims data,

4.13.7.1.3.2. Medical records,

4.13.7.1.3.3. Operational process details, and

4.13.7.1.3.4. Source code used to calculate performance measures to the EQRO as specified by the Department.

4.13.7.2. Auto-Assignment Algorithm

4.13.7.2.1 As indicated in Section 4.3.4 (Auto-Assignment), the auto-assignment algorithm shall, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members.

4.13.7.2.2 The measures used to determine auto-assignment shall not be limited to alignment with the priority measures assigned to the program MCM Withhold and Incentive Program, as determined by the Department.

4.13.7.3. Quality Performance Withhold

4.13.7.3.1 As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by the Department and indicated to the MCO in periodic guidance.

4.14 Network Management

4.14.1 Network Requirements

4.14.1.1. The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.14.1.1.1 Supported by written agreements; and

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4.14.1.1.2 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)]

4.14.1.2. In developing its Participating Provider network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.14.1.3. The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1); 42 CFR 455.101; Section 1932(d)(5) of the Act].

4.14.1.4. The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.14.1.5. The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.14.1.6. 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.

4.14.1.7. The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions. [42 CFR 438.3(q)(1)]

4.14.1.8. The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(3)]

4.14.1.9. The MCO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.14.1.10. The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.14.1.11. When contracting with DME Providers, the MCO shall contract with and have in its network all qualified Willing Providers in the State.

4.14.2 **Provider Enrollment**

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4.14.2.1. The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.14.2.2. The MCO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by the Department for determination of the MCO's network adequacy.

4.14.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.14.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the MCO.

4.14.2.2.3 The MCO 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.

4.14.2.3. The MCO 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.

4.14.2.4. If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.14.2.5. The requirements in 42 CFR 438.12(a) shall not be construed to:

4.14.2.5.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.14.2.5.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.14.2.5.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1-3)]

4.14.2.6. The MCO shall ensure that Participating Providers are enrolled with the Department 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]

4.14.3 Provider Screening, Credentialing and Re-Credentialing

4.14.3.1. The Department shall screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

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4.14.3.2. The MCO 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)]

4.14.3.3. The MCO 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.

4.14.3.4. The MCO 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)]

4.14.3.5. The MCO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)]

4.14.3.6. The MCO 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.

4.14.3.7. For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.14.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with the Department;

4.14.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.14.3.7.3 Concurrently work through MCO and the Department contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.14.3.7.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.14.3.7.4.1. Authorization of out-of-network services;

4.14.3.7.4.2. Single case agreements for an individual Member; and

4.14.3.7.4.3. If agreed upon by the prospective Participating

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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.

4.14.3.8. The MCO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.14.3.8.1 [Amendment #4:] For PCPs (and mental health providers effective January 1, 2026) , within thirty (30) calendar days of receipt of clean and complete credentialing applications; RSA 420-J:4, I(h)

4.14.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications; and

4.14.3.8.3 For any Provider submitting new or missing information for its credentialing application, the MCO shall act upon the new or updated information within ten (10) business days.

4.14.3.9. The start time for the approval process begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.14.3.10. A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.14.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.14.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.14.3.11. In the event the MCO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in this section.

4.14.3.12. For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by the Department or its designee, the MCO shall be fined in accordance with Exhibit N(Liquidated Damages Matrix).

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4.14.3.13. Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.14.4 **Provider Engagement**

4.14.4.1. Provider Support Services

4.14.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

4.14.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.14.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday, and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision, except Department-approved holidays.

4.14.4.1.1.3. Ability for Providers to contact the MCO regarding contracting, billing, and service provisions;

4.14.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, health-related social needs, and quality, privacy and confidentiality of certain conditions;

4.14.4.1.1.5. Training curriculum, to be developed, in coordination with the Department that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for

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EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.14.4.1.1.6. Training on billing and required documentation;

4.14.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.14.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as described this Agreement; and

4.14.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

4.14.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.14.4.1.3 As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of Department-approved holidays. The Provider call center shall meet the following minimum standards, which may be modified by the Department as necessary:

4.14.4.1.3.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

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4.14.4.1.3.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds; and

4.14.4.1.3.3. 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).

4.14.4.1.4 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.14.4.1.5 The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.14.4.1.6 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs.

4.14.4.1.7 The Department may provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

4.14.4.1.8 The MCO 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.

4.14.5 Provider Advisory Board

4.14.5.1. The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback

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on the MCM program, and shall include representation from at least one (1) FQHC, and at least one (1) CMH Program.

4.14.5.2. The Provider Advisory Board should meet face-to-face and/or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.14.6 **Provider Contract Requirements**

4.14.6.1. General Provisions

4.14.6.1.1 The MCO's agreement with health care Providers shall:

4.14.6.1.1.1. Be in writing;

4.14.6.1.1.2. Be in compliance with applicable State and federal laws and regulations; and

4.14.6.1.1.3. Include the requirements in this Agreement.

4.14.6.1.2 The MCO shall submit all model Provider contracts to the Department for review before execution of the Provider contracts with NH Medicaid Providers.

4.14.6.1.3 The MCO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.14.6.1.4 The Department retains the right to reject or require changes to any Provider contract.

4.14.6.1.5 In all contracts with Participating Providers, the MCO 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.

4.14.6.1.6 In all contracts with Participating Providers, the MCO 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)]

4.14.6.1.7 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act

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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.

4.14.6.1.8 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.14.6.1.9 The MCO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.14.6.1.10 Within 90 days upon availability or in accordance with applicable law, the MCO shall include in Provider contracts or MCO provider office reference manual a requirement securing cooperation with the QAPI program and shall align the QAPI program to other Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.15 (Alternative Payment Models).

4.14.6.1.11 The MCO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.14.6.1.12 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.15 (Alternative Payment Models).

4.14.6.1.13 The MCO may execute Participating Provider agreements and begin credentialing, 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 the Department that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120)

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day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.14.6.1.14 [Amendment #2:] The MCO shall notify the Department on a Department developed form no later than fourteen (14) calendar days in advance of the one hundred twenty (120) calendar day termination period to request the Department's assistance with NH Medicaid provider enrollment ~~which may be available for~~ pending ~~enrollment~~ applications.

4.14.6.1.15 The MCO shall notify impacted Members upon the MCO's Provider termination at the end of the one hundred twenty (120) day period.

4.14.6.1.16 The MCO shall maintain a Provider relations presence in NH, as approved by the Department.

4.14.6.1.17 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.14.6.1.17.1. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.14.6.1.17.2. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by the Department.

4.14.6.1.17.3. Provider materials shall comply with State and federal laws and the Department and NHID requirements.

4.14.6.1.17.4. The MCO 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.

4.14.6.1.17.5. Any revisions to the Provider Manual(s) and Provider training materials required by the Department shall be provided to

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the MCO within thirty (30) calendar days.

4.14.6.1.18 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and all Participating Providers, including any necessary specialty manuals (e.g., behavioral health).

4.14.6.1.18.1. The Provider Manual shall be available and easily accessible on the web and updated no less than annually.

4.14.6.1.18.2. The Provider Manual shall consist of, at a minimum:

4.14.6.1.18.2.1 A description of the MCO's enrollment and credentialing process;

4.14.6.1.18.2.2 How to access MCO Provider relations assistance;

4.14.6.1.18.2.3 A description of the MCO's medical management and Case Management programs;

4.14.6.1.18.2.4 Detail on the MCO's Prior Authorization processes;

4.14.6.1.18.2.5 A description of the Covered Services and Benefits for Members,

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including EPSDT and pharmacy;

4.14.6.1.18.2.6 A description of Emergency Services coverage;

4.14.6.1.18.2.7 Member parity;

4.14.6.1.18.2.8 The MCO Payment policies and processes; and

4.14.6.1.18.2.9 The MCO Member and Provider Grievance System.

4.14.6.1.19 The MCO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1-2)]

4.14.6.1.19.1. The MCO shall require the Provider 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)]

4.14.6.1.20 In all contracts with Participating Providers, the MCO shall require Participating Providers to remain neutral when assisting potential Members and Members with enrollment decisions.

4.14.6.1.21 The MCO shall not include any provision in a contract with a Provider that incentivizes a Provider not to

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contract, or prohibits or discourages the Provider from contracting, with any other Managed Care Organization to provide services to such other Managed Care Organization's members. [NH RSA 420-I et al]

4.14.6.2. Compliance with MCO Policies and Procedures

The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.14.6.2.1.1. The MCO's DRA policy;

4.14.6.2.1.2. The Provider Manual;

4.14.6.2.1.3. The MCO's Compliance Program;

4.14.6.2.1.4. The MCO's Grievance and Appeal Processes and Provider Appeal Processes;

4.14.6.2.1.5. Clean Claims and Prompt Payment requirements;

4.14.6.2.1.6. ADA requirements;

4.14.6.2.1.7. Clinical Practice Guidelines; and

4.14.6.2.1.8. Prior Authorization requirements.

4.14.6.2.2 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO and periodically thereafter, about the following requirements:

4.14.6.2.2.1. Member grievance and appeal processes as described in Section 4.5 (Member Grievances and Appeals), including:

4.14.6.2.2.1.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.14.6.2.2.1.2 The Member's

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right to file grievances and appeals and the requirements and timeframe for filing;

4.14.6.2.2.1.3 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)];

4.14.6.2.2.1.4 The Member's right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]; and

4.14.6.2.2.1.5 The Member's right to request continuation of benefits

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that the MCO 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)]

4.14.6.3. Requirement to Return Overpayment

4.14.6.3.1 Requirements for the Provider to comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.14.6.3.1.1. 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.

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4.14.6.4. Background Screening

4.14.6.4.1 The MCO shall require the Provider to conduct background screening of its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists.

4.14.6.4.1.1. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the MCO.

4.14.6.5. Books and Records Access

4.14.6.5.1 The selected MCO must maintain the following records during the resulting contract term where appropriate and as prescribed by the Department:

4.14.6.5.1.1. 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).

4.14.6.5.1.2. 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

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time cards, payrolls, and other records requested or required by the Department.

4.14.6.5.1.3. 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.

4.14.6.5.2 Medical records on each patient/recipient of services.

4.14.6.5.3 During the term of the resulting contract(s) and the 10-year period for retention, 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).

4.14.6.5.4 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth in this Agreement and in the MCO's Member Handbook.

4.14.6.6. Continuity of Care

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4.14.6.6.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by the Department and included in the Department's Model Member Handbook.

4.14.6.7. Anti-Gag Clause

4.14.6.7.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient:

4.14.6.7.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.14.6.7.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.14.6.7.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.14.6.7.1.4. 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. [Section 1932(b) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.14.6.7.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Member Appeal). [42 CFR 438.410(b)]

4.14.6.8. Anti-Discrimination

4.14.6.8.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or

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certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment.

4.14.6.8.2 This paragraph shall not be construed to prohibit an organization from:

4.14.6.8.2.1. Including Providers only to the extent necessary to meet the needs of the organization's Members;

4.14.6.8.2.2. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization; or

4.14.6.8.2.3. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.14.6.8.3 If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

4.14.6.8.4 In all contracts with Participating Providers, the MCO'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)]

4.14.6.9. Access and Availability

4.14.6.9.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.5 (Timely Access to Service Delivery).

4.14.6.10. Payment Models

4.14.6.10.1 The MCO shall negotiate rates with Providers in accordance with Section 4.15 (Alternative Payment Models) and Section 4.16 (Provider Payments) of this Agreement, unless otherwise specified by the Department (e.g., minimum Medicaid fee schedule rates, directed payments).

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4.14.6.10.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the PBM.

4.14.6.10.3 The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.14.6.11. Non-Exclusivity

4.14.6.11.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.14.6.12. Proof of Membership

4.14.6.12.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.14.6.13. Other Provisions

4.14.6.13.1 The MCO's Provider contract shall also contain:

4.14.6.13.1.1. All required activities and obligations of the Provider and related reporting responsibilities;

4.14.6.13.1.2. Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement; and

4.14.6.13.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.14.7 **Reporting**

4.14.7.1. The MCO 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.

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4.14.7.2. The MCO 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 MCO. [42 CFR 438.608(a)(4)]

4.14.7.3. The MCO shall notify the Department within seven (7) calendar days of any significant changes to the Participating Provider network.

4.14.7.4. As part of the notice, the MCO shall submit a Transition Plan to the Department to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.

4.14.7.5. A significant change is defined as:

4.14.7.5.1 A decrease in the total number of PCPs by more than five percent (5%);

4.14.7.5.2 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

4.14.7.5.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.14.7.5.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

4.14.7.6. The MCO shall provide to the Department and/or the Department's Subcontractors (e.g., the EQRO) 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, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.15 Alternative Payment Models

4.15.1 General

4.15.1.1. The Department is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization. The Department will define a Medicaid APM Strategy that may include supporting

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guidance, worksheets, and templates that will build upon the parameters set forth in this Agreement.

4.15.1.2. The Department will implement 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, with a focus on engaged primary and preventive care model and in a manner that is transparent to the Department, Providers, and the stakeholder community.

4.15.1.3. 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:

4.15.1.3.1 Clearly and effectively communicate the Department requirements through use of the defined categories established by HCP-LAN;

4.15.1.3.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.15.1.3.3 Provide an established framework for monitoring MCO performance on APMs.

4.15.2 Prior to and/or over the course of the Term of this Agreement, the Department shall develop the Department's Medicaid APM Strategy, which shall result in additional guidance, templates, worksheets, required provider contractual provisions and other material that elucidate the requirements to which the MCO is subject under this Agreement.

4.15.3 The MCOs shall develop APMs consistent with guidance in the Department's Medicaid APM Strategy including, but not limited to:

4.15.3.1. Incentivize primary care clinicians to engage attributed Members in Primary and Prevention Focused Model and Provider Delivered Care Coordination.

4.15.4 According to models that incentivize consistent quality outcomes as prescribed by the Department.

4.15.5 Within the guidance parameters established and issued by the Department and subject to Department approval, the MCO shall design Qualifying APMs as defined in Section 4.15.9 (Qualifying Alternative Payment Models) consistent with the Department Medicaid APM strategy and in conformance with CMS guidance.

4.15.6 The MCO shall support the Department in developing the Department's Medicaid APM Strategy through participation in regular stakeholder meetings and planning efforts, implementing required provider contractual provisions, providing all required and otherwise requested information related to APMs, sharing Confidential Data and analysis, and other activities as specified by the Department.

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4.15.7 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and the Department shall ensure that it:

4.15.7.1. 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;

4.15.7.2. Uses a common set of quality performance measures across all similarly situated Providers as directed in the Department's Medicaid APM Strategy;

4.15.7.3. Does not set the amount or frequency of the expenditures; and

4.15.7.4. Does not permit the Department to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.15.8 Required Use of Alternative Payment Models

4.15.8.1. The MCO shall ensure through its APM Implementation Plan as described in Section 4.15.10 (MCO Alternative Payment Model Implementation Plan), and confirmed through Exhibit O: Quality and Oversight Reporting Requirements, reporting that fifty percent (50%) of all Covered Services medical expenditures are in Qualifying APMs, as defined by the Department, subject to the following:

4.15.8.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have twelve (12) months to meet this requirement; and

4.15.8.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.15.8.2. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 12-month period.

4.15.8.3. The MCO shall implement the Qualifying APM models as directed by the Department in the Department's Medicaid APM Strategy including, but not limited to, directed payments with quality incentives for achieving statewide outcomes for Community Mental Health Centers and providers, total cost of care models with large providers including quality metrics incentivizing Provider-Delivered Care Coordination and Primary Care and Prevention Focused care.

4.15.8.4. For failure to meet Section 4.15.8 (Required Use of Alternative Payment Models), the Department reserves the right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N (Liquidated Damages Matrix).

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4.15.8.5. Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined Department, MCO, and Providers to achieve the purpose of the incentives.

4.15.8.6. The MCO shall be subject to incentives, at the Department's sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new Members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.15.9 **Qualifying Alternative Payment Models**

4.15.9.1. A Qualifying APM is a payment approach required and approved by the Department as consistent with the standards specified in this Section 4.15.9 (Qualifying Alternative Payment Models) and the Department's Medicaid APM Strategy.

4.15.9.2. 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.

4.15.9.3. HCP-LAN Categories 3A, 3B, 4A, 4B and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the Department's Medicaid APM Strategy.

4.15.9.4. The Department shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.15.12.3 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to the Department, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.15.9.5. Under no circumstances shall the Department consider as a Qualifying APM a payment methodology that takes cost of care into account without also paying providers for achieving quality outcomes consistent with those set forth in the Department's Medicaid APM Strategy. Providers participating in Qualifying APMs shall have the opportunity to share in cost savings through a formula that is no less than 50/50 split in favor of the participating providers and shall incorporate a opportunity to share up to an additional #% of total payments paid through the APM as provider incentive payments for achieving quality outcomes as part of the Qualifying APM.

4.15.9.6. At the sole discretion of the Department, additional APMs specifically required by and defined as an APM by the Department shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.15.9.7. Standards for Large Providers and Provider Systems

4.15.9.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the Department's Medicaid APM Strategy, including incentives for the Primary Care and

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Prevention Focused Model inclusive of Provider Delivered Care Coordination.

4.15.9.8. Treatment of Payments to Community Mental Health Programs

4.15.9.8.1 The CMH Program payment model prescribed by DHHS in Section 4.12.20 (Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.15.9.9. Alternative Payment Models for Substance Use Disorder Treatment

4.15.9.9.1 The MCO shall include in its APM Implementation Plan:

4.15.9.9.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to birthing parents and infants born affected by exposure to substance use; and

4.15.9.9.1.2. At least one (1) APM that promotes greater use of Medication for treatment of substance use disorders through a bundled payment as set forth in the Department's Medicaid APM Strategy.

4.15.9.10. Accommodations for Other Providers

4.15.9.10.1 The MCO may develop Qualifying APM models appropriate for other primary care Providers, and Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy to incentivize engaged primary and preventive care.

4.15.9.10.2 For example, the MCO 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.

4.15.9.11. Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.15.9.11.1 The MCO shall incentivize Providers participating in the Qualifying APMs by paying incentives for achieving quality outcomes established by the Department in the Department's Medicaid APM Strategy.

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4.15.9.11.2 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden, incentivize primary and preventive care and promote the integration of Behavioral Health.

4.15.9.11.3 The MCO may incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Advanced APM."

4.15.10 **MCO Alternative Payment Model Implementation Plan**

4.15.10.1. The MCO shall submit to the Department for review and approval an APM Implementation Plan in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.15.10.2. 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.

4.15.10.3. Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements and/or through additional guidance.

4.15.10.4. Alternative Payment Model Transparency

4.15.10.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and evaluating Participating Provider performance in the APM, as described in Section 4.15.11 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how the MCO intends to achieve Provider to Member engagement in Primary Care and Prevention model and Provider-Delivered Care Coordination including health and wellness assessments and integrated behavioral health care through the APM.

4.15.10.5. Intentionally Left Blank

4.15.10.6. Provider Engagement and Support

4.15.10.6.1 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

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strategies the MCO shall use to assess and advance such readiness over time.

4.15.10.6.2 The APM Implementation Plan shall outline in detail what strategies the MCO 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. The MCO shall ensure regular and consistent engagement with Providers around APMs on at least a quarterly basis through direct or virtual visits by the MCOs key staff responsible for the MCOs provider relations and APM Implementation Plan.

4.15.10.6.3 The MCO 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.

4.15.10.6.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.15.10.7. Implementation Approach

4.15.10.7.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.15.10.7.1.1. In advance of the Program Start Date;

4.15.10.7.1.2. During the first year of this Agreement; and

4.15.10.7.1.3. Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

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4.15.10.7.2 The APM Implementation Plan shall include the MCO'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 MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.15.10.7.3 The MCO 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.

4.15.10.7.4 For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM and notifies the Providers with clarity throughout the APM period of their progress against incentive payment formulas at least quarterly.

4.15.10.7.5 In addition, the MCO shall provide Member and Provider level Confidential Data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.15.10.7.6 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 MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.15.10.7.7 The information provided shall be consistent with the requirements outlined under Section 4.15.11 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.15.11 Alternative Payment Model Transparency and Reporting Requirements

4.15.12 Transparency

4.15.12.1. In the MCO APM Implementation Plan, the MCO shall provide to the Department for each APM, as applicable, the following information at a minimum:

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4.15.12.1.1 The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.15.12.1.2 The methodology for incentivizing Providers engage Members in Provider-Delivered Care Coordination and Primary Care and Prevention, including, but not limited to, health and wellness screenings;

4.15.12.1.3 The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, and the attachment points for cost targets, and risk adjustment methodology;

4.15.12.1.4 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

4.15.12.1.5 The frequency at which the MCO shall regularly report Confidential Data related to APM performance to Providers on cost, quality, evaluation of progress towards incentive payments and the information that shall be included in each report.

4.15.12.2. 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 MCO requests and receives the Department approval for specified information not to be made available.

4.15.12.3. Standardized Assessment of Alternative Payment Model Usage

4.15.12.3.1 Additional information may be required by the Department's Medicaid APM Strategy and 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 MCO requests and receives the Department approval for specified information not to be made available.

4.15.12.4. Standardized Assessment of Alternative Payment Model Usage

4.15.12.4.1 The MCO 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.

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4.15.12.4.2 Thereafter, the MCO 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.

4.15.12.4.3 If the MCO reaches an agreement with the Department that its implementation of the required APM model(s) may be delayed, the MCO shall comply with all terms set forth by the Department for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.15.12.5. Additional Reporting on Alternative Payment Model Outcomes

4.15.12.5.1 The MCO 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.

4.15.13 Development Period for MCO Implementation

4.15.13.1. Consistent with the requirements for new MCOs, outlined in Section 4.15.9 (Qualifying Alternative Payment Models) above, the Department acknowledges that MCOs may require time to advance their MCO Implementation Plan. The Department shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.15.14 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.15.14.1. The MCO's APM Implementation Plan shall adopt the quantitative, measurable clinical outcomes required by the Department in the Department's Medicaid APM Strategy and additional outcomes the MCO seeks to improve through its APM and QAPI initiative(s).

4.15.14.2. At a minimum, the MCO shall address the priorities identified in this Section 4.15.4 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by the Department in the Department's Medicaid APM Strategy.

4.15.14.3. State Priorities in RSA 126-AA

4.15.14.3.1 The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:

4.15.14.3.1.1. [Amendment #4:] Appropriate use of emergency departments relative to low acuity non-emergent visits Opportunities to

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decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

4.15.14.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.15.14.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of births of infants born affected by exposure to substance use;

4.15.14.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission;

4.15.14.3.1.5. Opportunities to incentivize, through payments to Providers and Member incentives, Provider engagement with attributed Members in primary and preventive care, health needs assessments, Provider-Directed Care Coordination at a frequency and in a manner set forth in the Department's Medicaid APM Strategy;

4.15.14.3.1.6. [Amendment #4:] Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing preferred drug ~~generic~~ prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing Polypharmacy, as described in

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Section 4.2.6 (Medication Management);

4.15.14.3.1.7. Opportunities to enhance access to and the effectiveness of medication to treat Substance Use Disorder treatment; and

4.15.14.3.1.8. Opportunities to address health-related social needs (further addressed in Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.15.14.4. Emerging State Medicaid and Public Health Priorities

4.15.14.4.1 The MCO shall address priorities identified by the Department in the Medicaid APM Strategy or related guidance.

4.15.14.4.2 If the Department adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of it APM Implementation Plan.

4.15.15 **Physician Incentive Plans**

4.15.15.1. The MCO shall submit all Physician Incentive Plans to the Department for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.15.15.2. The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by the Department.

4.15.15.3. [Amendment #2:] Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," "the Department," and "Members," respectively and 42 CFR 438.3(i). These include that:

4.15.15.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or

indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.15.15.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.15.15.3.3 [Amendment #4:] [Amendment #2:] Effective July 1, 2026, all of MCO's Physician Incentive Plans to a Provider must adhere to the following requirements: (i) have a defined performance period that can be tied to the applicable MLR reporting periods ~~the performance period of the physician incentive contract with the Provider must align with the MLR reporting period;~~ (ii) the Provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCO; (iii) the physician incentive contract with the Provider must include a specific dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including an ~~and~~ expected date of payment for meeting the required metrics; and (iv) the physician incentive contracts with the Provider must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e. defined and linked to an applicable MLR reporting period or periods). [42 438.608(e); 42 CFR 438.3(i)(3) and (4)]

4.15.15.3.4 [Amendment #2:] Effective July 1, 2026, for each of MCO's Physician Incentive Plans with a Provider, MCO must (i) maintain documentation of (a) the methodology used by MCO to determine Member attribution, and sharing information on Member attribution with Provider; (b) the mechanism(s) used to determine cost benchmarks, and Provider's performance against those cost benchmarks, including cost targets and calculations, the attachment point of cost targets, and risk adjustment calculations;

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and (c) MCO's evaluation and assessment of Provider's performance against quality benchmarks; (ii) not rely on Provider attestations as the basis for Provider's meeting performance and quality metrics for incentive amounts included in the MLR calculation; and (iii) provide copies of each Physician Incentive Plan with Providers and supporting documentation upon request of the Department and at a frequency determined by the Department.

4.15.15.4. The MCO 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) Physician Incentive Plans, as described in Exhibit O: Quality and Oversight Reporting Requirements.

4.15.15.5. Annual Physician Incentive Plan reports shall provide assurance satisfactory to the Department that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any Department request to understand the terms of Provider payment arrangements.

4.15.15.6. The MCO shall provide to Members upon request the following information:

4.15.15.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.15.15.6.2 The type of incentive arrangement; and

4.15.15.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.16 Provider Payments

4.16.1 General Requirements

4.16.1.1. The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.16.1.2. The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) under the following circumstances: [Section 1903 of the Social Security Act]:

4.16.1.2.1 When furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

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4.16.1.2.2 When furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX 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);

4.16.1.2.3 When 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 or if the individual or entity has not completed their federally required enrollment revalidation with the Department;

4.16.1.2.4 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; and [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]

4.16.1.2.5 When furnished by a Participating Provider or entity that is not enrolled with NH Medicaid or whose Medicaid participation has been terminated by the Department.

4.16.1.3. No payment shall be made to a Participating Provider other than by the MCO for services covered under the Agreement between the Department and the MCO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR 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]

4.16.1.4. The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by the Department, the MCO shall contact the Department and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.16.1.4.1 [Amendment #1:] For Providers and Covered Services eligible for minimum fee schedule reimbursement as described in Section 4.16.2 (Provider Payment Requirements) of this Agreement or under terms of a Provider's contractual terms with the MCO, u~~U~~pon a

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change to the State's Medicaid FFS fee schedule, the MCO shall implement a code or rate change in the MCO's claims adjudication system to effectuate the updated State's Medicaid FFS fee schedule in the MCO's referenced system. The MCO shall complete implementation of the updated State's Medicaid fee schedule as soon as possible and no later than the latter of:

4.16.1.4.1.1. The effective date of the State's Medicaid FFS fee schedule change; or

4.16.1.4.1.2. Sixty (60) calendar days from the date the Department notifies the MCO of such State Medicaid FFS fee schedule change.

4.16.1.4.2 To the extent the MCO's effective date of implementing a change in the State's Medicaid FFS fee schedule is later than the effective date of the State's Medicaid FFS fee schedule change, the MCO shall retroactively reimburse Provider claims based on the State's effective date of the then current State Medicaid FFS fee schedule.

4.16.1.5. The MCO shall permit Providers up to one hundred and twenty (120) calendar days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.

4.16.1.6. Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.16.1.6.1 A Member providing the wrong Medicaid identification number;

4.16.1.6.2 Natural disasters; or

4.16.1.6.3 Failed information technology systems.

4.16.1.7. The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.16.1.8. Within the first one hundred and eighty (180) calendar days of the Program Start Date, the Department has discretion to direct MCOs to extend the one hundred and twenty (120) calendar days on case by case basis.

4.16.1.9. The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

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4.16.1.10. The MCO 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)]

4.16.1.11. [Amendment #4:] The MCO shall implement and maintain arrangements or procedures for prompt reporting within 30 calendar days of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste or Abuse, to the Department. [42 CFR 438.608(a)(2)]

4.16.1.12. The MCO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider Preventable Conditions.

4.16.1.12.1 The MCO shall not make payments to a Provider for a Provider Preventable Condition that meets the following criteria:

4.16.1.12.1.1. Is identified in the Medicaid State Plan;

4.16.1.12.1.2. 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;

4.16.1.12.1.3. Has a negative consequence for the Member;

4.16.1.12.1.4. Is auditable; and

4.16.1.12.1.5. 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)]

4.16.1.12.2 The MCO 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

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CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.16.1.12.3 Any directed payments proposed to CMS shall be described in the program's actuarial certification for the rating period.

4.16.1.12.3.1. [Amendment #3:] State directed payments payable at minimum fee schedules are excluded for Covered Services in which the Member has active Medicare or other insurance at the time the service was rendered.

4.16.1.12.4 The MCO shall not impose an administrative fee, cost or any other charge upon any form of payment (e.g., electronic or paper checks) to Providers rendering Covered Services to Members.

4.16.1.12.5 The term "minimum fee schedule" in this Section 4.16 (Provider Payments), shall infer the minimum Provider reimbursement amount(s) permissible under the terms of this Agreement.

4.16.2 **Provider Payment Requirements**

4.16.2.1. Ambulance, Stretcher, and Wheelchair Van Providers

4.16.2.1.1 [Amendment #1:] The MCO shall reimburse directed payments to ambulance, stretcher, and wheelchair van Providers for Covered Services, as follows:

4.16.2.1.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), the MCO shall reimburse Participating Providers for all ambulance, stretcher, and wheelchair van Covered Services at no less than NH Medicaid fee schedule rates.

4.16.2.2. Birthing Centers

4.16.2.2.1 [Amendment #1:] The MCO shall reimburse eligible Participating Provider hospital-based and free-

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standing birthing centers directed payments for Covered Services, as follows:~~For the rating period ending August 31, 2024 (subject to future rating period extension(s)), the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.~~

4.16.2.2.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services in accordance with rates that are no less than NH Medicaid FFS rates.

4.16.2.3. [Amendment #1:] Community Mental Health Programs (CMH Programs)~~Centers (CMHCs)~~

4.16.2.3.1 [Amendment #1:] The MCO shall enter into an agreement, defined and approved by the Department, with CMH Programs~~CMHCs Community Mental Health Centers~~ effective September 1, 2024.

4.16.2.3.1.1. [Amendment #3:] [Amendment #2:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s) and reporting required by the Department), the MCO shall reimburse each CMH Program, including CCBHCs that are a CMH Program provider, in accordance with the ~~directed~~ payment minimum monthly directed payment capitated amounts for identified Covered Services provided by a CMH Program~~The agreement shall be defined by the Department and~~

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~~requires a monthly per member rate payment to the Community Mental Health Centers consistent with the directed payment and incentives (subject to CMS approval, as appropriate)~~ for the treatment of Members with Severe/Persistent Mental Illness, Severe Mental Illness, Low Utilizers, Serious Emotionally Disturbed Children (SED and SED-I) in accordance with guidance issued by the Department, and as described in the program's actuarial certification for the rating period. ~~as directed by the Department and detailed in the Department's Medicaid APM Strategy.~~

4.16.2.3.1.1.1 [Amendment #1:] The monthly capitated amount for each CMH Program shall be based on a per Member per month amount, and such per Member per month rate shall be equal to the per Member per month rate determined by the Department for each CMH Program, for each of the following categories (i)

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Severe/Persistent Mental Illness, (ii) Severe Mental Illness, (iii) Low Utilizers, and (iv) Serious Emotionally Disturbed Children (SED and SED-I).

4.16.2.3.1.1.2 [Amendment #1:] The MCO shall determine the aggregate monthly capitated amount to be paid to each CMH Program based on the CMH Program's monthly Member eligibility count in accordance with Department guidance.

4.16.2.3.1.1.3 [Amendment #1:] In the event the MCO is unable to make the monthly capitated payments to

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any CMH Program in accordance with Section 4.16.2.3.2, and in the amount as directed by the Department, the MCO shall make monthly interim payments to the CMH Program in an amount determined by the Department. When such interim payment is invoked, the MCO shall be subject to liquidated damages as specified in Exhibit N (Liquidated Damages Matrix).

4.16.2.3.1.1.4 [Amendment #1:] All such monthly interim payments to a CMH Program shall be reconciled by the MCO against the amount the

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MCO would have reimbursed each CMH Program receiving an interim payment if the MCO reimbursed the CMH Program in accordance with Sections 4.16.2.3.1.1 through 4.16.2.3.1.1.2.

4.16.2.3.1.2. [Amendment #1:] A separate and distinct ~~This~~ directed payment shall include an incentive pool to pay CMHCs for achieving quality outcomes established by the Department consistent with the statewide mental health improvement goals and objectives.

4.16.2.3.1.2.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the

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Department), directed payment amounts determined by the Department shall comprise a fee schedule adjustment or uniform dollar increase for ~~assertive community treatment~~, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, timely access to services following application for CMH Program services, and step down community residence beds for individuals dually diagnosed with serious mental illness

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and developmental disabilities, within the CMH Program class of network providers, as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.3.1.3. The MCO shall not amend, modify, or change the MCO-CMHC agreement effective September 1, 2024 unless MCO obtains prior written approval from the Department.

4.16.2.3.2 [Amendment #1:] The MCO shall reimburse eligible Community Mental Health Programs (CMHPs) directed payments for covered Community Residential Services ~~for Covered Services~~, as follows:

4.16.2.3.2.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30 ~~20~~, 2026 ~~2025~~ ~~ending August 31, 2024~~ (subject to future rating period extension(s) and other changes, and reporting required by the Department), directed payment remittance shall comprise a minimum fee schedule at least at the Medicaid FFS rates established by the Department ~~for Community Residential Services~~.

4.16.2.3.3 [Amendment #3:] [Amendment #2:] ~~Effective January 1, 2025~~ For the rating period July 1, 2025 ~~September~~

~~1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s) and other changes) for the CCBHC's CMH Program eligible population, the MCO shall reimburse each qualifying CCBHC a directed payment at a NH Medicaid center-specific monthly sub-capitation amount, and at least at NH Medicaid fee schedule rates for all other Members who receive CCBHC services in accordance with separate guidance.

4.16.2.3.3.1. [Amendment #3:] [Amendment #2:] ~~Beginning with the January 2025 payment~~, The MCO shall reimburse each CCBHC ~~its January 2025 CCBHC~~ their center specific monthly subcapitation amount as set forth in the program's actuarial certification based on the effective date of each CCBHC's designation. Failure to do so will be grounds for liquidated damages in accordance with Exhibit N (Liquidated Damages Matrix).

4.16.2.4. [Amendment #1:] Qualifying New Hampshire Hospitals ~~Critical Access Hospitals (CAHs)~~

4.16.2.4.1 [Amendment #1:] Critical Access Hospitals (CAHs): The MCO shall remit directed payment(s) to CAHs in accordance with separate guidance, as follows:

4.16.2.4.1.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of MCO's Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services

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utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State directed payment preprint approved by CMS. [~~Amendment #1:] For the rating period September 1, 2024 through June 30, 2025current rating period ending August 31, 2024 (subject to future rating period extension(s), and other changes, and reporting required by the Department), directed payment amounts determined by the Department shall comprise a uniform rate increase for all inpatient discharges and outpatient qualified encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.~~

4.16.2.4.1.2. [Amendment #3:] [Amendment #1:] Intentionally left blank ~~For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse qualifying facilities for inpatient services at no less than NH Medicaid fee schedule rates.~~

4.16.2.4.2 [Amendment #3:] [Amendment #1:] Prospective Payment System (PPS) Hospitals: The MCO shall remit directed payment(s) to in-state general acute care PPS hospitals ~~CAHs~~ in accordance with separate guidance, as follows:

4.16.2.4.2.1. [Amendment #3:] [Amendment #2:] [Amendment #1:] For the rating period July 1, 2025

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through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State directed payment preprint approved by CMS. ~~For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse in-state critical access hospitals and prospective payment systems hospitals specified by the Departmentqualifying facilities at uniform price increase directed payment amounts for inpatient discharges and outpatient encounters as determined by the Department, andshall comprise a uniform rate increase for encounters as approved by CMS., including any alternate CMS-approved directed payment methodology. Qualified Such uniform price increase directed payments are tied to actual inpatient and outpatient hospital services reported by in-state critical access hospitals and prospective payment~~

~~system hospitalsqualifying Providers~~.

4.16.2.4.2.2. [Amendment #3:] [Amendment #2:] [Amendment #1:] Intentionally left blank For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse qualifying facilities in-state and out-of-state hospitals for inpatient services (except for out-of-state hospital services secured with a single case agreement) at no less than NH Medicaid fee schedule rates.

4.16.2.4.3 [Amendment #3:] Non-Profit Academic Medical Centers with Level I Adult Trauma Center and Level II Pediatric Trauma Center Designations: The MCO shall remit uniform price increase directed payments to in-state non-profit academic medical centers with a Level I adult trauma center and a level II pediatric trauma center in accordance with separate guidance, as follows:

4.16.2.4.3.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of MCO's Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State

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directed payment preprint approved by CMS.

4.16.2.4.4 [Amendment #3:] Inpatient Hospital Minimum Fee Schedule:

4.16.2.4.4.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse in-state and out-of-state hospital Providers for inpatient services (except for out-of-state hospital services secured with a single case agreement) at no less than NH Medicaid fee schedule rates.

4.16.2.5. DME Providers

4.16.2.5.1 [Amendment #1:] The MCO shall reimburse DME Providers directed payments for DME and DME related supplies and services, as follows:

4.16.2.5.1.1. [Amendment #3:] [Amendment #1:] For the current rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.6. Hospice Payment Rates

4.16.2.6.1 The Medicaid hospice payment rates shall be calculated based on the annual hospice rates established under Medicare. These rates are authorized by 1814(i)(1)(ii) of the Social Security Act

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which also provides for an annual increase in payment rates for hospice care services.

4.16.2.7. Indian Health Care Providers

4.16.2.7.1 The MCO 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 MCO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i-ii)]

4.16.2.7.2 For contracts involving IHCPs, the MCO 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)]

4.16.2.7.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the MCO shall be paid an amount equal to the amount the MCO 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 MCO pays and what the IIHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.16.2.7.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.16.2.7.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the Department shall make a supplemental payment to

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the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.16.2.8. Private Duty Nursing Services

4.16.2.8.1 [Amendment #1:] The MCO shall remit directed payments for private duty nursing Covered Services, as follows: ~~reimburse private duty nursing agencies for private duty nursing services at least at the FFS rates established by the Department.~~

4.16.2.8.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse covered private duty nursing services in accordance with rates that are no less than NH Medicaid FFS rates.

4.16.2.9. Substance Use Disorder Providers

4.16.2.9.1 [Amendment #1:] The MCO shall reimburse eligible Substance Use Disorder Providers, including Peer Recovery Programs, directed payments for Covered Services, as follows: ~~in accordance with rates that are no less than the equivalent DHHS FFS rates on the applicable Substance Use Disorder Provider fee schedule.~~

4.16.2.9.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s)), other changes, and reporting required by the Department), the MCO shall reimburse Substance Use Disorder Providers, including Peer Recovery Programs, in accordance with rates that are no less than NH Medicaid FFS rates.

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4.16.2.10. Transition Housing Program

4.16.2.10.1 [Amendment #1:] The MCO shall reimburse eligible Transition Housing Programs directed payments for Covered Sservices, as follows: ~~at least at the FFS rates established by the Department~~.

4.16.2.10.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), directed payment remittance shall comprise a minimum fee schedule at least at the Medicaid FFS rates established by the Department.

4.16.2.11. Designated Receiving Facility (DRF)

4.16.2.11.1 [Amendment #1:] The MCO shall reimburse eligible Medicaid enrolled DRFs as designated by the Commissioner directed payments, as follows:

4.16.2.11.1.1. [Amendment #3:] [Amendment #1:] For the current rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ ~~ending August 31, 2024~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 NH Medicaid State Plan DRG fee schedule payment amounts.

4.16.2.11.2 For administrative days and post stabilization care services delivered under the inpatient and outpatient service categories, the MCO shall pay State-Owned Hospitals and other State determined IMDs for mental illness at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate

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community-based care and services. Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in State-Owned Hospitals and other State determined IMDs for mental illness.

4.16.2.12. Neuropsychological Testing Services

4.16.2.12.1 [Amendment #1:] The MCO shall reimburse eligible Medicaid-enrolled Providers directed payments for covered neuropsychological testing services, as follows:

4.16.2.12.1.1. [Amendment #3:] [Amendment #1:] For the ~~current~~ rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025 ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.13. [Amendment #1:] State-Owned Inpatient Psychiatric Hospitals

4.16.2.13.1 [Amendment #3:] [Amendment #1:] The MCO shall reimburse state-owned New Hampshire Hospital ~~and Hampstead Hospital~~ directed payments as described below:

4.16.2.13.1.1. [Amendment #3:] [Amendment #1:] For inpatient psychiatric services, the MCO shall reimburse state-owned New Hampshire Hospital ~~and Hampstead Hospital~~, as follows:

4.16.2.13.1.1.1 [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025

~~September 1,~~ ~~2024~~ through June 30, 2026 ~~2025 current rating period ending August 31, 2024~~ (subject to future rating period extension(s) other changes, and reporting required by the Department), the state-owned facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.16.2.13.2 [Amendment #3:] [Amendment #1:] ~~For psychiatric professional services, t~~The MCO shall reimburse psychiatric—professional services delivered at the state-owned New Hampshire Hospital ~~and Hampstead Hospital~~ directed payments, as follows:

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4.16.2.13.2.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~,~~current rating period ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes~~)~~, and reporting required by the Department), directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for eligible psychiatric professional services delivered in the state-owned facilities established and periodically adjusted by CMS.

4.16.2.14. [Amendment #1:] ~~4.16.3.3~~ Qualifying Children's Hospitals

4.16.2.14.1 The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:

4.16.2.14.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the directed payment amounts determined by the Department shall comprise a uniform rate increase for each eligible inpatient and outpatient hospital service encounter.

4.16.2.15. [Amendment #1:] Certain Primary Care Services

4.16.2.15.1 [Amendment #1:] The MCO shall reimburse eligible primary care Providers directed payments for certain primary care services identified by the Department and specified in separate guidance.

4.16.2.15.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to

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future rating period extension(s) and reporting required by the Department), the MCO shall reimburse eligible Providers, including Federally Qualified Health Centers (FQHC), FQHC Look-Alike clinics, Rural Health Clinics/Hospital-Based/Non-Hospital Based and other eligible providers, for certain services at rates that are no less than NH Medicaid FFS rates.

4.16.2.16. [Amendment #1:] Federally Qualified Health Centers and Rural Health Clinics

4.16.2.16.1 [Amendment #1:] FQHCs and RHCs shall be paid at minimum the encounter rate paid by Department at the time of service and shall also be paid for Department -specified CPT codes outside of the encounter rates.

4.16.2.16.2 [Amendment #1:] The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.16.2.16.3 [Amendment #1:] The MCO shall reimburse Providers for only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

4.16.2.16.3.1. [Amendment #1:] Subsequent to the first encounter, the Member suffers an illness or injury with a different diagnosis; or

4.16.2.16.3.2. [Amendment #1:] Subsequent to the first encounter, the Member received a different treatment at a different time of the same day.

4.16.3 [Amendment #1:] Intentionally left blank~~The MCO shall reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent New Hampshire Medicaid FFS rates~~.

4.17 Readiness Requirements Prior to Operations

4.17.1 General Requirements

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4.17.1.1. Prior to the Program Start Date, the MCO 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).

4.17.1.2. The Readiness Review requirements shall apply to all MCOs regardless of whether they have previously contracted with the Department. [42 CFR 438.66(d)(1)(ii)]

4.17.1.3. The MCO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by the Department.

4.17.1.4. The Readiness Review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.17.1.5. In order to demonstrate its readiness, the MCO shall cooperate in the Readiness Review conducted by the Department.

4.17.1.6. If the MCO 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).

4.17.1.7. The MCO shall participate in all the Department trainings in preparation for implementation of the Agreement.

4.17.2 **Emergency Response Plan/Disaster Recovery Plan**

4.17.2.1. The MCO 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.

4.17.2.2. The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.17.2.2.1 Staff and Provider training;

4.17.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.17.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.17.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.17.2.2.5 Plans to ensure continuity of services to Providers and Members;

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4.17.2.2.6 How the MCO shall coordinate with and support the Department and the other MCOs; and

4.17.2.2.7 How the plan shall be tested, updated and maintained.

4.17.2.3. On an annual basis, or as otherwise specified in Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.18 Managed Care Information System

4.18.1 System Functionality

4.18.1.1. The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.18.1.1.1 Complies with the Exhibit Q: IT Requirements Workbook;

4.18.1.1.2 Collects, analyzes, integrates, and reports Confidential Data; [42 CFR 438.242(a)];

4.18.1.1.3 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.18.1.1.4 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)];

4.18.1.1.5 Is capable of meeting the requirements listed throughout this Agreement; and

4.18.1.1.6 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.

4.18.1.1.7 Demonstrates to the Department's satisfaction prior to Program Start its readiness and ability to meet all State IT and information security standards as further set forth in Exhibit K: DHHS Information Security Requirements.

4.18.1.2. The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

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4.18.1.2.1 Collection and maintenance of sufficient Member Encounter Confidential Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.18.1.2.2 Submission of Member Encounter Confidential Data to the Department at the frequency and level of detail specified by CMS and by the Department;

4.18.1.2.3 Submission of all Member Encounter Confidential Data that NH is required to report to CMS; and

4.18.1.2.4 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]

4.18.1.3. All Subcontractors shall meet the same standards, as described in this Section 4.18 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.18.1.4. The MCO MCIS shall include, but not be limited to:

4.18.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.18.1.4.2 Management of Provider Enrollment and Credentialing;

4.18.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.18.1.4.4 Eligibility Verification;

4.18.1.4.5 Encounter Data;

4.18.1.4.6 Reference File Updates;

4.18.1.4.7 Service Authorization Tracking, Support and Management;

4.18.1.4.8 Third Party Coverage and Cost Avoidance Management;

4.18.1.4.9 Financial Transactions Management and Reporting;

4.18.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);

4.18.1.4.11 Reporting (Ah hoc and Pre-Defined/Scheduled and On-Demand);

4.18.1.4.12 Call Center Management;

4.18.1.4.13 Claims Adjudication;

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4.18.1.4.14 Claims Payments; and

4.18.1.4.15 QOS metrics.

4.18.1.5. Specific functionality related to the above shall include, but is not limited to, the following:

4.18.1.5.1 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;

4.18.1.5.2 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;

4.18.1.5.3 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;

4.18.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;

4.18.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

4.18.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all Department reporting and encounter requirements;

4.18.1.5.7 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;

4.18.1.5.8 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

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4.18.1.5.9 The Encounter Confidential Data system shall have a mechanism in place to receive, process, and store the required data.

4.18.1.6. The MCO 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.

4.18.1.7. The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect 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)]

4.18.1.8. MCIS capability shall include, but not be limited to the following:

4.18.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.18.1.8.2 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;

4.18.1.8.3 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 MCO system(s) and to perform appropriate reporting and operational activities;

4.18.1.8.4 The Department access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals; and

4.18.1.8.5 Documented instructions and user manuals for each component.

4.18.1.9. Managed Care Information System Up-Time

4.18.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by the Department. The maintenance period shall not exceed four (4) consecutive hours without prior the Department approval.

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4.18.1.9.2 MCO 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.

4.18.2 **Information System Confidential Data Transfer**

4.18.2.1. Effective communication between the MCO and the Department requires secure, accurate, complete, and auditable transfer of Confidential Data to/from the MCO and the Department Confidential Data management information systems. Elements of Confidential Data transfer requirements between the MCO and the Department management information systems shall include, but not be limited to:

4.18.2.1.1 Department read access to all MCM 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;

4.18.2.1.2 Exchanges of Confidential Data between the MCO and the Department in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the Confidential Data source and target;

4.18.2.1.3 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;

4.18.2.1.4 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;

4.18.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.18.2.1.6 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,

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automate the ETL processes, and provide for source to target or source to specification mappings;

4.18.2.1.7 Mechanisms to support the electronic reconciliation of all Confidential Data extracts to source tables to validate the integrity of Confidential Data extracts; and

4.18.2.1.8 A given day's Confidential Data transmissions, as specified in this Section 4.19.2 (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.

4.18.2.2. The MCO shall designate a single point of contact to coordinate Confidential Data transfer issues with the Department.

4.18.2.3. The Department shall provide for a Centralized Electronic Repository, providing for secure access to authorized MCO and the Department staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.18.2.4. Confidential Data transmissions from the Department to the MCO shall include, but not be limited to the following:

4.18.2.4.1 Provider Extract (Daily);

4.18.2.4.2 Recipient Eligibility Extract (Daily);

4.18.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.18.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.18.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.18.2.4.6 Claims History (Bi-Weekly); and

4.18.2.4.7 Capitation Payment Confidential Data (Monthly).

4.18.2.5. Confidential Data transmissions from the MCO to the Department shall include, but not be limited to the following:

4.18.2.5.1 Member Demographic changes (Daily);

4.18.2.5.2 Member Primary Care Physician Selection (Daily);

4.18.2.5.3 MCO Provider Network Confidential Data (Daily);

4.18.2.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.18.2.5.5 Member Encounter Confidential Data including paid, denied, adjustment transactions by pay period (Weekly);

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4.18.2.5.6 Financial Transaction Confidential Data (Weekly); and

4.18.2.5.7 Updates to Third Party Coverage Confidential Data (Weekly).

4.18.2.5.8 Behavioral Health Certification Data (Monthly).

4.18.2.6. The MCO shall provide Department staff with access to timely and complete Confidential Data and shall meet the following requirements:

4.18.2.6.1 All exchanges of Confidential Data between the MCO and the Department shall be in a format, file record layout, and scheduled as prescribed by the Department;

4.18.2.6.2 The MCO 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;

4.18.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide the Department with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between the Department and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.18.2.6.4 The MCO shall provide support to the Department and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data; and

4.18.2.6.5 The MCO shall be responsible for correcting Confidential Data extract errors in a timeline set forth by the Department as outlined within this Agreement.

4.18.3 **Systems Operation and Support**

4.18.3.1. Systems operations and support shall include, but not be limited to:

4.18.3.1.1 On-call procedures and contacts;

4.18.3.1.2 Job scheduling and failure notification documentation;

4.18.3.1.3 Secure (encrypted) Confidential Data transmission and storage methodology;

4.18.3.1.4 Interface acknowledgements and error reporting;

4.18.3.1.5 Technical issue escalation procedures;

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4.18.3.1.6 Business and Member notification;

4.18.3.1.7 Change control management;

4.18.3.1.8 Assistance with UAT and implementation coordination;

4.18.3.1.9 Documented Confidential Data interface specifications – Confidential Data imported and extracts exported including database mapping specifications;

4.18.3.1.10 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.18.3.1.11 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.

4.18.3.2. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.18.3.2.1 Network diagram that fully defines the topology of the MCO's network;

4.18.3.2.2 DHHS/MCO connectivity;

4.18.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and

4.18.3.2.4 Web access for the Department staff, Providers and recipients.

4.18.3.3. The MCO shall utilize either its own or the State's open model Electronic Visit (EVV) system as prescribed by the Department in separate guidance for all Medicaid personal care services and home health Covered Services that require an in-home visit by a Provider in accordance with Section 12006(a) of the 21st Century Cures Act. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver, as applicable.

4.18.4 **Ownership and Access to Systems and Data**

4.18.4.1. The MCO shall make available to the Department and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.18.4.2. Confidential Data accumulated, as part of the MCM program shall remain the property of the State.

4.18.4.3. The MCO shall provide the Department with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports,

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as well as the ability to respond promptly to ad-hoc requests to support the Department Confidential Data and information needs.

4.18.4.4. The Department acknowledges the MCO'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 MCO's systems.

4.18.5 **Records Retention**

4.18.5.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.18.5.2. 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.

4.18.5.3. 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.

4.18.5.4. 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.

4.18.5.5. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

4.18.6 **Web Access and Use by Providers and Members**

4.18.6.1. The MCIS shall include web access for use by and support to Participating Providers and Members.

4.18.6.2. The services shall be provided at no cost to the Participating Provider or Members.

4.18.6.3. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.18.6.4. The MCO 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:

4.18.6.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.18.6.4.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

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4.18.6.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

4.18.6.4.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.18.6.5. Providers shall have access to drug information;

4.18.6.5.1 The website shall provide an encrypted e-mail link to the MCO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.18.6.5.2 The website shall provide a link to the State's Medicaid website;

4.18.6.5.3 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.18.6.5.4 Access shall be limited to verified users.

4.18.6.6. The MCO 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.

4.18.6.7. System Support Performance Standards shall include:

4.18.6.7.1 Email inquiries–one (1) business day response;

4.18.6.7.2 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;

4.18.6.7.3 Routine maintenance;

4.18.6.7.4 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

4.18.6.7.5 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, MCO shall redirect user to site to install appropriate browser.

4.18.7 Contingency Plans and Quality Assurance

4.18.7.1. Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

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4.18.7.2. The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.18.7.3. 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 MCO and the Department.

4.18.7.4. 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 MCO.

4.18.7.5. [Amendment #1:] Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with Exhibit KG: ~~IT~~ Technical Requirements Workbook and security and access rights granted to users.

4.18.7.6. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall submit the following documents and corresponding checklists for the Departments Information Security review:

4.18.7.6.1 Disaster Recovery Plan;

4.18.7.6.2 Business Continuity Plan;

4.18.7.6.3 Security Plan;

4.18.7.6.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for Department review:

4.18.7.6.4.1. Risk Management Plan;

4.18.7.6.4.2. Systems Quality Assurance Plan; and

4.18.7.6.4.3. Confirmation of 5010 compliance and Companion Guides.

4.18.7.7. 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 MCO's change management process:

4.18.7.7.1 The complete system shall have proper configuration management/change management in place (to be reviewed by the Department).

4.18.7.7.2 The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

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4.18.7.7.3 The MCO 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 MCO and the Department and/or the fiscal agent.

4.18.7.7.4 The Department retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.18.7.7.5 The MCO 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.

4.18.7.7.6 The MCO shall provide the Department with official points of contact for MCIS issues on an ongoing basis.

4.18.7.7.7 The MCO shall ensure appropriate testing is done for all system changes. MCO 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.

4.18.7.7.8 The MCO 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.

4.18.7.8. The Department, or its agent, may conduct a Systems readiness review to validate the MCO's ability to meet the MCIS requirements.

4.18.7.9. 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 MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from the Department.

4.18.7.10. 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.

4.18.7.11. If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by the Department, either correct such deficiency or

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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.

4.18.7.12. QOS metrics shall include:

4.18.7.12.1 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:

4.18.7.12.1.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring;

4.18.7.12.1.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system; and

4.18.7.12.1.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.18.7.12.2 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.

4.18.7.12.3 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.

4.18.8 **Interoperability and Patient Access**

4.18.8.1. The MCO 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

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Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data.

4.18.8.1.1. The MCO 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:

4.18.8.1.2 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)];

4.18.8.1.2.1. [Amendment #4:] Effective July 1, 2026, implement and maintain a Patient Access Application Programming Interface (API) required in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the MCO, and:

4.18.8.1.2.1.1 [Amendment #4:] Include all encounter data, including encounter data from any network providers compensated by the MCO based on capitation payments and adjudicated claims and encounter data from any Subcontractors

4.18.8.1.2.1.2 [Amendment #4:]

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Exclude covered outpatient drugs as defined in section 1927(k)(2) of the Act.

4.18.8.1.2.1.3 [Amendment #4:] Report metrics specified in 42 CFR 431.60(f) (total members whose data are transferred to an API and total members whose data were transferred more than once). [42 CFR 438.242(b)(5)]

4.18.8.1.3 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

4.18.8.1.4 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)].

4.18.8.2. The MCO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60, and include(s):

4.18.8.2.1 Confidential Data concerning adjudicated claims, including claims Confidential Data for payment decisions that may be appealed, were appealed, or

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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;

4.18.8.2.2 Encounter data, including encounter Confidential Data from any network providers the MCO 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

4.18.8.2.3 Clinical data, including laboratory results, if the MCO maintains any such data, no later than one (1) business day after the Confidential Data is received by the State.

4.18.8.2.4 Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)]

4.18.8.3. [Amendment #2:] The MCO shall implement and maintain a publicly accessible standards-based API 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), as well as Section 5123(c) of the Consolidated Appropriations Act, 2023, amended section 2107(e)(1)(G) of the Act to apply section 1902(a)(83) of the Act to States for CHIP in effect no later than July 1, 2025. [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)~~]~~; SMD 18-007]

4.19 Claims Quality Assurance Standards

4.19.1 Claims Payment Standards

4.19.1.1. For purposes of this Section 4.20 (Claims Quality Assurance Standards), the Department has adopted the claims definitions established by CMS. [42 CFR 447.25(b)]

4.19.1.1.1 “Clean Claim” as defined in Section 2.1 (Definitions); and

4.19.1.1.2 “Incomplete Claim” means a claim that is rejected for the purpose of obtaining additional information from the Provider.

4.19.1.1.3 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is

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received in the MCO's mailroom by its date stamp or the date an electronic claim is submitted.

4.19.1.2. 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]

4.19.1.3. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.19.1.4. The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt, or receipt of additional information.

4.19.1.5. The MCO 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].

4.19.1.6. The MCO 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. Upon request, the MCO shall make available Provider support staff to review Incomplete Claims, and support and educate Providers in the submission of Clean Claims.

4.19.2 **Claims Quality Assurance Program**

4.19.2.1. The MCO shall verify the accuracy and timeliness of Confidential Data reported by Providers, including Confidential Data from Participating Providers the MCO is compensating through a capitated payment arrangement.

4.19.2.2. The MCO shall screen the Confidential Data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

4.19.2.3. The MCO 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.

4.19.2.4. As indicated in Exhibit O: 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.

4.19.2.5. The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to the Department.

4.19.3 **Claims Financial Accuracy**

4.19.3.1. 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.

4.19.3.2. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

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4.19.4 Claims Payment Accuracy

4.19.4.1. 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.

4.19.4.2. The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.19.5 Claims Processing Accuracy

4.19.5.1. 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.

4.19.5.2. The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

5.1.1.1. As indicated throughout this Agreement, the Department shall document ongoing MCO reporting requirements through Exhibit O: Quality and Oversight Reporting Requirements and additional specifications provided by the Department.

5.1.1.2. The MCO shall provide data, reports, and plans in accordance with Exhibit O: Quality and Oversight Reporting Requirements, this Agreement, and any additional specifications provided by the Department.

5.1.1.3. The MCO shall comply with all NHID rules for Confidential Data reporting, including those related to the NH CHIS, NH code of Administrative Rule, Chapter Ins 4000. Failure to submit timely, accurate, and/or complete files to the NH CHIS shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.1.4. For all historical files submitted under NH Code of Administrative Rule, Chapter Ins 4000 after the submission start date, if DHHS or NHID notifies the MCO of not meeting compliance, the MCO shall remediate all related files within forty-five (45) calendar days after such notice.

5.1.1.5. If the MCO fails to comply with either error resolution timeline, DHHS shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.1.6. The MCO shall make all collected Confidential Data available to the Department upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.7. The MCO shall collect Confidential Data on Member and Provider characteristics as specified by the Department and on services furnished to

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Members through a MCIS system or other methods as may be specified by the Department. [42 CFR 438.242(b)(2)]

5.1.1.8. The MCO shall ensure that Confidential Data received from Providers are accurate and complete by:

5.1.1.8.1 Verifying the accuracy and timeliness of reported data;

5.1.1.8.2 Screening the Confidential Data for completeness, logic, and consistency; and

5.1.1.8.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.9. The Department shall at a minimum collect, and the MCO shall provide, 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 MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.9.1 Enrollment and disenrollment data;

5.1.1.9.2 Member grievance and appeal logs;

5.1.1.9.3 Medical management committee reports and minutes;

5.1.1.9.4 Audited financial and encounter data;

5.1.1.9.5 The MLR summary reports;

5.1.1.9.6 Customer service performance data;

5.1.1.9.7 Performance on required quality measures; and

5.1.1.9.8 The MCO's QAPI Plan.

5.1.1.10. The MCO 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:

5.1.1.10.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.10.2 A description of the innovative programs the MCO has developed and the outcomes associated with those programs;

5.1.1.10.3 A description of how the MCO is addressing health-related social needs and the outcomes associated with MCO-implemented interventions;

5.1.1.10.4 A description of how the MCO is improving health outcomes in the State; and

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5.1.1.10.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.11. 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 MCO policies and procedures and/or other administrative documentation.

5.1.1.11.1 The Department shall deem materials as pass or fail following the Department review.

5.1.1.11.2 The MCO shall complete and submit a Department-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.11.3 The Department may require modifications to MCO policies and procedures or other documentation at any time as determined by the Department.

5.1.1.12. The MCO shall submit all required data to meet CMS standards for submission to the Transformed Medicaid Statistical Information System.

5.1.2 **Requirements for Waiver Programs**

5.1.2.1. The MCO 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 MCO. These include but are not limited to:

5.1.2.1.1 Substance Use Disorder and Severe Mental Illness Institute for Mental Disease 1115 waiver;

5.1.2.1.2 Mandatory managed care 1915b waiver; and

5.1.2.1.3 Granite Advantage 1115 waiver.

5.1.3 **Encounter Data**

5.1.3.1. The MCO 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 MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO meets all Department reporting requirements.

5.1.3.3. The MCO shall submit to the Department for review, during the Readiness Review process, its policies and procedures that detail the MCO's encounter

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process. The MCO-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 MCO's encounter process;

5.1.3.3.2 Encounter specific source to target mapping detail that traces the inbound provider claim, in the applicable format, to the MCO's encounter system data storage location. The MCO shall provide the level of detail for each transmission of the source data that is used to create the encounter files that are submitted to DHHS;

5.1.3.3.3 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.4 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4. The MCO shall, as requested by the Department, submit updates to and revise upon request its policies and procedures that detail the MCO'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 MCO shall submit Encounter Confidential Data to the EQRO and the Department or its designated vendor upon the Department's request 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 MCO'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 MCO shall ensure that encounter records are consistent with the Department requirements and all applicable State and federal laws.

5.1.3.9. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.9.1 The MCO shall submit claim and claim line denial reason codes in the level of detail and format as specified by the Department.

5.1.3.10. The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

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5.1.3.11. The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12. The MCO shall have a computer and 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 MCO 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 MCO 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 MCO'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 Health Care Common Procedure Coding System (HCPCS);

5.1.3.16.2 CPT codes;

5.1.3.16.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.16.4 National Drug Codes which is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.16.5 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);

5.1.3.16.6 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;

5.1.3.16.7 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC

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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

5.1.3.16.8 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 MCO 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 (P – Professional and I - Institutional) or at the discretion of the Department the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NH file format, and other proprietary file layouts as defined by the Department.

5.1.3.18. All MCO encounters shall be submitted with MCO 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. [Amendment #3:] The paid amount (or FFS equivalent) submitted with Encounter Confidential Data shall be the final net amount paid to Providers by the MCO or any Subcontractor and, not limited to the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities.

5.1.3.19.1 [Amendment #3:] For example, the MCO paid amount submitted with pharmacy claim Encounter Confidential Data shall be the amount ultimately paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The submission of only the amount paid to the MCO's PBM is not acceptable

5.1.3.20. [Amendment #3:] Intentionally left blank ~~This requirement means that, for example for pharmacy claims, the MCO paid amount shall include the amount paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The amount paid to the MCO's PBM is not acceptable.~~

5.1.3.21. The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.22. The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.23. The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Confidential Data for all Covered Services.

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5.1.3.24. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.25. The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.25.1 Batch and Online Transaction Types are as follows:

5.1.3.25.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.25.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.25.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction;

5.1.3.25.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction;

5.1.3.25.1.5. ASC X12N 837P Professional Claim/Encounter Transaction;

5.1.3.25.1.6. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.25.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.25.2 Online transaction types are as follows:

5.1.3.25.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

5.1.3.25.2.2. ASC X12N 276 Claims Status Inquiry;

5.1.3.25.2.3. ASC X12N 277 Claims Status Response;

5.1.3.25.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and

5.1.3.25.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.26. 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.

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5.1.3.27. The MCO shall submit summary reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements, to be used to validate Encounter submissions.

5.1.3.28. The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by the Department for reporting Encounters and fee- for-service claims.

5.1.3.29. Any exceptions shall be considered on a code-by-code basis after the Department receives written notice from the MCO requesting an exception.

5.1.3.30. The MCO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.31. The MCO 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.

5.1.3.32. The MCO 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).

5.1.3.33. The MCO shall assign staff to participate in encounter technical work group meetings as directed by the Department.

5.1.3.34. The MCO shall provide complete and accurate encounters to the Department.

5.1.3.35. The MCO shall implement review procedures to validate Encounter Confidential Data submitted by Providers. The MCO shall meet the following standards:

5.1.3.35.1 Completeness

5.1.3.35.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.35.2 Accuracy

5.1.3.35.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions of

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each individual batch and online transaction type.

5.1.3.35.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.35.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.35.2.4. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.35.2.5. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.35.2.6. The MCO 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.

5.1.3.35.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Confidential Data quality.

5.1.3.35.2.8. The end to end test shall include a review of the Provider claim to what Confidential Data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.35.2.9. The MCO shall report a pass or fail to the Department. If the

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result is a fail, the MCO shall also submit a root cause analysis that includes plans for remediation.

5.1.3.35.2.10. If the Department or the MCO identifies a Confidential Data defect, the MCO 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.

5.1.3.35.2.11. If two (2) or more Encounter Confidential Data defects are identified within a rolling twelve (12) month period, the Department may require the MCO to contract with an external vendor to independently assess the MCO Encounter Confidential Data process. The external vendor shall produce a report that shall be shared with the Department.

5.1.3.35.3 Timeliness

5.1.3.35.3.1. Encounter Confidential Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.35.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.35.3.3. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.35.4 Error Resolution

5.1.3.35.4.1. For all historical encounters submitted after the submission

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start date, if the Department or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.35.4.2. For all ongoing claim encounters, if the Department or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

5.1.3.35.4.3. If the MCO 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).

5.1.3.35.4.4. The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by the Department.

5.1.3.35.5 Survival

5.1.3.35.5.1. All Encounter Confidential Data accumulated as part of the MCM 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

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Section 7.2 (Termination for Other Reasons).

5.1.3.35.6 Reporting

5.1.3.35.6.1. The MCO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to the MCO, including base Confidential Data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

5.1.3.35.6.2. When requested by the Department, the MCO 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.

5.1.3.35.6.3. The MCO'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 MCO shall be certified by one (1) of the following:

5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CFO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

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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 MCO 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 MCO shall submit the MCO 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 MCO shall have a Confidential Data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.14.3 (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 MCO 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 MCO 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 MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1. Section 3.10 (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 MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board

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of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The MCO 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 MCO 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 MCO 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 MCO 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 MCO 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 MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2. Within thirty (30) calendar days from the date of contract signing and annually thereafter, the MCO shall submit all updates and modifications to the Department for approval at least thirty (30) calendar days in advance of the effective date. The MCO 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 MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and re-credentialing processes.

5.3.1.4. The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 Section 1902(a)(68) of the Social Security Act;

5.3.1.4.2 42 CFR Section 438;

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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 MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of Fraud, Waste and Abuse, and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to the Department.

5.3.1.6. The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against Fraud, waste and abuse.

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 MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9. The MCO 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 MCO program integrity meetings with the Department following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

5.3.1.9.1.1. The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.2 Discussion at these meetings shall include, but not be limited to, case development and monitoring, implementation of Fraud, Waste, and Abuse Annual Plans, plan use of data analytic Fraud detection algorithms required in Section 5.3.2.2.4.4, quality control and review of Encounter Confidential Data submitted to the Department, and corrective actions from the Department Program Integrity audits.

5.3.1.9.3 The MCO shall ensure Subcontractors attend monthly meetings based on relevant agenda items and ensure

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agenda items are removed if essential MCO or Subcontractor staff are unavailable;

5.3.1.9.4 Participation in any MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned; and

5.3.1.9.5 Participation in meetings with MFCU, as determined by MFCU and the Department.

5.3.2 **Fraud, Waste and Abuse**

5.3.2.1. The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste and Abuse. [42 CFR 438.608(a)]

5.3.2.2. The arrangements or procedures 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:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

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5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i-vii)]

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such as inducements;

5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or Fraud, Waste and Abuse to the Department within thirty (30) business days;

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5.3.2.2.4 The MCO shall maintain and report as requested specific controls to detect and prevent potential Fraud, Waste and Abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.4.4. 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 MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change based on outcomes of the algorithms and Department approval;

5.3.2.2.4.5. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.6. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or

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inappropriate use of Medicaid services and a description demonstrating the results of such protocols when requested by the Department;

5.3.2.2.4.7. 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 MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.8. Provider and Member materials identifying the MCO's Fraud and Abuse reporting hotline number;

5.3.2.2.4.9. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.10. The Department reserves the right to require at least ten (10) specific on-site investigations based on the MCO's request to open an investigation;

5.3.2.2.4.11. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency

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of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.12. 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

5.3.2.2.4.13. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and/or abusive, incorrect billing trends with a particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.5 [Amendment #4:] A provision for the prompt reporting within 30 calendar days of all Overpayments identified and recovered, specifying the Overpayments due to potential Fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider Fraud, Waste and Abuse that the MCO or Subcontractor identifies to the Department Program Integrity and any potential Fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO'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

5.3.2.2.8 A provision for notification to the Department when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O: Quality and Oversight Reporting Requirements.

5.3.2.3. The MCO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide

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detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4. The MCO, and if required by the MCO's Subcontractors, shall post and maintain 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.

5.3.2.5. [Amendment #3:] By October, 1, 2025, the MCO shall establish protocols to identify and report any NH Medicaid Member concurrently enrolled in the corporate entity's other state Medicaid plan(s) (as applicable), and also report Members discovered to be enrolled in any other State Medicaid program in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

5.3.3 **Identification and Recoveries of Overpayments**

5.3.3.1. The MCO shall maintain an effective Fraud, Waste and Abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2. The MCO 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.

5.3.3.4. The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to Fraud, Waste and Abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5. The MCO 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. [Amendment #4:] The Department may recover Overpayments that are not recovered by or returned to the MCO within ninety (90) ~~sixty (60)~~ calendar days

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of the end of the appeal timeframe ~~notification by final findings letter to the Provider by the MCO~~ unless the MCO has a recovery agreement with the Provider,or is actively recovering through claims recoupment. The Department will notify MCO if the Department has plans to pursue recovery.

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.

5.3.3.8. Any settlement reached by the MCO 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 MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.10. If the MCO does not meet the required metrics related to expected Fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O: Quality and Oversight Reporting Requirements, the Department shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

5.3.4 **Referrals of Credible Allegations of Fraud, Waste or Abuse and Provider and Payment Suspensions**

5.3.4.1. General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to 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 MCO 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. The Department’s Program Integrity Unit shall have fifteen (15) business days to respond to the MCO’s “Request to Open” form.

5.3.4.1.3 When the MCO or its Subcontractor has concluded that a credible allegation of Fraud or abuse exists, the MCO shall make a referral to the Department’s 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 MCO nor a Subcontractor

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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 [Amendment #2:] The MCO shall employ pre-payment review when directed or approved by the Department.

5.3.4.1.6 [Amendment #2:] The MCO may employ pre-payment review with approval from the Department when requirements specified in separate guidance are met.~~In addition, the MCO may employ pre-payment review in the following circumstances without approval:~~

5.3.4.1.6.1. [Amendment #2:] Intentionally left blank~~Upon new Participating Provider enrollment;~~

5.3.4.1.6.2. [Amendment #2:] Intentionally left blank~~For delayed payment during Provider education;~~

5.3.4.1.6.3. [Amendment #2:] Intentionally left blank~~For existing Providers with billing inaccuracies; or~~

5.3.4.1.6.4. [Amendment #2:] Intentionally left blank.~~Fraud 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 MCO's Compliance Officer

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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 an exception to suspension does not apply, as determined by the Department under 42 CFR 455.23.

5.3.4.1.8 The Department shall notify the MCO 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, Waste or Abuse referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this section of the Agreement.

5.3.4.1.10 Upon receipt of notification from the Department, the MCO 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

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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 MCO.

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 MCO is notified by the Department that there is insufficient evidence of Fraud, Waste or Abuse by the Provider; or

5.3.4.1.12.2. The MCO is notified by the Department that the legal proceedings related to the Provider's alleged Fraud, Waste or Abuse are completed.

5.3.4.1.13 The MCO 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 as set forth in 42 CFR 455.23.

5.3.4.1.15 Every thirty (30) calendar days that a payment suspension exists, the Department shall direct the

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MCO to continue, reduce, or remove the payment suspension.

5.3.4.1.16 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.1.16.1. Details of payment suspensions that were imposed in whole or in part; and

5.3.4.1.16.2. Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.1.17 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of Fraud, Waste or Abuse without good cause, and the Department directed the MCO to suspend payments, the Department may impose liquidated damages.

5.3.4.1.18 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 MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.1.19 Furthermore, the MCO 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 MCO 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.

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5.3.4.1.20 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 MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate Fraud, Waste and Abuse.

5.3.5.2. The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3. The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, the Department, OIG, and CMS).

5.3.5.4. The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5. The MCO 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 MCO 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 MCO 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 MCO 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.

5.3.5.9. These refunds shall be reported to the Department as Overpayments.

5.3.5.10. The Department shall conduct investigations related to suspected Provider Fraud, Waste or Abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO has not submitted a request to open or for which the MCO has not continued to pursue the case. The State shall notify the MCO of any investigation it intends to open prior to contacting the Provider.

5.3.5.11. Investigations should be concluded within nine (9) months of the approval of the request to open. The MCO must submit a justification for the investigation remaining open if it exceeds nine (9) months with an expected date for the conclusion of the investigation and receive approval from the Department to continue the investigation. The MCO may be penalized if the justification is not approved in accordance with Exhibit N: Liquidated Damages

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Matrix. A case shall be considered completed when a final conclusion letter is sent to the provider or a referral has been made to MFCU.

5.3.5.11.1 The MCO shall submit a final letter to the Department's Program Integrity Unit for each investigation, which explains the outcome of the case and actions taken by the MCO.

5.3.5.12. The MCO shall conduct a follow up investigation twelve (12) months after the final recovery letter date to ensure the same issue is not repeated.

5.3.6 **Reporting**

5.3.6.1. Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

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:

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.

5.3.6.1.3 As part of this report, the MCO shall submit to the Department the Overpayments it recovered, certified by its CFO that this information is accurate to the best

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of their information, knowledge, and belief, as required by Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.606]

5.3.6.2. Reporting Member Fraud

5.3.6.2.1 The MCO shall notify the Department of any cases in which the MCO believes there is a serious likelihood of Member Fraud, Waste and Abuse by sending a secure email to the Department Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member Fraud, Waste and Abuse and referring Member Fraud, Waste or Abuse to the Department. The MCO shall provide initial allegations, investigations and resolutions of Member Fraud, Waste and Abuse to the Department.

5.3.6.3. Termination Report

5.3.6.3.1 The MCO 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 MCO shall submit to the Department demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 [Amendment #4:] The MCO shall report at least annually to the Department, and as otherwise required by this Agreement, on all ~~their recoveries of~~ Overpayments identified and recovered. [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 MCO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the MCO shall provide the Department program integrity staff (or its designee), real time access to all of the MCO electronic encounter and claims Confidential Data (including the

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Department third-party liability) from the MCO's current claims reporting system.

5.3.7.2. The MCO shall provide the Department with the capability to access accurate, timely, and complete Confidential Data as specified in Section 4.20.2 Claims Quality Assurance Program).

5.3.7.3. The MCO and the MCO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.

5.3.7.4. The MCO 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 Medical 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 an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

5.3.7.6. Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate the Department, MFCU or other State or federal agencies.

5.3.7.7. The MCO and the MCO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours. [42 CFR 438.3(h)]

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5.3.7.8. The MCO 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 MCO or its Subcontractors at the MCO's expense.

5.3.7.10. The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.11. The Department shall conduct, or contract for the conducting of, periodic audits of the MCO 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 MCO. [42 CFR 438.602(e)]

5.3.7.12. This shall include, but not be limited to, any records relevant to the MCO'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 MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 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 MCO resulting from the State's periodic audit; and

5.3.8.1.4 Performance metrics and outcomes.

5.4 **MCM Withhold and Incentive Program**

5.4.1 [Amendment #3:] Beginning September 1, 2024, t~~T~~he Department shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted Capitation Payment will be recouped from the MCO and be available for distribution ~~in future years~~ upon meeting specific criteria set forth in program guidance issued by the Department.

5.4.2 The Department shall issue Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by the Department.

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5.4.3 [Amendment #3:] Beginning September 1, 2024, t~~T~~he Department shall institute a Withhold and Incentive Program which directs an annual actuarially sound two percent (2%) retention of the MCO'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.

5.4.4 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall:

5.4.4.1. 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;

5.4.4.2. Not be renewed automatically;

5.4.4.3. Be made available to both public and private contractors under the same terms of performance;

5.4.4.4. Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements; and

5.4.4.5. Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.5 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.5.1. Pursuant to 42 CFR 438.6(b)(2), this incentive arrangement shall:

5.4.5.1.1 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;

5.4.5.1.2 Not be renewed automatically;

5.4.5.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.5.1.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.5.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.6 Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

5.4.7 [Amendment #1:] Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the

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Withhold and Incentive Program is to maintain withhold funds in the program for actuarial soundness, should there be a remaining amount in withheld funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract closeout period~~term~~ in accordance with separate guidance.

5.4.8 [Amendment #4:] In accordance with RSA 126-A:3, the Department will seek to implement an outpatient procedure incentive program beginning as early as January 1, 2026, subject to review and approval from the fiscal committee of the general court.

5.5 Remedies

5.5.1 Reservation of Rights and Remedies

5.5.1.1. The MCO 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 MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State 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 MCO'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

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non-compliance, and update Exhibit N: Liquidated Damages Matrix as needed via contract amendment.

5.5.2.2. DHHS and the MCO agree that it shall be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event the MCO 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: Liquidated Damages Matrix, 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 MCO 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.

5.5.2.8. At its sole discretion, the Department may temporarily provide the MCO 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 MCO 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 MCO in

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excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 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 MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide 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 $25,000 for each failure to provide medically necessary services, and may also:

5.5.4.2.2.1. Appoint temporary management for the MCO,

5.5.4.2.2.2. In the event of multiple MCOs, 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 MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.2.5. Suspend payments for new enrollments to the MCO 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

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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 $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 MCO;

5.5.4.2.3.2. Grant Members the right to disenroll without cause;

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or 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 one hundred thousand dollars ($100,000) for each determination by the Department of discrimination. The Department may impose a civil monetary penalty of up to fifteen thousand dollars ($15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar ($100,000) maximum. The Department may also:

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5.5.4.2.4.1. Appoint temporary management to the MCO;

5.5.4.2.4.2. Grant Members the right to disenroll without cause;

5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or 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 $25,000 for each instance of misrepresentation. The Department may also:

5.5.4.2.5.1. Appoint temporary management to the MCO;

5.5.4.2.5.2. Grant Members the right to disenroll without case;

5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

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5.5.4.2.5.4. Suspend payments for new enrollments to the MCO 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 one hundred thousand dollars ($100,000) for each instance of misrepresentation. The Department may also:

5.5.4.2.6.1. Appoint temporary management to the MCO;

5.5.4.2.6.2. Grant Members the right to disenroll without cause;

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or 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);

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1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.7 Fails to comply with the Medicare Physician Incentive Plan requirements, in which case, DHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply. DHHS may also:

5.5.4.2.7.1. Appoint temporary management to the MCO;

5.5.4.2.7.2. Grant Members the right to disenroll without cause;

5.5.4.2.7.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.7.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3. The Department shall have the right to impose civil monetary penalty of up to $25,000 for each distribution if the Department determines that the MCO 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 MCO's Members in other MCOs if the Department determines that the MCO 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

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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 MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b-d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6. The Department shall only have the right to impose the following intermediate sanctions when the Department determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of 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 MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or 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.

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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 MCO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.1.4. The Department shall impose mandatory temporary management when the MCO 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 MCO 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**

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5.5.6.1. If requested by the Department, the MCO 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) business days of receipt.

5.5.6.3. The MCO 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 MCO 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 MCOs 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. MCOs 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 MCO;

5.5.8.1.5 Whether a CAP is being requested; and

5.5.8.1.6 The timeframe and procedure for the MCO to dispute the Department's determination.

5.5.8.2. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.3. 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 MCO'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 to allow for adjustments to start-up operations; thereafter,

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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 The Department, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right to audit the records and/or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.2 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 MCO or its Subcontractors pertaining to:

5.6.2.1. The ability of the MCO to bear the risk of financial losses; and

5.6.2.2. Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, no later than forty (40) business days after the end of the State Fiscal Year, the MCO shall provide the Department a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.4 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.

5.6.5 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:

5.6.5.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

5.6.5.2. Written assertion by the MCO's management about whether:

5.6.5.2.1 The aforementioned description fairly presents the system in all material respects;

5.6.5.2.2 The controls were suitably designed to achieve the control objectives stated in that description; and

5.6.5.2.3 The controls operated effectively throughout the specified period to achieve those control objectives.

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5.6.5.3. Report of the MCO's auditor, which:

5.6.5.3.1 Expresses an opinion on the matters covered in management's written assertion; and

5.6.5.3.2 Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

5.6.6 The MCO shall notify the Department if there are significant or material changes to the internal controls of the MCO.

5.6.7 If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

5.6.8 The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

5.6.9 The Department may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing CAPs and review MCO compliance with requirements and standards as specified in this Agreement.

5.6.10 The MCO shall use reasonable efforts to respond to the Department oral and written correspondence within one (1) business day of receipt.

5.6.11 The MCO shall file annual and interim financial statements in accordance with the standards set forth below.

5.6.12 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 MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]

5.6.13 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.

5.6.14 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.

5.6.15 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

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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 MCO may protest such action or decision by the delivery of a written notice of protest to the Department and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director").

5.7.1.2. The MCO 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 MCO 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 MCO 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 MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of the Department under RSA chapter 541-A, if applicable, or any applicable

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provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from 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 MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO 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 MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

6.1.6 The MCO shall submit Confidential Data on the basis of which the Department has the ability to determine that the MCO has made adequate provisions against the risk of insolvency.

6.1.7 The MCO 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 MCO to perform under this Agreement.

6.1.8 [Amendment #3:] The MCO shall not participate in and shall prohibit clawback business arrangements, network access fees, transaction fees, and all other similar types of arrangements with its Pharmacy Benefit Managers (PBM) or any other Subcontractor for Covered Services whereby such PBM or Subcontractor reimburses network pharmacies or other Providers an initial reimbursement amount and subsequently the PBM or

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other Subcontractor receives remuneration for a portion of that fee. Such clawback or similar arrangements include, but are not limited to, both rate guarantee agreements between the PBM and MCO and the PBM and the network pharmacy. Rate guarantee agreement solely between the MCO and PBM shall not be considered a prohibited clawback business arrangement under this Agreement, but must be reported in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

6.2 **Capitation Payments**

6.2.1 Capitation payments made by the Department and retained by the MCO 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 MCO 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 Capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.

6.2.3.1. The risk adjustment process shall use the most recent version of the CDPS+Rx model to assign scored individuals to a demographic category and disease categories based on their medical claims and drug utilization during the study period. The methodology shall also incorporate a custom risk weight related to the cost of opioid addiction services, as deemed necessary by the Department and its actuary. Scored individuals are those with at least six months of eligibility and claims experience in the base data. The methodology shall exclude diagnosis codes related to radiology and laboratory services to avoid including false positive diagnostic indicators for tests run on an individual. Additionally, each scored member with less than 12 months of experience in the base data period shall also be assigned a durational adjustment to compensate for missing diagnoses due to shorter enrollment durations, similar to a missing data adjustment.

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6.2.3.2. Each unscored member shall be assigned a demographic-only risk weight instead of receiving the average risk score for each MCO's scored members in the same rate cell. The risk adjustment methodology shall also incorporate a specific adjustment to address cost and acuity differences between the scored and unscored populations, which shall be documented by a thorough review of historical data for those populations based on generally accepted actuarial techniques.

6.2.3.3. Members shall be assigned to MCOs and rate cells using the actual enrollment by MCO in each quarter to calculate risk scores in order to capture actual membership growth for each MCO.

6.2.3.4. The Department and its actuary reserve the right to modify the risk adjustment methodology.

6.2.4 The MCO 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)]

6.2.5 The MCO and the Department agree the Capitation Rates 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.

6.2.6 The MCO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, including base Confidential Data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.7 When requested by the Department, the MCO shall submit Encounter Data, financial data, and other Confidential Data to the Department to ensure actuarial soundness in development of the capitation rates, or any other actuarial analysis required by the Department or State or federal law.

6.2.8 The MCO'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 capitation rates, is complete and accurate. [42 CFR 438.606]

6.2.9 The MCO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The MCO may retain such recoveries, subject to the parameters in the Agreement, since the capitation rates are calculated net of expected MCO recoveries.

6.2.10 The Department shall make a monthly payment to the MCO for each Member enrolled in the MCO's plan as the Department currently structures its capitation payments.

6.2.10.1. Capitation Payments for all standard Medicaid Members shall be made retrospectively with a one month plus five (5) business day lag.

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6.2.10.2. Capitation Payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.11 The capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.12 [Amendment #1:] The Department may adjust the capitation rate based on Member enrollment span changes (e.g., category of eligibility, enrollment termination, age) that occurred during the month that are not otherwise recognized in capitation adjustments. ~~The 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~~.

6.2.13 Capitation adjustments are processed systematically each month by the Department's MMIS.

6.2.14 The Department shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.15 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.

6.2.16 **Capitation Settlement**

6.2.16.1. The Department has sole discretion over the capitation settlement process.

6.2.16.2. The MCO shall follow policies and procedures for the settlement process as developed by the Department.

6.2.16.3. Based on the provisions herein, the Department shall not make any further retroactive adjustments other than those described herein or elsewhere in this Agreement.

6.2.16.4. The Department and the MCO agree there is a nine (9) month limitation from the date of the Capitation Payment and is applicable only to retroactive Capitation Payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO.

6.2.16.5. 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.

6.2.16.6. For each live birth, the Department shall:

6.2.16.6.1 Make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.16.6.2 This payment is a global fee to cover all delivery care.

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6.2.16.6.3 In the event of a multiple birth DHHS shall make only one (1) maternity kick payment.

6.2.16.6.4 A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.16.7. Make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.16.7.1 This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services.

6.2.16.7.2 Enrolled babies shall be covered under the MCO capitated rates thereafter.

6.2.16.7.3 Different rates of newborn kick payments may be employed by the Department, in its sole discretion, to increase actuarial soundness.

6.2.16.7.4 Two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns.

6.2.16.7.5 Each type of payment is distinct and only one payment is made per newborn.

6.2.16.7.6 The MCO shall submit information on maternity and newborn events to DHHS, and shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.16.8. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025 ending August 31, 2024~~ (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.17.3 below.

6.2.16.8.1 The kick payment shall be specific to the corresponding Peer Groups established by DHHS. Separate kick payments exist for Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09.

6.2.16.8.2 Psychiatric admissions for dually eligible Members are not subject to the kick payment and shall be paid out of the capitation rates.

6.2.16.8.3 [Amendment #3:] Psychiatric admissions for Members at New Hampshire Hospital ~~and Hampstead Hospital~~

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are not subject to the kick payment and shall be paid out of the MCO's capitation rates.

6.2.16.9. [Amenment #4:][Amendment #2:] Beginning f~~F~~or services effective January 1, 2025, for the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each of three (3) new kick payments to cover juveniles and adults who are incarcerated to comply with new service requirements as part of the implementation of the expansion of its Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance Treatment and Recovery Access 1115 Demonstration Waiver~~Intentionally left blank~~.

6.2.16.10. Intentionally left blank.

6.2.16.11. Intentionally left blank.

6.2.16.12. Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to the Department's MMIS by the MCO.

6.2.16.13. [Amendment #1:] Eligibility for a capitation payment from the MCO to the CMH Program is based on a valid behavioral health certification and the Member having had an encounter in the last three (3) months. ~~The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months.~~

6.2.16.14. [Amendment #1:] Changes to a Member's behavioral health certification enrollment span are reflected in Capitation Payments as described in Section 6.2.12 of this Agreement. ~~Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.~~

6.2.17 **Capitation Adjustments**

6.2.17.1. After the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted Capitation Payment net of directed payments to the MCO shall be calculated as having been withheld by the Department. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance.

6.2.17.1.1 Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by the Department as indicated in Section 5.4 (Withhold and Incentive Payment Program).

6.2.17.1.2 The Department shall inform the MCO of any required program revisions or additions in a timely manner.

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6.2.17.1.3 The Department may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.17.2. The Department shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.17.3. In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member.

6.2.17.4. The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.17.5. 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 MCO must do no work on that part after the effective date of the loss of program authority.

6.2.17.6. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.17.7. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work.

6.2.17.8. If the State paid the MCO 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.

6.2.17.9. However, if the MCO 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 MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6.2.18 Other Reimbursement Considerations

6.2.18.1. Unless MCOs 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 MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

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6.3 Medical Loss Ratio (MLR) Reporting and Settlement

6.3.1 Minimum MLR Performance and Rebate Requirements

6.3.1.1. The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2. [Amendment #1:] In the event the MCO's MLR for any single reporting year is below the minimum ~~of the~~eighty-five percent (85%) requirement as reported by the MCO in accordance with Section 6.3.2 of this Agreement, or determined by the State's actuary or the State's contracted MLR examiner required under CMS rule, the MCO 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 MCO from the Department multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR.

6.3.1.3. If the MCO 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 MCO 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 MLR

6.3.2.1. The MCO 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)]

6.3.2.2.1 The calculation of the MLR will be updated to consider new provisions added or amended by CMS through published rules and guidance.

6.3.2.3. Each MCO 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.

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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 MLR report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims, expenditures for activities that improve health care quality or licensing and regulatory fees or federal and state taxes.

6.3.2.5.1 Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue-based assessments.

6.3.2.5.2 Expenses for administrative services may include amounts that exceed a third party's costs (profit margin), but these amounts must be justified and consistent with prudent management and fiscal soundness requirements to be includable when these transactions are between related parties. [42 C.F.R. § 422.516(b)].

6.3.2.6. Health Care Quality Improvement (HCQI) expenses are limited to the portion of salaries and benefits for employees directly performing administrative functions for inclusion in the MLR calculation. Expenses for items such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, equipment, computer and telephone usage, travel and entertainment, company parties and retreats, information technology infrastructure and systems, and software licenses do not qualify as direct HCQI expenses.

6.3.2.7. The MCO may add a credibility adjustment in accordance with 42 CFR 438.8(h) to a calculated MLR if the MLR reporting year experience is partially credible.

6.3.2.7.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.7.2 The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

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6.3.2.7.3 If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 **MLR Reporting**

6.3.3.1. The MCO shall submit MLR summary reports quarterly to the Department in accordance with Exhibit O: 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 MCO 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)]

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6.3.3.5. The MCO 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 MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying Confidential Data associated with MLR reporting to the MCO 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 MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.6.1 [Amendment #2:] Effective July 1, 2026, the MCO shall require its Subcontractors responsible for the delivery or administration of the covered outpatient drug benefit to report separately to the MCO the amounts related to:

6.3.3.6.1.1. [Amendment #2:] The incurred claims described in 42 CFR 438.8(e)(2) such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to Providers or pharmacies for dispensing or administering a covered outpatient drug; and

6.3.3.6.1.2. [Amendment #2:] Administrative costs, fees and expenses of the Subcontractor. [42 CFR 438.3(s)(8)]

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 MCO 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)]

6.3.3.8. The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.4 **Risk Mitigation**

6.3.4.1. Risk Pool Protections

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6.3.4.1.1 [Amendment #3:] [Amendment #1:] High-Cost Pharmacy Risk Pool. The Department will provide an actuarially sound High-Cost Pharmacy Risk Pool (HCPRP) funded though the MCO capitation rates that will allocate HCPRP funding to each MCO based on the qualifying pharmacy claim payments for Members with annual pharmacy claim payments over a specified threshold. The HCPRP will offer the Department and the MCOs protection for Members with total pharmacy spend exceeding a predetermined threshold. Any pharmacy costs above the threshold are included in the HCPRP pool amount (excluding medications typically included as part of the NH Medicaid DRG grouper reimbursement methodology; gene therapies and other high-cost medications should be billed separate from the DRG grouper for inclusion in the HCPRP), and first subject to an at-risk coinsurance amount that is the responsibility of the MCOs. The remaining HCPRP amount will be redistributed across MCOs based on actual experience of the remaining pharmacy expenses (i.e., in excess of the threshold after coinsurance is applied). All associated pharmacy funding, including the HCPRP amounts, will be prospectively included in the capitation rates by rate cell. The HCPRP amount will be subject to a separate HCPRP risk corridor to provide further protection from under or over funding of the HCPRP amount~~provide MCO protection for Members with pharmacy claims in access of the attachment point. Detailed program features and parameters will be established on an annual basis in guidance~~.

6.3.4.1.1.1. [Amendment #1:] During the contract year, the MCO will be required to pay pharmacy claims as normal.

6.3.4.1.1.2. [Amendment #1:] Reconciliation and reallocation of HCPRP amounts will be based on actual HCPRP expenditures as described in separate guidance.

6.3.4.1.1.3. [Amendment #1:] The HCPRP includes threshold, coinsurance, and risk corridor features, as follows:

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6.3.4.1.1.3.1 [Amendment #3:] [Amendment #1:] For the July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ rating period and annually thereafter, the threshold is set at $250,000 total drug spend per Member.

6.3.4.1.1.3.2 [Amendment #3:] [Amendment #1:] For the July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ rating period, the MCO is at-risk for coinsurance across all eligible rate cells, as follows:

6.3.4.1.1.3.2.1 [Amendment #1:] 30% coinsurance for members with a total drug spend of $250,000 - $750,000;

6.3.4.1.1.3.2.2 [Amendment #1:] 20% coinsurance for members with a total drug spend of $750,000 - $1,250,000; and

6.3.4.1.1.3.3.2.3 [Amendment #1:] 10% coinsurance for

members with a total drug spend greater than $1,250,000.

6.3.4.1.1.4. [Amendment #3:] [Amendment #1:] For the ~~September~~July 1, 2025 ~~2024~~ through June 30, 2026 ~~2025~~ rating period, the Department shall implement a risk corridor for pharmacy costs as described in Section 6.3.4.1.1 of this Agreement ~~for all pharmacy costs (excluding inpatient pharmacy services) around the HCPRP to offer additional protection against under/over funding of the HCPRP~~, as follows:

Under/Overfunding	DHHS Share	MCO Share
Less than Pool Fund -10%	100%	0%
Pool Fund -10% to -5%	50%	50%
Pool Fund -5% to +5%	0%	100%
Pool Fund +5% to +10%	50%	50%
Greater than Pool Fund +10%	100%	0%

6.3.4.1.2 The Department shall implement a budget neutral-risk pool for services provided at Boston Children's Hospital in order to better allocate funds based on MCO-specific spending for these services. Inpatient and outpatient facility services provided at Boston Children's Hospital qualify for risk pool calculation.

6.3.4.2. Minimum and Maximum MLR

6.3.4.2.1 The Department reserves the right to modify its risk mitigation strategies in accordance with actuarially sound practices.

6.3.4.2.2 For each year under this Agreement, the Department and its actuary will determine if a minimum and maximum MLR should be implemented due to unforeseen events that could materially impact the level of uncertainty associated with the financial soundness of the MCM program. The MCM program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such

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as enrollment projections, emerging utilization experience, and retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period based on the target MLRs determined by the Department.

6.3.4.2.2.1. [Amendment #2] [Amendment #1] For the September 1, 2024 through June 30~~August 31~~, 2025 rating period, the Department is committed to reviewing more mature emerging experience to evaluate the need for additional modifications to the acuity adjustment factors that could be required due to a potential deterioration of the aggregate program MLR. As part of the Amendment #2 capitation rate development process, the Department will request additional information from the MCO and conduct a review of recent MLR results. If these results show a material deterioration of the program MLR in aggregate, the Department and its actuaries may implement corrective adjustments to address this deterioration in financial performance retroactive to September 1, 2024.

6.3.4.2.3 Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation (i.e., High-Cost Drug Risk Pool, Boston Children's Hospital risk pool, prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.2.4 Minimum MLR settlement operational requirements include:

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6.3.4.2.4.1. 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 not include costs related to quality improvement activities or Fraud, Waste and Abuse prevention.

6.3.4.2.5 The denominator for the actual MLR shall equal the risk adjusted capitation revenue including risk mitigation settlement amounts as described in Section 6.3.4 (Risk Mitigation).

6.3.4.2.6 Payments and revenue related to directed payments and premium taxes shall be excluded from the numerator and denominator for the actual MLR.

6.3.4.2.7 Any incentive payments made to higher-performing MCOs as part of the Withhold Program shall not impact the minimum or maximum MLR provision of the Agreement.

6.3.4.2.8 The timing of the minimum and maximum MLR settlement shall occur after the contract year is closed and substantial paid claims runout is available.

6.3.4.2.9 Payments or recoupments related to the Withhold and Incentive Program shall be excluded from the MLR settlement. The Withhold and Incentive Program settlement shall occur after the MLR settlement is complete.

6.3.4.2.10 [Amendment #4:] The MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available. At the Department's discretion, a final revised MLR settlement calculation may occur upon completion of an MLR audit for the period, if applicable, to consider any adjustments identified during the MLR audit impacting the final MLR settlement calculation.

6.3.4.2.11 [Amendment #1:] The projected overall MCO MLR for at-risk services excludes the impact of the separate payment term directed payments and the 2.0% premium tax allowance in both the numerator and denominator of the MLR calculation. The following

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overall MCO MLRs are projected under this Agreement:

6.3.4.2.11.1. [Amendment #1:] For the September 1, 2024 through June 30, 2025 rating period, at-risk services are projected as follows:

6.3.4.2.11.1.1 [Amendment #2:][Amendment #1:] For September 1, 2024 through December 31, 2024, at-risk services are projected as 91.2% ~~90.9%~~ for the Standard Medicaid population and 90.3% ~~89.9%~~ for the GAHCP population which includes an overall 7.3%~~7.6%~~ administrative cost allowance for the Standard Medicaid population, and 8.2% ~~8.6%~~ for the GAHCP population; and 1.5% risk margin applied as a percentage of revenue prior to the

directed payments and the premium tax allowance; and

6.3.4.2.11.1.1.1 [Amendment #2:] For January 1, 2025 through June 30, 2025, at-risk services are projected as 91.2% for the Standard Medicaid population and 90.4% for the GAHCP population which includes an overall 7.3% administrative cost allowance for the Standard Medicaid population, and 8.1% for the GAHCP population; and 1.5% risk margin applied as a percentage of revenue prior to the directed payments and the premium tax allowance; and

6.3.4.2.11.1.2 [Amendment #2:] [Amendment #1:] For the September 1, 2024 through June 30, 2025 rating period, the minimum MLR is set on a program-wide basis for each major population,

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such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target, the minimum MLR will be 88.7% for the Standard Medicaid population and 87.9% for the GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above The minimum e target MLR, such that MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR will be 94.7% for the

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Standard Medicaid population and 93.9% for the GAHCP population.

6.3.4.2.11.1.3 [Amendment #4:] [Amendment #3:] For the July 1, 2025 through June 30, 2026 rating period, the capitation rates reflect an average target MLR, which measures the projected medical service costs as a percentage of the total at-risk capitation rates. The minimum MLR will limit MCO gains if the actual MLR is lower than the minimum MLR. The maximum MLR will limit MCO losses if the actual MLR is higher than the maximum MLR. The average

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target MLR for at-risk services is 91.2%~~90.9%~~ for Standard Medicaid and 90.3%~~90.0%~~ for GAHCP based on the SFY 2026 projected enrollment distribution. The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs for the rating period, the minimum MLR will be 88.7%~~88.4%~~ for the Standard Medicaid population and 87.8%~~87.5%~~ for the

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GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCO will have a maximum loss of 2%. Based on the target MLRs for the rating period, the average maximum MLR will be 94.7%~~94.4%~~ for the Standard Medicaid population and 93.8%~~93.5%~~ for the GAHCP population.

6.3.4.2.12 [Amendment #1:] Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation (i.e., High-Cost Drug Risk Pool, Boston Children's Hospital risk pool, prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.3. [Amendment #3:] [Amendment #2] [Amendment #1:] CMH Programs: For the July 1, 2025 ~~September 1, 2024~~ through June 30~~August 31, 2026~~ ~~2025~~ rating period, the Department shall mitigate the MCO and Department gains and losses due to significant changes under the new CMH Program payment

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model when experience is above or below the actuarial estimate of a 12.0% ~~14.0%~~ adjustment for the three-month lookback. Specifically, the Department shall review whether the CMH Program outreach efforts targeted at serving more members within the three-month lookback period are higher or lower than the estimate included in the rating period's capitation rates. To compensate for higher or lower utilization estimates, a risk corridor around the 12.0% ~~14.0%~~ adjustment for the three-month lookback shall be included in the development of the CMH Program specific capitation rates for the period. The risk corridor shall reduce or increase overall MCO capitation payment funding for the CMH Programs if actual experience is outside a plus or minus 2% range for the three-month lookback adjustment factor of 12.0% ~~14.0%.~~

6.4 **[Amendment #1:] Financial Responsibility for ~~Dual-Eligible~~ Members with Other Insurance**

6.4.1 For Medicare Part A crossover claims and Medicare Part B crossover claims billed on the UB-04, the MCO shall pay the patient responsibility amount (deductible and coinsurance) for Covered Services.

6.4.1.1. [Amendment #4:] For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment.

6.4.2 For Part B crossover claims billed on the CMS-1500, the MCO shall pay the lesser of:

6.4.2.1. The patient responsibility amount (deductible and coinsurance) for Covered Services, or

6.4.2.2. The difference between the amount paid by the primary payer and the Medicaid allowed amount.

6.4.2.3. [Amendment #4:] Intentionally left blank ~~For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment~~.

6.4.3 [Amendment #1:] For all medical and pharmacy claims with other insurance payment (e.g., commercial, Medicare Advantage), excluding Medicare Part A, Part B, and Part D, the MCO shall use the lessor logic described below unless otherwise stipulated in this Agreement:

6.4.3.1. [Amendment #1:] The patient responsibility amount (deductible, Co-payment, or coinsurance), or

6.4.3.2. [Amendment #1:] The difference between the amount paid by the primary payer and the Medicaid allowed amount, if less than the patient responsibility amount, or

6.4.3.3. [Amendment #1:] If the Member responsibility amount is "0" then the MCO shall make no payment.

6.4.4 [Amendment #4:] [Amendment #1:] For all claims (medical and pharmacy) with other insurance or Medicare Advantage plans, the MCO shall follow

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coordination of benefit processes described in entirety of this Section 6.4, ~~the primary insurance claim process in paying as secondary~~ unless otherwise stipulated in this Agreement.

6.4.4.1. [Amendment #2] For CMHCs and State certified CCBHCs, for (1) Covered Services statutorily excluded from Medicare (excluding Medicare Advantage plans), the MCO shall institute a claims edit approving payment for such Covered Service and shall not require the CMHC or CCBHC to first bill Medicare (excluding Medicare Advantage plans); and (2) Members also enrolled in a Medicare Advantage plan or private commercial plan, the MCO shall only require CMHCs and CCBHCs to receive one denial per year, from the Member's Medicare Advantage plan or private commercial plan, for functional support services or targeted case management Covered Services provided by the CMHC or CCBHC, and MCO shall institute a claims edit approving functional support services or targeted case management Covered Services provided by the CMHC or CCBHC when CMHC or CCBHC has received the required one denial per year from the Member's Medicare Advantage plan or private commercial plan.

6.4.4.2. [Amendment #4:] [Amendment #3:] Beginning March 1, 2026, t~~T~~he MCO shall pay ~~claims~~ as primary payer ~~when a provider~~ for Medicare Part A and Part B claims when the provider is not enrolled with Medicare on the date of service ~~as a participating provider~~.

6.4.4.3. [Amendment #4:] Beginning March 1, 2026, the MCO is responsible for Member Cost Sharing, (e.g., Copayment, deductible) (excluding Medicare Part D medications), as applicable, when other insurance, Medicare Part A or Part B, or Medicare Advantage pays as primary for a Covered Service via an automated crosswalk table or other methodology to effectuate payment regardless of whether the primary payer uses a different billing code for the same Covered Service.

6.4.5 [Amendment #4] The MCO shall not pay Member Cost Sharing for Medicare Part D covered medications regardless of whether the Member has one or both Medicare Part A and/or Medicare Part B.

6.5 Medical Cost Accruals

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The MCO shall permit the Department or its designee(s) and/or the NHID to inspect and audit any of the financial records of the MCO 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,

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appropriateness or timeliness of services and reasonableness of their costs. [SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The MCO 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 MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant.

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 MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.7 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 **Member Liability**

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1. The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2. The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3. The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4. Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c); section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly

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[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 MCO 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 MCO 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 MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 **Federal Matching Funds**

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the MCO by the Department.

6.10 **Third Party Liability**

6.10.1 NH Medicaid shall be the payer of last resort for all Covered Services in accordance with federal regulations.

6.10.2 The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.3 The Department and the MCO shall cooperate in implementing cost avoidance and cost recovery activities.

6.10.4 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.10.5 The Department shall conduct, at times solely determined by the Department, policy and procedure audits of the MCO and its Subcontractors.

6.10.5.1. Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

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6.10.6 The MCO shall have one (1) dedicated contact person for the Department for TPL.

6.10.7 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.

6.10.8 [Amendment #2] All cost recovery amounts shall be retained by the MCO, except overpayments by other insurance. For recoveries over the Provider paid amount see Section 6.10.1112.5.3. of this Agreement.

6.10.9 The MCO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.10.9.1. 42 CFR 433.138;

6.10.9.2. 42 CFR 433.139; and

6.10.9.3. RSA 167:14-a.

6.10.10 **Cost Avoidance**

6.10.10.1. The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, Medicare Advantage plans, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 42 U.S.C. 1396a(a)(25) plans and workers compensation.

6.10.10.2. The MCO shall establish claims edits and deny payment of claims when active Medicare, Medicare Advantage Plans, or active private insurance exist at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.10.10.3. The MCO shall deny payment on a claim that has been denied by Medicare Advantage Plan 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.

6.10.10.4. The MCO shall establish claim edits to ensure claims with Medicare, Medicare Advantage plan, or private insurance denials are properly adjudicated based on the denial reason. The MCO is required to determine which specific Medicare, Medicare Advantage plan, and private insurance denials should be processed for payment or denial by the MCO.

6.10.10.5. The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance, Medicare, or Medicare Advantage plans if either:

6.10.10.5.1 The primary payer does not cover the services and the MCO does; or

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6.10.10.5.2 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.

6.10.10.6. If a claim is denied by the MCO based on active Medicare, Medicare Advantage Plan, or private insurance, the MCO shall provide the Medicare, Medicare Advantage Plan, or private insurance information to the Provider.

6.10.10.7. To ensure the MCO is cost avoiding, the MCO shall implement a file transfer protocol between the Department MMIS and the MCO's MCIS to send new, terminated, and changed Medicare or private insurance information and other information as required pursuant to 42 CFR 433.138.

6.10.10.8. The MCO 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.

6.10.10.9. The MCO shall perform monthly electronic confidential data matches with private insurance companies (medical and pharmacy) unless the Department performs these functions.

6.10.10.9.1 Should the Department establish data matching and provide to the MCO individual member private insurance data, then the MCO will not be required to perform direct data matching.

6.10.10.9.2 The date of the Department transmission of the data will be considered the date of discovery for the plan regarding member private insurance. The MCO will be required to meet cost avoidance requirements outlined in this section of this Agreement within two (2) business days of the date of discovery and four (4) business days for any subcontractors.

6.10.10.9.3 The Department shall provide the MCO with the Member name, Medicaid ID, private insurance company name, the Department's private insurance ID, private insurance policy number, type of coverage, policy begin date, policy end date (if open, end date will be 12/31/9999), and policy holder information, if available.

6.10.10.10. If the Department is not performing the data matching with other insurances, then it will be the responsibility of the MCO to establish, and shall ensure the MCO and its Subcontractors utilize, monthly electronic Confidential Data matches with private insurance companies (Medical and pharmacy), and Medicare Advantage plans that sell insurance in the State to obtain current and accurate private insurance information for their Members in accordance with

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this Agreement. This provision may be satisfied by a contract with a third-party vendor to the MCO or its Subcontractors.

6.10.10.11. Upon audit, the MCO 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 MCO. All communication with the insurer relating to and including the Confidential data matching agreements shall be in writing and in accordance with this Agreement.

6.10.10.12. The MCO 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:

6.10.10.12.1 Member's first and last name;

6.10.10.12.2 Member's policy number;

6.10.10.12.3 Member's group number, if available;

6.10.10.12.4 Policyholder's first and last name, if available;

6.10.10.12.5 Policy coverage type to include at a minimum:

6.10.10.12.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.10.10.12.5.2. Hospital coverage;

6.10.10.12.5.3. Pharmacy coverage;

6.10.10.12.5.4. Dental coverage; and

6.10.10.12.5.5. Vision Coverage.

6.10.10.12.6 Begin date of insurance; and

6.10.10.12.7 End date of insurance (when terminated).

6.10.10.13. The MCO shall submit any new, changed, or terminated private insurance Confidential Data to the Department through file transfer on a monthly basis.

6.10.10.14. [Amendment #2:] The MCO shall not cost avoid claims for preventive pediatric services, including screening, diagnosis, and treatment services covered under the ~~(including~~ EPSDT~~)~~ benefit, as well as related medical benefit services ancillary to pediatric services covered under Medicaid fee-for-service (e.g., anesthesia for oral health services), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3).

6.10.10.15. [Amendment #2:] The MCO shall pay all preventive pediatric services, including screening, diagnosis, and treatment services covered under

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the EPSDT benefit, as well as related medical benefit services ancillary to pediatric services covered under Medicaid fee-for-service (e.g., anesthesia for oral health services), and collect reimbursement from private insurance after the Medicaid managed care claim adjudicates.

6.10.10.16. The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable or any other agreement to payment in the MCO/Provider contract.

6.10.10.17. [Amendment #3:] [Amendment #2:] Intentionally left blank. ~~The MCO shall disregard the TPL lesser of logic payment methodology for claims that require provider reimbursement at rates no less than Medicaid or Medicare minimum fee schedule rates under this Agreement as described in Section 4.16 (Provider Payments).~~

6.10.10.17.1 [Amendment #3] [Amendment #2:] Intentionally left blank. ~~The MCO shall pay the difference between the TPL amount and the minimum Medicaid or Medicare fee schedule amount required in accordance with separate guidance.~~

6.10.10.17.2 [Amendment #3:] Intentionally left blank. ~~If the TPL payment is more than the Medicaid or Medicare minimum fee schedule amount requirement, then the MCO pays nothing.~~

6.10.10.18. On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O: Quality and Oversight Reporting Requirements.

6.10.10.19. This report shall reflect the number of claims and billed dollar amount avoided by private insurance, including Medicare and Medicare Advantage plans for all types of coverage as follows:

6.10.10.19.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.10.10.19.2 Hospital coverage;

6.10.10.19.3 Pharmacy coverage;

6.10.10.19.4 Dental coverage; and

6.10.10.19.5 Vision coverage.

6.10.11 **Pay and Chase Private Insurance**

6.10.11.1. If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company, including Medicare Advantage plans.

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6.10.11.2. The MCO shall submit quarterly TPL billed and recovery reports, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

6.10.11.3. These reports shall reflect detail and summary information of the MCO's billing, collection efforts, and recovery from Standards Medicare, Medicare Advantage Plans, and private insurance for all types of coverage as follows:

6.10.11.3.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

6.10.11.3.2 Hospital coverage;

6.10.11.3.3 Pharmacy coverage;

6.10.11.3.4 Dental coverage; and

6.10.11.3.5 Vision Coverage.

6.10.11.4. [Amendment #4:] The MCO shall have five (5) months ~~one-hundred-twenty (120) calendar days~~ from the original paid date to bill ~~initiate recovery of funds from~~ private insurance. The MCO shall have six (6) years to recover funds with the following exceptions:

6.10.11.4.1 The Department may, beginning one year from the date the MCO paid the claim, directly bill and recover the private insurance amount paid by the MCO but not collected. The Department shall inform the MCO in writing any claims in which the Department plans to pursue Pay and Chase recovery, and the Department shall retain any recovered funds.

6.10.11.4.2 If a recovery is closed on the Exhibit O: 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 closure, and retain any funds recovered.

6.10.11.4.3 [Amendment #4] The Department may directly bill and recover the private insurance amount paid by the MCO if the MCO has not billed the private insurance within five (5) months from the MCO original paid date. The Department shall inform the MCO in writing of any claims in which the Department plans to pursue Pay and Case recovery and retain any recovered funds.

6.10.11.5. The MCO shall treat funds recovered from private insurance and Medicare Advantage plans as offsets to claims payments by posting within the claim system.

6.10.11.5.1 The MCO shall post all payments to claim level detail by Member.

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6.10.11.5.2 Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.10.11.5.3 [Amendment #2:] The MCO shall submit amounts beyond a Member's outstanding MCO payment to the Department semi-annually to determine if the Department has any claims to apply the funds. If there are no claims in which to apply the funds, the MCO must return any remaining over payments to the Member annually.

6.10.11.6. The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.10.11.7. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.11.8. The MCO or its Subcontractor shall follow up on any billed TPL that is not collected or properly denied by the other insurance once a $1,500 cumulative minimum threshold for medical claims is reached per member or single claim of fifty dollars ($50) and one hundred dollars ($100) per cumulative prescription is reached per member.

6.10.11.9. Subrogation Recoveries

6.10.11.9.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.10.11.9.2 The MCO is responsible for class action lawsuits when the member is enrolled in an MCO on the date of injury and only includes MCO claims related to the class action. If the class action has fee for service and MCO claims, the Department is responsible for the case and will settle for both MCO and fee for service claims and will retain all funds.

6.10.11.9.3 The MCO shall act upon any information from insurance carriers or attorneys regarding potential subrogation cases. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.10.11.9.4 The MCO shall establish detailed policies and procedures for determining, processing, and

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recovering funds based on accident and trauma Subrogation cases.

6.10.11.9.5 The MCO shall submit its policies and procedures, including those related to their case tracking system as described in Section 6.10.11.9.7 of this Agreement, to the Department for approval during the Readiness Review process. The MCO shall have in its policies and procedures, at a minimum, the following:

6.10.11.9.5.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party.

6.10.11.9.5.2. The claims required to be identified, at a minimum, should include ICD-10 diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y".

6.10.11.9.5.3. The MCO shall present a list of ICD-10 diagnostic codes to the Department for approval in identifying claims for review.

6.10.11.9.5.4. The Department reserves the right to require specific codes be reviewed by MCO.

6.10.11.9.5.5. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members.

6.10.11.9.5.6. The MCO shall submit a report of questionnaires generated and sent as described in Exhibit O: Quality and Oversight Reporting Requirements.

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6.10.11.9.5.7. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indictors.

6.10.11.9.5.8. The MCO shall respond to accident referrals and lien request within twenty-one (21) calendar days of the notice per RSA 167:14-a.

6.10.11.9.6 The MCO shall establish a case tracking system to monitor and manage Subrogation cases.

6.10.11.9.7 This system shall allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

6.10.11.9.7.1. Date inquiry letter sent to Member, if applicable;

6.10.11.9.7.2. Date inquiry letter received back from Member, if applicable;

6.10.11.9.7.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;

6.10.11.9.7.4. Date case is established;

6.10.11.9.7.5. Date of incident;

6.10.11.9.7.6. Reason for incident;

6.10.11.9.7.7. Claims associated with incident;

6.10.11.9.7.8. All correspondence and dates;

6.10.11.9.7.9. Case comments by date;

6.10.11.9.7.10. Lien amount and date updated;

6.10.11.9.7.11. Settlement amount;

6.10.11.9.7.12. Date settlement funds received; and

6.10.11.9.7.13. Date case closed.

6.10.11.9.8 The MCO shall submit Subrogation reports in accordance with Exhibit O: Quality and Oversight

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Reporting Requirements. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.11.9.9 DHHS shall inform the MCO of any claims related to an MCO Subrogation cases. The MCO shall pursue the Department's claim recovery as part of their case.

6.10.11.9.10 The MCO shall submit to the Department any and all information regarding the case upon request if the Department also has a Subrogation lien.

6.10.11.9.11 The MCO shall coordinate with the Department on any dual Subrogation settlement recoveries identified in writing by the Department.

6.10.11.9.11.1. The MCO shall pay the Department claims first in the event of any settlement less than the combined total MCO and Department lien amount.

6.10.11.9.11.2. The MCO shall be liable for repayment to the Department for the total Department lien amount in situations when the Department informed the MCO of the State's lien in advance of the settlement, regardless of whether the Department lien amount exceeds the total settlement amount recovered when the MCO settles a subrogation case and accepts a settlement amount without written authorization from the Department.

6.10.11.9.12 If the MCO notifies the Department that they have closed a case prior to the case settling, the Department reserves the right to pursue and retain payment of any remaining paid MCO and FFS claims related to the case.

6.10.11.9.13 The MCO shall submit to the Department for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement.

6.10.11.9.14 The Department shall have twenty (20) business days to review the case once the MCO provides all relevant

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information as determined by the Department to approve the settlement from date received from the MCO.

6.10.11.9.15 If the Department does not respond within twenty (20) business days, the MCO may proceed with settlement.

6.10.11.9.16 If the Department does not approve of the settlement agreement, then the Department may work with the MCO and other parties on the settlement.

6.10.11.9.17 The MCO must notify the Department TPL unit within ten (10) calendar days of a Subrogation case in which the Member was not eligible under the MCO for the date of incident. The MCO cannot close these cases with no lien letter until the Department responds to the notification.

6.10.11.9.18 The Department shall have exclusive rights to pursue subrogations in which the MCO does not have an active subrogation case within ninety (90) calendar days of receiving a referral, of sending the first questionnaire as referenced in 6.10.11.9.5.5 of this Agreement, or of claim paid date if no action was taken since claims paid date, or if the MCO closes the case, as noted on the MCO Subrogation.01 report which indicates the MCO is no longer pursuing the case.

6.10.11.9.18.1. The Department shall retain and manage any restitution cases.

6.10.11.9.18.2. The MCO shall notify the Department's TPL Unit within ten (10) calendar days of any new class action lawsuit.

6.10.11.9.19 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign the Department all rights to such cases to complete and collect on those Subrogation settlements.

6.10.11.9.20 The Department shall retain all recoveries after Agreement termination.

6.10.11.9.21 The MCOs shall report on all subrogation recoveries in a manner prescribed by the Department.

6.10.11.10. Medicare

6.10.11.10.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable.

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6.10.11.10.2 The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process. [42 CFR 438.3(t)]

6.10.11.10.3 A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.10.11.10.4 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.10.11.10.4.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

6.10.11.10.4.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.10.11.10.4.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and shall establish claims edits and deny part D for those part C Members.

6.10.11.10.4.4. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.10.11.10.5 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the Medicare timely filing requirements.

6.10.11.10.5.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.10.11.10.6 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.10.11.10.7 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4

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(Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment. The MCO shall not pay any member liability for Medicare Part D claims.

6.10.11.11. The MCO shall pay any wrap around services not covered by Medicare that are Covered Services under the Medicaid State Plan Amendment and this Agreement.

6.10.12 **Estate Recoveries**

6.10.12.1. 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 MCO:

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.

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7.2 **Termination for Other Reasons**

7.2.1 The MCO 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 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 MCO prompt written notice of such termination.

7.2.3 Notwithstanding the above, the MCO shall not be relieved of liability to the Department or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.4 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to the Department immediately on demand.

7.2.5 The Department may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if the Department determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.6 In such event, Section 4.7.9 (Access to Providers During Transitions of Care) shall apply.

7.3 **Claims Responsibilities**

7.3.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.5.2 (Service Authorization/Continuity of Care) of this Agreement, 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 MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the MCO's outstanding final financial obligations.

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7.4.2 If all financial obligations of the MCO have been satisfied, amounts due to the MCO for unpaid premiums, risk settlement, High-Cost Drug Risk Pool, and other risk mitigation initiatives identified in this Agreement by the Department shall be paid to the MCO 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 MCO 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 MCO shall work cooperatively with the Department and/or its designee to process service authorization requests received.

7.5.2.1.1 Disputes between the MCO 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 MCO shall give written notice to the Department of all service authorizations that are not decided upon by the MCO 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 4.7.9 (Access to Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.5.2.4. The Member shall be referred to appropriate Participating Providers.

7.5.2.5. The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization Confidential Data from the new MCO 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.

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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 MCO must;

7.6.1.9.1 Only use a State email address assigned to them with a "@ affiliate.DHHS.NH.Gov".

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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 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 Agreement, said End User may face removal from the Agreement, 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 Agreement. The solicitation or disclosure of PHI, PII, or other Confidential Information shall be

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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 this Agreement 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.

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EXHIBIT C – Payment Terms – Amendment #4

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit B. 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 of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

Eligibility Category **Medicaid Care Management**	**July-December 2025**
Foster Care / Adoption	$521.56
Severely Disabled Children	3,711.62
Low Income Children - Age 0-11 Months	516.60
Low Income Children - Age 1-18 Years	298.49
Low Income Adults	884.52
Elderly and Disabled Adults - Age 19-64	2,266.18
Dual Eligibles	331.69
Elderly and Disabled Adults - Age 65+	1,774.17
CHIP	256.42
Behavioral Health Population Rates	
Severe/Persistent Mental Illness - Dual	$1,850.85
Severe/Persistent Mental Illness - Non-Dual	3,253.46
Severe Mental Illness - Dual	1,240.34
Severe Mental Illness - Non-Dual	2,690.32
Low Utilizer - Dual	797.69
Low Utilizer - Non-Dual	2,488.18
Serious Emotionally Disturbed Child	1,368.33
Medicaid Expansion	
Granite Advantage - Medically Frail	$1,974.97
Granite Advantage - Non-Medically Frail	873.24
Maternity /Newborn Kick Payments	
Maternity Kick Payment	$7,114.07
Newborn Kick Payment	11,789.92
Neonatal Abstinence Syndrome Kick Payment	36,970.20

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EXHIBIT C – Payment Terms – Amendment #4

Eligibility Category **Medicaid Care Management**	**January-June 2026**
Foster Care / Adoption	$522.21
Severely Disabled Children	$3,715.47
Low Income Children - Age 0-11 Months	$517.18
Low Income Children - Age 1-18 Years	$298.84
Low Income Adults	$853.55
Elderly and Disabled Adults - Age 18-64	$2,245.97
Dual Eligibles	$330.34
Elderly and Disabled Adults - Age 65+	$1,772.69
CHIP	$256.72
Behavioral Health Population Rates	
Severe/Persistent Mental Illness - Dual	$1,849.22
Severe/Persistent Mental Illness - Non-Dual	$3,217.89
Severe Mental Illness - Dual	$1,240.45
Severe Mental Illness - Non-Dual	$2,663.70
Low Utilizer - Dual	$797.28
Low Utilizer - Non-Dual	$2,436.20
Serious Emotionally Disturbed Child	$1,369.64
Medicaid Expansion	
Granite Advantage - Medically Frail	$1,956.32
Granite Advantage - Non-Medically Frail	$856.45
Maternity /Newborn Kick Payments	
Maternity Kick Payment	$7,117.72
Newborn Kick Payment	$11,795.97
Neonatal Abstinence Syndrome Kick Payment	$36,989.15

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.

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EXHIBIT C – Payment Terms – Amendment #4

Any rate adjustments shall be subject to the availability of State appropriations.

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for the twelve month contract period covering the State Fiscal Year 2026 period of July 1, 2025 – June 30, 2026 to be served among all contracts is 2,100,862. Accordingly, the price limitation increase for the twelve month contract period July 1, 2025 – June 30, 2026 among all contracts is $25,535,137 based on the projected members per month. The full price limitation is $2,768,763,464.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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Medicaid Care Management Services Contract
Exhibit N - Amendment 4
Liquidated Damages Matrix

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
1. LEVEL 1 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing or recurring failure to meet minimum Primary Care and Prevention Focused Model of Care general requirements (Section 4.10)	$25,000 per week of violation
	1.6 Continuing or recurring failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including the full continuum of care for members with substance use disorders	$25,000 per week of violation
	1.7 Continuing or recurring failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7)	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan; $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.9 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$10,000 per month of violation (for each month that DHHS determines the MCO is not substantially in compliance)
	1.10 Continuing or recurring failure to resolve member appeals and grievances within specified timeframes	$25,000 per violation
	1.11 Failure to submit timely, accurate, and/or complete encounter data records 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 MCO in that month until such time as the required submission is made)*	$5,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$25,000 per violation
	1.13 Failure to adhere to the Preferred Drug List requirements	$25,000 per violation
	1.14 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 2 violation	$25,000 per violation
	1.15 Continued or recurring failure to comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder	$50,000 per violation for continuing failure
	1.16 Continued or recurring failure to meet the requirements for minimizing psychiatric boarding	$5,000 per day for continuing failure

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.17 Failure to ensure non-emergency medical transportation (NEMT) driver services and vehicle safety requirements conform with Section 4.1.9.3; 4.1.9.8.1.1 - 4.1.9.8.1.7	$25,000 per violation
	1.18 [Amendment #1:] Failure to deliver or recover a confirmed NEMT ride, resulting in disruption to a Covered Service (Section 4.1.9.8.5.~~1~~)	$5,000 per violation for the first five (5) occurrences; $15,000 for each additional violation; No more than 50% of any liquidated damage amount for failing to meet this standard shall be imposed on the Subcontractor by the MCO
	1.19 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled; $500 per additional day provider is not suspended once MCO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.20 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 MCO, its Subcontractor or a Provider	$50,000 per violation
	1.21 Two or more Level 1 violations within a contract year	$75,000 per occurrence

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.22 [Amendment #2:] [Amendment #1:] Failure to make capitated payments to a Community Mental Health Program (CMH Program) or a Certified Community Behavioral Health Clinic (CCBHC) in accordance with Sections 4.16.2.3.1.1 through 4.16.2.3.1.1.2 and Section 4.16.2.3.3.1, respectively; and as directed by, and in amounts determined by, the Department. Any monthly interim payment made by the MCO to a CMH or CCBHC Program shall not be considered as compliance with this standard	[Amendment #1:] $100,000 per violation for the first month of non-compliance. Liquidated Damages double for each month of non-compliance after month 1. For example only, non-compliance in month 1, 2, and 3 would equal a Liquidated Damage of $500,000.
2. LEVEL 2 MCO action(s) or inaction(s) that jeopardize the integrity of the managed care program but does not necessarily jeopardize member(s) health, safety, and welfare or access to care.	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified)
	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 of such information and/or timely report violations in the access, use, and disclosure of PHI	$100,000 per violation
	2.3 Failure to meet prompt payment requirements and standards	$25,000 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	$50,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	provide adequate information to determine cost avoidance percentage as determined by DHHS	
	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	$50,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud or abuse to DHHS annually	$10,000 unless good cause determined by Program Integrity
	2.8 EQR reports with “not met” findings that have been substantiated by DHHS	$10,000 per violation
	2.9 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	2.11 Member in pharmacy “lock-in” program not locked into a pharmacy and no documentation as to waiver or other excuse for not being locked in	$500 per member per occurrence and total pharmacy claims amount paid while not locked-in
	2.12 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 3 violation	$25,000 per week of violation
	2.13 Failure to suspend or terminate providers when instructed by DHHS	$500 per day of violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	2.14 Failure to timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.15 Failure to meet any performance standards in the contract which may include, but not necessarily be limited to: 2.15.1 Care Coordination and Care Management measures (Sections 4.11.3.4, 4.11.5.7); 2.15.2 Claims processing (Sections 4.19.1.4, 4.19.1.5, 4.19.3.2, 4.19.4.2, 4.19.5.2); 2.15.3 Call center performance (Sections 4.4.10.3.1, 4.4.10.3.2, 4.4.10.3.3, 4.14.4.1.3.1, 4.14.4.1.3.2, 4.14.4.1.3.3); 2.15.4 [Amendment #1:] Non-emergency medical transportation (Sections 4.1.9.8.4, 4.1.9.8.4.1, and 4.1.9.8.5.1 ~~4.1.9.8.7 and 4.1.9.8.8~~); 2.15.5 Service authorization processing (Sections 4.2.4.9, 4.8.4.2.1.1, 4.8.4.3.1, 4.8.4.3.5); and 2.15.6 Childhood Lead Testing Requirements (Section 4.8.2.3.2)	$1,000 per violation
	2.16 Failure to meet 99% of claims financial accuracy requirements (Section 4.19.3.1, 4.19.3.2), and 95% of post service authorization processing requirements (Section 4.8.4.3.5)	$1,000 per violation
	2.17 Two or more recurring Level 2 violations within a contract year	$50,000 per occurrence
	2.18 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence
3. LEVEL 3	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories,	$10,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	provider agreements, etc. requiring DHHS review and/or approval or as requested by an audit	
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	$10,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	$10,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$10,000 per violation
	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$25,000 per violation
	3.7 [Amendment #1:] Failure to submit ~~and obtain DHHS review and~~ applicable Subcontract~~sor~~ contracts for Department review.	$25,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$10,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 4 violation	$25,000 per week of violation
	3.10 Failure to meet minimum social services and community care requirements, as described in Section 4.11.7 (Provider-Delivered Care	$10,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	Coordination and Integration with Social Services and Community Care) of the contract, with respect to unmet resource needs of members	
	3.11 Failure to ensure that clinicians conducting or contributing to a comprehensive assessment are certified in the use of New Hampshire's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within the specified timeframe	$10,000 per violation
	3.12 Two or more Level 3 violations within a contract year	$100,000 per occurrence
4. LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete, 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 submit timely, accurate, and/or complete files to NH CHIS per NH Code of Administrative Rules, Chapter Ins 4000	$2,500 per day the submission or resubmission is late
	4.3 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
	4.4 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

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	4.5 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence
	4.6 Failure to meet staffing requirements of Key Personnel set forth in Section 3.11.1 of the Agreement	$25,000 per violation if the position is not filled on a full-time basis within 90 days of the start of the vacancy. In addition, if the position is not filled on a full-time basis in accordance with the terms of the Agreement within (i) 180 days an additional $50,000 penalty per violation shall apply; (ii) 240 days an additional $75,000 penalty per violation shall apply; and (iii) within 365 days an additional $100,000 penalty per violation shall apply. In addition, if the position is not filled on a full-time basis within 365 days of the initial vacancy a penalty of $100,000 shall be applied each quarter until the position is filled on a full-time basis
	4.7 Failure to ensure provider agreements include all required provisions	$10,000 per violation
	4.8 [Amendment #4:] Failure to meet adherence targets established by the Department for an applicable period as set forth in Section 4.2.3.1.1-4.2.3.1.3	[Amendment #4:] The Department may assess a penalty equal to the

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
		full amount of the lost rebates for the adherence period

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Date 12/9/2025

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders. Addressed through Senate Bill 313.	Legislative Presentation	Agreement Year	Annually	TBD			X						X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan	Varies	Annually	May 1st									X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table	Varies	Quarterly	4 Months after end of Measurement Period									X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report	Agreement Year	Annually	October 31st									X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X			X			
APPEALS.18	Services Authorized within 72 Hours Following a Reversed Appeal	Count and percent of services authorized within 72 hours following a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHDRUG.01	Severe Mental Illness (SMI) and Serious Emotional Disturbance (SED) Drug Prior Authorization	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table	Calendar Year	Annually	January 31st			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCO's program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. The initial Plan shall address but not be limited to how the MCO shall 1) assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare; 2) assure appropriateness of diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; 3) assure promotion of Integrated Care; 4) reduce Psychiatric Boarding; 5) reduce Behavioral Health Readmissions; 6) reduce Behavioral Health related emergency department utilization; 7) support the NH 10-Year Mental Health Plan; 8) assure appropriateness of psychopharmacological medication; 9) assure access to appropriate services; 10) implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and 11) other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.	Plan	Agreement Year	Annually	May 15th									X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table	Calendar Year	Annually	June 30th								X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.1H survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.1H Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.1H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.1H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.06	Adult CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Adult Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	July 15th				X					
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X					X	X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.1H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X					X	
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.1H Survey Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.1H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	
CAHPS_CCC.06	Child w CCC CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Child Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	July 15th				X					
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X	X				X	X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CARECOORD.05	Members Receiving Provider-based Care Coordination	Count and percent of members receiving provider-based care coordination during the measurement quarter.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.06	Members Receiving Provider-based Care Coordination by Provider Group Practice	Count and percent of members receiving provider-based care coordination at the end of the measurement quarter, by Provider Group Practice.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.09	Tracking for Social Service and Community Care Referrals	Standard template capturing quarterly counts of referrals for social services and community care provided to Required Priority Population Members by Member type.	Table	Quarter	Quarterly	TBD									X
CAREMGT.39	Members Enrolled in MCO-Delivered Care Management	Count and percent of members enrolled in MCO-delivered care management on the last day of the measurement period. This measure provides the total count of members receiving care management as a member in a Required Priority Population or at the option of the MCO.	Measure	Month	Monthly	1 Month after end of Measurement Period						X	X		X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.47	Comprehensive Plan: Provider-Delivered Care Coordination; MCO-Delivered Care Management; Health Risk Assessment Screening; and Primary Care and Prevention Focused Model	The MCO shall submit a plan at time of Readiness Review and implement procedures to 1) facilitate integrated Provider-Delivered Care Coordination and MCO-Delivered Care Management, 2) facilitate and operate systems of Provider-Delivered and MCO-Delivered health risk assessments screenings , and 3) implement, administer and facilitate the Primary Care and Prevention Focused Care Model, which must demonstrate authentic engagement between Members and PCPs to ensure each Member has an ongoing source of care appropriate to their needs, and includes procedures for confidentiality, consent, or informed consent. [42 CFR 438.208(b)] The MCO-Delivered Care Management portion must include the plan to implement and operate Care Management for the Required Priority Populations and include how the MCO will take social determinants of health into account.	Plan	Readiness and Agreement Year	Annually	May 1st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.48	Provider-based Care Coordination, MCO-Delivered Care Management, Health Risk Assessment Screening, and Primary Care and Prevention Focused Care Model Report	Narrative report describing: 1) the status of the Provider-based Care Coordination program, including successes and challenges, how it is going with provider engagement, what providers, etc. Include data to illustrate findings. 2) the status of the MCO care management program for Required Priority Populations and members enrolled in other MCO-Delivered Care Management, including successes and challenges, and how the MCO took social determinants of health into account. Include data to illustrate findings. 3) implementation, facilitation and operation of Provider-Delivered and MCO-Delivered health risk assessment screening systems. Include data to illustrate findings. 4) implementation, administration and facilitation of the Primary Care and Prevention Focused Care Model. Include data to illustrate findings and demonstrate the level of authentic engagement between Members and PCPs.	Narrative Report	Quarter for first Agreement Year, then Agreement Year	Quarterly for first Agreement Year, then Annually	2 Months after end of Measurement Period for first Agreement Year, then August 31st									X
CAREMGT.49	MCO-Delivered Care Management Enrollment	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by Required Priority Populations outlined in the Care Management section of the MCM Contract, and members enrolled in other MCO-Delivered Care Management.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
CAREMGT.50	Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.51	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Members with Behavioral Health Hospitalizations	Count and percent of members included in the Members with Behavioral Health Hospitalizations Required Priority Population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.52	Members Receiving MCO-Delivered Care Management in Required Priority Populations: DCYF-Involved Members	Count and percent of members included in the DCYF-Involved Members Required Priority Population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.53	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Low Birth Weight Infants	Count and percent of members included in the Low Birth Weight Infants required priority population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.54	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Adult Community Reentry Waiver Members	Count and percent of members with behavioral health needs (e.g., substance use disorder, mental health) who were incarcerated in the State's prisons and are eligible for participation in the Department's Community Reentry demonstration waiver who are enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.56	Members Receiving MCO-Delivered Care Management in Required Priority Populations: TBD	Count and percent of members included in Yet to Be Determined Required Priority Populations enrolled in MCO-based care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.58	Members Receiving MCO-Delivered Care Management in Required Priority Populations: NAS Infants	Count and percent of members included in the Neonatal Abstinence Syndrome (NAS) Infants required priority population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.59	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Youth Reentry Members	Count and percent of members who were incarcerated youth and are eligible for any Medicaid eligibility group, or determined eligible for the mandatory eligibility group for former foster care children, immediately before becoming an inmate of a public institution or while an inmate of a public institution who are enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.60	Priority Population Members Receiving MCO-Delivered Care Management	Count and percent of members enrolled in MCO-delivered care management on the last day of the measurement period, based on a deduplicated total of members included in one or more Required Priority Population group.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period						X			X
CCBHC_AMM.01	Antidepressant Medication Management - Effective Acute Phase Treatment for CCBHC Clients	Count and percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_AMM.02	Antidepressant Medication Management - Effective Continuation Phase Treatment for CCBHC Clients	Percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months).	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CCBHC_GSD.01	Glycemic Status Assessment for Patients With Diabetes (<8.0%) (GSD-AD)	Provide, at DHHS direction, CCBHC oversample of GSD HEDIS measure to comply with CCBHC demonstration requirements. Applies to data reporting year 2025 forward. Since it is not yet clear if CCBHC reporting will require GSD or older HBD, we will retire unnecessary one once clarified.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_GSD.02	Glycemic Status Assessment for Patients With Diabetes: HbA1c Poor Control (>9.0%) (GSD-AD)	Provide, at DHHS direction, CCBHC oversample of GSD HEDIS measure to comply with CCBHC demonstration requirements. Applies to data reporting year 2025 forward. Since it is not yet clear if CCBHC reporting will require GSD or older HBD, we will retire unnecessary one once clarified.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_HBD.01	Hemoglobin A1c Control for CCBHC Patients with Diabetes: HbA1c Control (<8.0%) (HBD-AD)	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was less than 8.0% during the measurement year. *Utilize the hybrid methodology in the SAMHSA specification for this measure.*	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_HBD.02	Hemoglobin A1c Control for CCBHC Patients with Diabetes: HbA1c Poor Control (>9.0%) (HBD-AD)	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was greater than 9.0% during the measurement year. *Utilize the hybrid methodology in the SAMHSA specification for this measure.*	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_MBR_LVL_DATA.01	CCBHC Demonstration Member Level Data	This file contains member/event level data for select CCBHC measures. Data will reflect the results for these measures in the corresponding CCBHC measures for the same measurement period. The list of DHHS-selected CCBHC measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year. There will be duplication of some data provided to DHHS in other Member Level Data Files.	Member Level Data File	Calendar Year	Annually	9 Months after end of Measurement Period							X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CCBHC_PCR.01	Plan All-Cause Readmissions for CCBHC Patients (PCR-AD)	CCBHC clinic specific calculation of PCR measure components	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure	Month	Monthly	110 Calendar Days after end of Measurement Period			X						X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.28	Timely Processing of Facility-to-Facility Transportation Claims: Thirty Days of Receipt	Count and percent of clean Facility-to-Facility Transportation claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Facility-to-Facility transportation claims are those rides where ambulance companies transport members from hospitals following discharge to other facilities such as rehabilitation facilities or nursing homes. The MCOs process these claims, NEMT brokers are not involved.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMHC.01	CMHC Capitation Payment Reporting	Template including data reflecting the following: Monthly units by rate cell for each CMHC and Total Monthly Payments by rate cell for each CMHC.	Table	Month	Monthly	1 Day after end of Measurement Period									X
CMHC.02	CMHC Capitation Payment Reporting: Same-Day Eligibility Reconciliations	Template reflecting the results of same-day eligibility reconciliations each quarter by CMHC and the pro-rated capitation amounts paid to each CMHC.	Table	Quarter	Quarterly	8 Months after end of Measurement Period									X
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported)	Measure	Calendar Year	Annually	September 30th				X			X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure	Calendar Year	Annually	September 30th				X	X				
CMS_A_GSD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%). The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_GSD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%). The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_INP_PQI15	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma in Younger Adults Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		

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CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CH_DEV.02	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure	Calendar Year	Annually	September 30th				X					
CMS_CORE_ SET.01	CMS Core Set Member Level Data	This file contains member/event level data for select CMS Core Set measures. Data will reflect the results for these measures in the corresponding CMS Core Set measures for the same measurement period. The list of DHHS-selected CMS Core Set measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year.	Member Level Data File	Calendar Year	Annually	September 30th				X					X
CMS_PDS.01	Postpartum Depression Screening and Follow-Up: Depression Screening	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PDS.02	Postpartum Depression Screening and Follow-Up: Follow-Up on Positive Screen	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_PRS.01	Prenatal Immunization Status: Influenza	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PRS.02	Prenatal Immunization Status: Tdap	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PRS.03	Prenatal Immunization Status: Combination	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CULTURAL COMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan	Agreement Year	Annually	May 1st									X
DHHS_LEAD.01	Pediatric Lead Screening – One-Year Screenings Completed	Count and percent of pediatric members with a completed one-year lead screening. One-year screenings occur when a member is at least 11 months of age and less than 23 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X
DHHS_LEAD.02	Pediatric Lead Screening – Two-Year Screenings Completed	Count and percent of pediatric members with a completed two-year lead screening. Two-year screenings occur when a member is at least 23 months of age and less than 36 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X
DHHS_LEAD.03	Pediatric Lead Screening – Both One-Year and Two-Year Screenings Completed	Count and percent of pediatric members with both a completed one-year and two-year lead screening. One-year screenings occur when a member is at least 11 months of age and less than 23 months of age. Two-year screenings occur when a member is at least 23 months of age and less than 36 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X

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EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan	Agreement Year	Annually	May 1st									X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan	Agreement Year	Annually	May 1st									X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report	6 Months	Semi-Annually	1 Month after end of Measurement Period									X

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FINANCIAL STMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report	MCO Financial Period	Annually	August 10th									X
FWA.02	Provider Fraud Log	Standard template log of all fraud related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table	Month	Monthly	15 Days after end of Measurement Period			X						X
FWA.04	Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
FWA.05	Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table	Quarter	Quarterly	1 Month after end of Measurement Period			X						X
FWA.06	Waste and Abuse Recovery Report	Standard template reporting waste and abuse identified and recovered by the MCO.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table	Quarter	Quarterly	15 Calendar Days after end of Measurement Period			X		X	X			
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period			X					X	
HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCQA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCQA audited results for all HEDIS measures and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.04	NCQA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCQA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in *Appendix AF - HEDIS Measures Included in HEDIS.06* and is subject to change each measurement year.	Member Level Data File	Calendar Year	Annually	June 30th					X				X

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure	1 Year Starting July 1 of Year Prior to Measurement Year to June 30 of Measurement Year.	Annually	June 30th				X			X	X	
HEDIS_AAF-E	Follow-Up After Acute Care and Urgent Care Visits for Asthma	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_ADD-E	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets and CCBHC Demonstration	Measure	1 Year Starting March 1 of Year Prior to Measurement Year to February 28 of Measurement Year.	Annually	June 30th				X			X	X	X
HEDIS_AIS-E	Adult Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CCBHC reporting.	Measure	May 1 of Year Prior to Measurement Year to Oct 31 of Measurement Year.	Annually	June 30th							X		X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X	X		X	X	X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X	X							X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	2 Calendar Years	Annually	June 30th				X				X	X
HEDIS_BPD	Blood Pressure Control for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X							X	X
HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2.	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_CCS-E	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	3 Calendar Years	Annually	June 30th				X				X	X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_CIS-E	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_COL-E	Colorectal Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year with a 10 Year Look-back	Annually	June 30th				X					
HEDIS_COU	Risk of Chronic Opioid Use	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X

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HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_DDM	Disability Description of Membership (DDM)	HEDIS Measure (New Health Plan Descriptive Information Measure)	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_EED	Eye Exam for Patients with Diabetes (EED)	HEDIS Measure, also utilized for CMS Core Sets.	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_FMC	Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th									X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Substance Use	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th		X		X	X		X	X	X
HEDIS_FUH	Follow-Up After Hospitalization for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	January 1 to December 1 of Measurement Year	Annually	June 30th				X			X	X	X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	January 1 to December 1 of Measurement Year	Annually	June 30th								X	X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th		X		X			X	X	X

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HEDIS_GSD	Glycemic Status Assessment for Patients With Diabetes	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. Race and ethnicity breakouts as specified in HEDIS Volume 2.	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_IET	Initiation and Engagement of Substance Use Disorder Treatment (IET)	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th	X			X	X		X	X	X
HEDIS_IMA-E	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_LDM	Language Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_MSC	Medical Assistance with Smoking and Tobacco Use Cessation	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_PDS-E	Postpartum Depression Screening and Follow-Up	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_PND-E	Prenatal Depression Screening and Follow-Up	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X

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HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure	1 Year Starting July 1 of Year Prior to Measurement Year to June 30 of Measurement Year.	Annually	June 30th								X	X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SNS-E	Social Needs Screening and Intervention	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X

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HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X				X	X
HEDIS_TSC-E	Tobacco Use Screening and Cessation Intervention	The percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user. Two rates are reported: 1) Tobacco Use Screening. The percentage of persons who were screened for tobacco use. 2) Cessation Intervention. The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_W30	Well-Child Visits in the First 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th			X	X					X

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HEDIS_WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th			X	X					X
HRA.12	Successful Completion and Review of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion and review of provider-based health risk assessment screenings during the 12 months tracked in the measurement period, as of the last day of the measurement period.	Measure	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period	X								X
HRA.13	Successful Completion, Review, and Referral or Follow-up as Needed on Provider-based Health Risk Assessment Screenings by Provider Group Practice	Count and percent of members for whom the MCO paid claims for completion, review, and referral or follow-up as needed on provider-based health risk assessment screenings during the measurement year, by provider group practice, as of the last day of the measurement year.	Table	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period									X
HRA.12	Successful Completion and Review of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion and review of provider-based health risk assessment screenings during the 12 months tracked in the measurement period, as of the last day of the measurement period.	Measure	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period	X								X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
IMD DISCHARGE.01	New Hampshire Hospital Discharges - Intake Appointments for New CMHC Patients within 7 Days of Discharge	Count and percent of New Hampshire Hospital discharges where the member had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days post member discharge AND was not a patient of the applicable CMHC at admission to New Hampshire Hospital. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
IMD DISCHARGE.03	New Hampshire Hospital Discharges - Member Received Discharge Instruction Sheet	Count and percent of discharges from New Hampshire Hospital where the member received a discharge instruction sheet prior to discharge, or no later than the next business day following the discharge. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
IMD DISCHARGE.04	New Hampshire Hospital Discharges - Discharge Plan Provided to Aftercare Provider within 7 Days of Discharge	Count and percent of members discharged from New Hampshire Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
INLIEUOF.02	In Lieu of Services: New or Modified Services and Annual Report	Standard report for MCO to submit requests for new or modified in lieu of services. This template will also be used for required annual reporting.	Table	Annually or Ad Hoc as Needed	Annually or Ad Hoc as Needed	March 15th, Ad Hoc			X						X
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan	Agreement Year	Annually	May 1st, Upon Revision			X						

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
INTEGRITY.02	Program Integrity Compliance and Fraud, Waste, and Abuse Narrative Report	A narrative report on the previous year's findings related to the MCO's internal fraud, waste, and abuse monitoring. The report should also include a description of how prior year's barriers to provider auditing were addressed.	Narrative Report	Agreement Year	Annually	August 31st									X
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked into a pharmacy for the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan	Agreement Year	Annually	May 1st									X
MCO_COMP_ ASSESS.02	MCO Comprehensive Assessments Completed for Required Priority Populations	Count and percent of members included in a Required Priority Population for which the MCO completed a comprehensive assessment during the measurement period, by age group and Required Priority Population category or Other MCO-Delivered Care Management.	Measure	Rolling 12 Months	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MCO_COMP _ASSESS.04	Timeliness of MCO Comprehensive Assessments	Count and percent of members for which the MCO completed the comprehensive assessments within 30 calendar days of identifying the Member as being part of one or more Required Priority Populations or in need of Other MCO-Delivered Care Management, based on a deduplicated total of members included in one or more Required Priority Population group and members enrolled in Other MCO-Delivered Care Management.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
MCO_COMP _ASSESS.05	Care Management Comprehensive Assessment Results within 14 Calendar Days	Count and percent of members with a comprehensive assessment completed during the measurement period, where the MCO shared the assessment results in writing with the member's care team within 14 calendar days of completion. The member's care team includes but is not limited to the member's PCP, specialists, behavioral health providers, and Area Agencies.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls received during the measurement period and answered by a live voice within 30 seconds, by health plan vendors as follows: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue during the measurement period, by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member calls received during the measurement period and answered by a live voice, by reason for inquiry as follows: A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages received after business hours and responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEM INCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEM INCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Plan	Agreement Year	Annually	May 1st									X
MHACT.04	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least six billed Assertive Community Treatment (ACT) services in each month of the measurement period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MH DISCHARGE.03	ED Visits for Mental Health Preceded by a State of NH IMD or Non-IMD DRF Hospital Stay in Past 30 Days	This file contains member/event level data reflecting mental health related emergency department (ED) visits where: 1) The member was discharged from a State of NH IMD Hospital or Designated Receiving Facility (DRF) up to 30 days prior to the ED visit, and 2) The primary diagnosis for the ED visit was mental health related, and 3) The ED visit did not result in an inpatient admission or direct transfer to a State of NH IMD Hospital or DRF. Data points will include PHI as well as indicators for follow-up received, CMHP Services Received, DCYF Involvement, and Medicare/Medicaid Dual Status. Given this file contains protected health information (PHI), MCOs will submit the file to DHHS via secure means.	Member Level Data File	Quarter	Quarterly	4 Months after end of Measurement Period									X
MH DISCHARGE.04	Follow-up Visits after Hospital Discharge for Mental Health-Related Conditions	This file contains member/event level data reflecting member discharges with a primary diagnosis for a mental health-related condition occurring in the measurement quarter where the member had at least one follow-up visit with a mental health practitioner within 7 and/or 30 days of discharge. Data points will include PHI as well as indicators for follow-up received, CMHP Eligibility (SMI/SED and Non-CMHC subpopulations), DCYF Involvement, and Medicare/Medicaid Dual Status.	Member Level Data File	Quarter	Quarterly	5 Months after end of Measurement Period						X			X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaiting placement within the prior 30, 60 and 90 days.	Table	TBD	TBD	TBD									X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	This template will provide DHHS with aggregate MCO member population data and member-level data. The MCO member population tab will provide DHHS with aggregate MCO member population data based on age group and member enrollment on the last day of the data period for the reporting period.	Table	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHREADMIT.08	Readmissions for Mental Health Conditions within 30, 90 and 180 Days of Discharge	This file contains member/event level data reflecting member admissions with a primary diagnosis for a mental health condition, where a previous discharge for a mental health-related condition occurred within 30, 90 and/or 180 days. Data points will include PHI as well as indicators for previous discharges, CMHP Services Received, DCYF Involvement, and Medicare/Medicaid Dual Status. Given this file contains protected health information (PHI), MCOs will submit the file to DHHS via secure means.	Member Level Data File	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan	Agreement Year	Annually	May 1st									X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information.	Table	Quarter	Quarterly	9 Months after end of Measurement Period			X						
MONTHLYOPS.01	Monthly Operations Report	This report will include details about various operational components required by the MCO contract, as determined by DHHS.	Table	Month	Monthly	TBD									X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
NCQA.01	NCQA Accreditation Review Results	Copies of all sections of the most current NCQA accreditation results to reflect 1) accreditation status, to include survey type and level (as applicable); 2) accreditation results, to include recommended actions or improvements, corrective action plans (CAPS) and summaries of findings and 3) expiration date of the accreditation.	Narrative Report	NCQA Accreditation Cycle	NCQA Accreditation Cycle	Within one week of receipt from NCQA								X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.15	NEMT Legs Delivered by Covered Medical Service Provider Type	Count and percent of Non-Emergency Medical Transportation (NEMT) delivery legs completed during the measurement period, by primary covered medical service provider type for the leg. The measure includes nine submeasures: A: Hospital, B: Medical Provider, C: Behavioral Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G. Other, H. Dialysis and I. Medical or DME Supplier. This measure excludes return legs (e.g. legs back to the original pick-up location, typically the member's home).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.22	Family and Friends Program NEMT Legs	Count and percent of Non-Emergency Medical Transportation one-way legs delivered through the Family and Friends Mileage program.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.24	Timeliness of Scheduled and Delivered NEMT Legs	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with and delivered by a contracted transportation provider during the measurement period, with an outcome of delivered on time. This measure excludes legs for methadone treatment, Family and Friends Mileage Reimbursement Program legs, legs provided by Easter Seals or other providers that offer their own NEMT services and directly transport members, and legs scheduled by a medical provider with a vendor other than the health plan's NEMT broker.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.25	NEMT Network Adequacy Report	A narrative report that describes at the county and transportation mode level how the MCO and/or NEMT broker determine fleet size, changes to the NEMT network during the measurement period, and any activities the MCO has performed to ensure adequate NEMT network adequacy.	Narrative Report	Quarter	Quarterly	1 Month after end of Measurement Period									X
NEMT.26	Timely Processing of Electronic NEMT Claims: Thirty Days of Receipt	Count and percent of clean electronic Non-Emergency Medical Transportation (NEMT) claims processed within 30 calendar days of receipt, for those claims received during the measurement period. This includes non-emergency ambulance rides for hospital discharges and any rides for individuals who require an ambulance for non-emergency transport.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.27	NEMT Network Adequacy Table	This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers. This is separate from NETWORK.01.	Table	TBD	TBD	TBD									X
NEMT.28	NEMT Complaint Log	Standard template providing a quarterly report of all Non-Emergency Medical Transportation (NEMT) complaints received from a member, medical provider, or transportation provider during the measurement quarter.	Table	Month	Monthly	15 Days after end of Measurement Period									X
NEMT.29	Timeliness of Scheduled NEMT Legs from Nursing Facilities	Count and percent of Non-Emergency Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests from nursing facilities scheduled and delivered during the measurement period, with an outcome of delivered on time.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.30	NEMT Legs Delivered	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with a contracted transportation provider during the measurement period where the final outcome was a delivered leg. This measure includes legs for Opioid Treatment Programs (OTPs).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.32	Scheduled NEMT Trips with Issues Impacting Delivery	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with a contracted transportation provider during the measurement period where an issue occurred that either resulted in no delivery or extra steps to ensure delivery of the leg. This measure includes legs for Opioid Treatment Programs (OTPs). Issues include: A. Member Canceled or Rescheduled, B. Member No Show, C. Transportation Provider Canceled Outside of Broker Timeframes, D. Transportation Provider No Show, E. Broker Unable to Secure Transportation, F. Incorrect Mode of Transportation Dispatched, and G. Other Reason Leg Wasn't Delivered.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table	Calendar Year	Annually	45 Calendar Days after end of Measurement Period		X	X		X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table	Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X		X	X			

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table	Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X		X	X			
OTPAUDIT.03	OTP Record Audits – Opioid Treatment Program Providers	Case level data from the MCO's audit of clinical records for Members receiving services provided by Opioid Treatment Programs (OTP).	Table	Measurement Year	Biennially (Every Two Years)	November 30th									X
OTPAUDIT.06	Quality and Performance Improvement Monitoring Report for Opioid Treatment Program Providers	Biennial narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.03 and any other provider performance reviews conducted by the MCOs to ensure the Opioid Treatment Program (OTP) full continuum of care is appropriately provided and supports Member access to timely and quality services. The report will include an analysis of the effectiveness of provider engagement activities over the past 12 months toward meeting the desired improved outcomes.	Narrative Report	Measurement Year	Biennially (Every Two Years)	January 31st									X
OTPAUDIT.08	Quality Improvement Progress Report for Opioid Treatment Programs	Biennial narrative report describing the implementation and continued monitoring of the MCO quality improvement activities included in the OTPAUDIT.06 report.	Narrative Report	Measurement Year	Biennially (Every Two Years)	August 31st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PCP_VISITS.01	Member Visits with Designated PCP or PCP Provider Team in the Last 12 Months	Percent of members who had one or more visits with their designated PCP or PCP Provider Team during the measurement period, by age group. This measure includes Non-Symptomatic Office Visits, Non-Urgent, Symptomatic Office Visits, Urgent, Symptomatic Office Visits, and Wellness Visits. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age or Older.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.02	Member Wellness Visits with Designated PCP or PCP Provider Team in the Last 12 Months	Count and percent of members who had one or more wellness visits with their designated PCP or PCP Provider Team during the measurement period, by age group. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age or Older.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.03	New Member Visits with Designated PCP or PCP Provider Team within 90 Days of PCP Selection/Assignment	Percent of new members who had one or more visits with their designated PCP or PCP Provider Team within 90 days of PCP selection/assignment, by age group. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age and Over.	Measure	Quarter	Quarterly	7 Months after end of Measurement Period									~~X~~

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.08	Private Duty Nursing Hospitalization and Network Adequacy Report	This template will capture member detail about hospitalized PDN members and PDN network adequacy.	Table	Month	Monthly	1 Month after end of Measurement Period									X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC-DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure	Calendar Year	Annually	April 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.10	Proportion of Days Covered - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure	Calendar Year	Annually	April 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.14	Proportion of Days Covered - Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite count and composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure	Calendar Year	Annually	April 30th									X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.10A	Child Psychotropic Medication Monitoring Report - Aggregate Data	Standard template of aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.10B	Child Psychotropic Medication Monitoring Report - DCYF PHI Data	Standard template of member specific information related to children 0-18 who have DCYF involvement and have multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.19	Provider-based Comprehensive Medication Review and Counseling Completions	Percent of eligible polypharmacy members who completed one or more comprehensive medication review and counseling (CMR) sessions in the six (6) months following the "Polypharmacy Initiation Date" by age group. This measure excludes Medicare/Medicaid dual enrollees until Medicare data is available. Age Groups include: Age 0-17 Years, Age 18-64 Years, and Age 65 and Over.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PHARMQI.21	Comprehensive Plan for Member Medical Record Information Sharing, Pharmacy Data Sharing, Medication Management, and Comprehensive Medication Reviews	Plan for data sharing efforts between the MCO and PCPs and behavioral health providers for member pharmacy data.	Plan	Agreement Year	Annually	May 1st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.22	Pharmacy Data Sharing Report	Narrative report describing outcome of data sharing efforts with providers, including successes and challenges, of the data sharing efforts.	Narrative Report	Quarter for first Agreement Year, then Agreement Year	Quarterly for first Agreement Year, then Annually	2 Months after end of Measurement Period for first Agreement Year, then October 31st									X
PHARMQI.23	Comprehensive Medication Review (CMR) Outcome Summary	Quarterly template providing DHHS with a summary of outcomes for the 6-month period following member comprehensive medication reviews.	Table	Quarter	Quarterly	5 Months after end of Measurement Period		X							X
PHARMQI.26	Comprehensive Medication Review (CMR) Log	Quarterly template that will provide DHHS with a log of members and providers who completed CMRs during the reporting period.	Table	Quarter	Quarterly	3 Months after end of Measurement Period			X						
PHARM UTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM UTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM UTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PMP.01	Program Management Plan	The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.	Plan	Agreement Year	Annually	May 1st									X
POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PRERELEASE.01	Community Reentry Pre-release Activity Log	Standard template for the MCO to report critical pre-release activity for adult and youth community reentry members. Template also includes log of key post-release events.	Table	Month	Monthly	1 Month after end of Measurement Period					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period			X						
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measurement period.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls received during the measurement period and answered by a live voice within 30 seconds by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Manager (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned while waiting in call queue during the measurement period by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider calls received during the measurement period and answered by a live voice by the following reasons for Inquiry: A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info., etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other	Measure	Month	Monthly	1 Month after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages received after business hours and responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROV COMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVOUTNET.01	Out of Network Providers	Standard template providing a listing of out of network providers for which the MCO had paid claims during the measurement month.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period			X						X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan	Calendar Year	Annually	November 30th			X						
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report	Calendar Year	Annually	September 30th			X						
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure	TBD	TBD	TBD									X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of Medical Service, Equipment, and Supply service authorization determinations for urgent requests, made within 72 hours after receipt of request for requests made during the measurement period. Exclude requests for non-emergency medical transportation from this measure. Exclude Pharmacy claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of Medical Service, Equipment, and Supply Service authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measurement period. Exclude authorization requests that extend beyond the 14-day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for Non-Emergency Medical Transportation (NEMT) from this measure. Exclude Pharmacy Claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period. Includes reporting by age breakouts (< Age 21 and Age 21+)	Table	Quarter	Quarterly	2 Months after end of Measurement Period					X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of Post-Delivery service authorization determinations made within 30 calendar days of receipt of routine requests for Medical Services, Equipment, and Supply services. Exclude requests for Non-Emergency Medical Transportation (NEMT) from this measure. Exclude Pharmacy Claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Count and percent of service authorization requests denied or partially denied during the measurement period, by each of the following waiver and non-HCBC waiver groups: A. Non-HCBC Waiver; B. Developmentally Disabled (DD) Waiver; C. Acquired Brain Disorder (ABD) Waiver; D. In-Home Supports (IHS) Waiver; E. Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Count and percent of Physical, Occupational and Speech Therapy service authorizations denied or partially denied during the measurement period, by each of the following waiver and non-HCBC waiver groups: A. Non-HCBC Waiver; B. Developmentally Disabled (DD) Waiver; C. Acquired Brain Disorder (ABD) Waiver; D. In-Home Supports (IHS) Waiver; E. Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.17	Service Authorization Annual Report	A report that lists all items and services requiring prior authorization for the previous calendar year and associated metrics for each item or service. This report will satisfy requirements for 42 CFR 438.210 (f) and will be used for federal MCPAR reporting. The report will be due to NH DHHS by February 28th annually for review and is required to be posted publicly on the MCO's website by March 31st annually.	Narrative Report	Calendar Year	Annually	2 Months after end of Measurement Period			X						X
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
STATEFAIR HEARING.01	MCM Member State Fair Hearing Request Log	Template to provide DHHS with a quarterly report of all member MCM State Fair Hearing requests in process and resolved during the quarter. Include the record in future quarterly reports until the State Fair Hearing request is reported resolved.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period			X						X
SUBROGATION.02	No Lien Report	List of members in which the MCO has a request for subrogation claims for which the MCO sent a letter stating there were no lien.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period									X
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers within their network with high opioid prescribing rates. The report should include the MCO's operational definition of a provider with a high opioid prescribing rate, and the process for identifying and intervening with providers. The report should include aggregate data about the number of providers that are identified with high morphine milligram equivalent dose (MME) rates and the interventions used. Age breakouts are 0-17, 18+; and should exclude duals.	Narrative Report	Federal Fiscal Year	Annually	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
SUD_CMS_ IMD.25	Readmissions among Members with SUD	Number of all-cause readmissions during the measurement period among Medicaid beneficiaries with substance use disorder (SUD), followed by an acute readmission within 30 days. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #25)	Measure	Agreement Year	Annually	4 Months after end of Measurement Period					X				X
SUDAUDIT.01	SUD Treatment Record Audits	This report will be used to provide DHHS with aggregate level data associated with the SUD audits conducted by the MCOs utilizing the NH MCO SUD Audit tool. Follow the instructions in the NH MCO SUD Audit tool to transfer data into the SUDAUDIT.01 report template.	Table	Measurement Year	Biennially (Every Two Years)	November 30th									X
SUDAUDIT.05	Quality and Performance Improvement Monitoring Report for SUD Treatment Providers	Biennial narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.01 and any other provider performance reviews conducted by the MCOs to ensure the SUD full continuum of care is appropriately provided and supports Member access to timely and quality services.	Narrative Report	Measurement Year	Biennially (Every Two Years)	January 31st									X
SUDAUDIT.07	Quality Improvement Progress Report for SUD Treatment Programs	Annual narrative report describing the implementation and continued monitoring of the MCO quality improvement activities included in the SUDAUDIT.05 report.	Narrative Report	Measurement Year	Biennially (Every Two Years)	August 31st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or subcontractor credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period									X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.04	Coordination of Benefits: Dual State Medicaid Enrollment	This template will provide DHHS with a monthly log of active NH Medicaid members in which the MCO has determined that the NH Medicaid member is concurrently enrolled in the corporate entity's other state Medicaid plan(s) (as applicable), or to report any Members discovered to be enrolled in any other State Medicaid program.	Table	TBD	TBD	TBD									X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report	Agreement Year	Annually	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
WELLNESS.01	Adult Preventive Wellness Visits	Count and percent of members 22 years of age and over who had at least one comprehensive wellness visit during the measurement period, by age group. Age groups include 22-44 Years of Age, 45-64 Years of Age, and 65 Years of Age and Over.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X

Docusign Envelope ID: 849507A8-3887-4735-8A7D-09610B87BB3E

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 BOSTON MEDICAL CENTER HEALTH PLAN, INC. is a Massachusetts Nonprofit Corporation registered to transact business in New Hampshire on December 08, 2011. 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: **662906**

Certificate Number: **0007186169**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 22nd day of May A.D. 2025.

David M. Scanlan

Secretary of State

Docusign Envelope ID: 849507A8-3887-4735-8A7D-09610B87BB3E

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 WELL SENSE HEALTH PLAN is a New Hampshire Trade Name registered to transact business in New Hampshire on July 24, 2012. 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: **675048**

Certificate Number: **0007186164**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 22nd day of May A.D. 2025.

David M. Scanlan

Secretary of State

Docusign Envelope ID: 7FDCB168-C544-4838-99A8-03A3ABFEB40E

WellSense HEALTH PLAN

BOSTON MEDICAL CENTER HEALTH PLAN, INC. d/b/a WellSense Health Plan

Clerk's Certificate

I, Serina Barkley, the duly elected and qualified Clerk of Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan, a Massachusetts non-profit corporation organized under Chapter 180 of the General Laws of Massachusetts, do hereby certify that the following individuals are authorized, acting singly or jointly, to execute, deliver, and file such agreements, documents, instruments and other papers and to take such actions, from time to time in the name of or behalf of the Corporation, they may deem necessary or appropriate, and that their authority to execute and deliver any such agreements, documents, instruments or other papers and to take any such further actions shall be conclusively evidenced by the execution and delivery thereof or the taking thereof:

Diana Cruz, Interim President of Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan
Darren Bennett, Treasurer and Chief Financial Officer of Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan
Serina Barkley, Clerk, of Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan
Alastair Bell, M.D., President and CEO of BMC Health System, Inc.
Jesse Souweine, Senior Vice President of BMC Health System, Inc.
David Beck, Clerk of BMC Health System, Inc.
Karen Fine, Controller of BMC Health System, Inc.,
Ankur Agrawal, Chief Financial Officer of BMC Health System, Inc.

I also certify that these votes have not been amended or revoked, and remain in full force and effect as of the December 9, 2025. This authority remains valid for thirty (30) days from the date of this Clerk's Certificate.

IN WITNESS WHEREOF, I have hereunto set my hand on this December 9, 2025.

DocuSigned by:
Serina Barkley
B705FE06E78D430...

Serina Barkley, Clerk

Docusign Envelope ID: 849507A8-3887-4735-8A7D-09610B87BB3E

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
09/18/2025

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
Aon Risk Services Northeast, Inc.
Boston MA Office
53 State Street
Suite 2201
Boston MA 02109 USA

CONTACT NAME:
PHONE (A/C. No. Ext): (866) 283-7122 **FAX (A/C. No.):** (800) 363-0105
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	Sentinel Insurance Company, Ltd	11000
INSURER B:		
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
Boston Medical Center Corporation
dba WellSense Health Plan
100 City Square Suite 200
Charlestown MA 02129 USA

COVERAGES **CERTIFICATE NUMBER:** 570115443882 **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. **Limits shown are as requested**

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	
							MED EXP (Any one person)	
							PERSONAL & ADV INJURY	
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	
	☐ OTHER:							
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	☐ ANY AUTO						BODILY INJURY (Per person)	
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	
	☐ DED ☐ RETENTION							
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N			10WECBK3RRL	09/15/2025	09/15/2026	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? Y	N / A					E.L. EACH ACCIDENT	$1,000,000
	(Mandatory in NH)						E.L. DISEASE-EA EMPLOYEE	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Coverage.

CERTIFICATE HOLDER

State of NH
Department of Health and Human Services
129 Pleasant Street
Concord NH 03301-3857 USA

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

Aon Risk Services Northeast, Inc.

Holder Identifier :

Certificate No : 570115443882

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CERTIFICATE OF INSURANCE

DATE: 6/12/2025

Strategic Risk Solutions (Cayman) Ltd.
Caribbean Plaza, North Building, 2nd Floor
878 West Bay Road
P.O. Box 1159
Grand Cayman, KY1-1102, Cayman Islands
alex.hurst@strategicrisks.com /
srscayman.certs@strategicrisks.com

This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.

INSURED

Boston Medical Center Health Plan
DBA WellSense Health Plan
Schrafft's City Center
529 Main Street
Suite 500
Charlestown, MA 02129

COMPANY AFFORDING COVERAGE

A BOSTON MEDICAL CENTER INSURANCE COMPANY, LTD.

COVERAGES

This is to certify that the Policies listed below have been issued to the Named Insured 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.

TYPE OF INSURANCE	CO. LTR.	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY	A	BMCIC-PR-A-25	06/30/2025	06/30/2026	EACH OCCURENCE	$2,000,000
					AGGREGATE	$2,000,000
COMMERCIAL GENERAL LIABILITY					PERSONAL & ADV INJURY	$
					EACH OCCURRENCE	$
CLAIMS MADE					FIRE DAMAGE	$
OCCURRENCE					MEDICAL EXPENSES	$
PROFESSIONAL LIABILITY					EACH OCCURENCE	$
					AGGREGATE	$
EXCESS/UMBRELLA LIABILITY					EACH OCCURENCE	$
					AGGREGATE	$

DESCRIPTION OF OPERATIONS/LOCATIONS/VECHICLES/SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)

Evidencing coverage is in effect.

CERTIFICATE HOLDER

State of New Hampshire, Department of Health and Human Services, Bureau of Contracts and Procurement
129 Pleasant St
Concord NH 03301

CANCELLATION

Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives. Boston Medical Center Insurance Company, LTD shall provide to the Certificate Holder identified herein, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

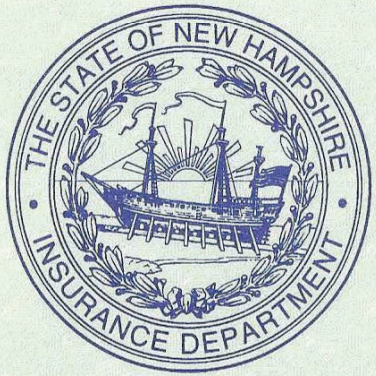
AUTHORIZED REPRESENTATIVES

Docusign Envelope ID: 849507A8-3887-4735-8A7D-09610B87BB3E

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

License No: 89278605

Presents that Boston Medical Center Health Plan, Inc.
is hereby authorized to transact HMO lines of Insurance
in accordance with State Statute RSA 420-B
Exclusions: 7. HMO Only



Effective Date: 06/15/2025
Expiration Date: 06/14/2026

David J. Bettencourt
Commissioner of Insurance

©GOES 746

LITHO IN U.S.A.

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State of New Hampshire
Department of Health and Human Services
Amendment #4

This Amendment to the Medicaid Care Management contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Granite State Health Plan, Inc. d/b/a New Hampshire Healthy Families ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on January 10, 2024 (Tabled Item 33), as amended on July 10, 2024 (Item #11A), as amended on December 18, 2024 (Item #13A) and most recently amended on June 25, 2025 (Item # 199A) 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:

   $2,768,763,464

2. Modify Exhibit B Scope of Services, Amendment #3 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 Scope of Services, Amendment #4 are outlined below:

3. Modify Exhibit B, Section 4.1.2.4, Summary of Covered Services by indicating Psychiatric Residential Treatment Facility Services are “Not Included in Managed Care (DHHS Covered).

4. Modify Exhibit B, Section 4.1.4.2.1 through 4.1.4.2.4, to read:

   4.1.4.2.1 A Copayment of four dollars ($4.00) shall be required for each preferred prescription drug and each refill of a preferred prescription drug; and

   4.1.4.2.2 A Copayment of four dollars ($4.00) shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug.

   4.1.4.2.3 Intentionally left blank.

   4.1.4.2.4 Intentionally left blank.

5. Modify Exhibit B, by adding Section 4.1.4.3.7, to read:

   4.1.4.3.7 Recommended medications, services, and items graded A or B by the U.S. Preventive Services Task Force, including nicotine cessation products and oral and injectable formulations of Pre-Exposure Prophylaxis (PrEP) for persons who are at high risk of HIV acquisition.

6. Modify Exhibit B, Section 4.1.4.4.6, to read:

   4.1.4.4.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within twelve (12) months after the month the pregnancy ended;

7. Modify Exhibit B, Section 4.1.9.3.2, to read:

   4.1.9.3.2 Has undergone a satisfactory safety inspection in accordance with the mutually agreed comprehensive safety checklist at the time of transportation provider enrollment into the Subcontractor's network, at least annually thereafter, and when a safety issue is

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reported for the transportation provider vehicle; and

8. Modify Exhibit B, Section 4.1.9.8.1, by adding Section 4.1.9.8.1.9, to read:

   4.1.9.8.1.9 Any vehicles used for the purpose of transporting individuals with disabilities must meet the requirements set forth in the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles. [49 CFR 38]

9. Modify Exhibit B, Section 4.2.3.1, by adding Sections 4.2.3.1.1 through 4.2.3.1.3, to read:

   4.2.3.1.1 In addition to the MCO's PDL compliance obligations under this Agreement, the MCO shall achieve Department specified minimum adherence targets for specific Department identified drugs' initial adherence targets measured from January 1, 2026 through June 30, 2026. The Department may update adherence targets annually and shall be maintained by the MCO annually thereafter as described in separate guidance.

   4.2.3.1.2 The MCO shall provide quarterly reporting on MCO's adherence targets in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

   4.2.3.1.3 Failure to meet adherence to targets will subject the MCO to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

10. Modify Exhibit B, Section 4.4.13, by adding Section 4.4.13.6, to read:

    4.4.13.6 Beginning March 31, 2026 and annually thereafter, the MCO shall report prior authorization data from the prior calendar year in accordance with Exhibit O: Quality and Oversight Reporting Requirements, excluding any and all drugs covered by the MCO. In addition, the MCO shall make this data accessible by posting the information on its website. [42 CFR 210(f)]

11. Modify Exhibit B, Section 4.5.1, by adding Section 4.5.1.14, to read:

    4.5.1.14 Beginning March 31, 2026, the MCO shall report for the prior calendar year publicly accessible prior authorization data on its plan website, excluding data on any and all drugs covered by the MCO. [42 CFR 438.210]

12. Modify Exhibit B, Section 4.5.3.5, to read:

    4.5.3.5 The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

13. Modify Exhibit B, Section 4.5.6.1, by adding Section 4.5.6.1.1, to read:

    4.5.6.1.1 Effective July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), in accordance with the timeframes established in 42 CFR 438.210(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information) as if such requirements applied directly to the MCO according to the decision timeframes in 42 CFR 438.210(d). [42 CFR 438.242(b)(8)]

14. Modify Exhibit B, Section 4.5.7.3, to read:

    4.5.7.3 Beginning July 1, 2026, for standard service authorization decisions, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed seven (7) calendar days following the date of receipt of 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 from the date of receipt of the request for service is permissible, if:

15. Modify Exhibit B, Section 4.5.9.2, to read:

    4.5.9.2 Under no circumstances may the MCO extend the appeal determination beyo four (44) calendar days from the day the MCO receives the appeal request e

Initial GMV

MCO does not have all the information necessary to make the decision.

16. Modify Exhibit B, Section 4.7, by adding Section 4.7.12 through 4.7.12.1, to read:

    4.7.12 Rural Health Care

    4.7.12.1 Beginning as early as January 1, 2026, the MCO shall support the Department's Rural Health Care activities authorized through the 2025 federal budget reconciliation bill as described in separate guidance. [H.R. 1; P.L. 119-21]

17. Modify Exhibit B, Section 4.8.4.3.1, to read:

    4.8.4.3.1 Beginning July 1, 2026 the determination of all other authorizations for per-service benefits (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed seven (7) fourteen calendar days for ninety-five percent (95%) of standard requests after the receipt of a request. [42 CFR 438.210(d)]

18. Modify Exhibit B, Section 4.8.4.3.2, to read:

    4.8.4.3.2 Beginning July 1, 2026, an extension of up to fourteen (14) calendar days after receiving the request is permissible for if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

19. Modify Exhibit B, Section 4.8.4.3.3, to read:

    4.8.4.3.3 Intentionally left blank.

20. Modify Exhibit B, Section 4.8.4.3.4, to read:

    4.8.4.3.4 Beginning July 1, 2026 notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than seven (7) calendar days after the earlier of:

21. Modify Exhibit B, Section 4.8.4.3.7, to read:

    4.8.4.3.7 Beginning July 1, 2026, the MCO shall notify the requesting provider, and give the enrollee written notice of any decision as expeditiously as the Member's condition requires, but may not exceed seven (7) calendar days after receiving the request for service.

22. Modify Exhibit B, Section 4.8.4.3.7, by adding Section 4.8.4.3.7.1, to read:

    4.8.4.3.7.1 Beginning July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), the MCO shall provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request to the MCO. [42 CFR 438.210(d)] Reasons may be communicated via portal (may include existing payer messaging portal), fax, email, mail, or phone. [42 CFR 438.242(b)(8)]

23. Modify Exhibit B, Section 4.11.2.2.2, to read:

    4.11.2.2.2 Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care

24. Modify Exhibit B, Section 4.11.4.2, to read:

    4.11.4.2 Intentionally left blank.

25. Modify Exhibit B, Section 4.14.3.8.1, to read:

    4.14.3.8.1 For PCPs, (and mental health providers effective January 1, 2026), within

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calendar days of receipt of clean and complete credentialing applications; RSA 420-J:4, I(h)

26. Modify Exhibit B, Section 4.15.14.3.1.1, to read:

    4.15.14.3.1.1 Appropriate use of emergency departments relative to low acuity non-emergent visits.

27. Modify Exhibit B, Section 4.15.14.3.1.6, to read:

    4.15.14.3.1.6 Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing preferred drug prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing Polypharmacy, as described in Section 4.2.6 (Medication Management);

28. Modify Exhibit B, Section 4.15.15.3.3, to read:

    4.15.15.3.3 Effective July 1, 2026, all of MCO's Physician Incentive Plans to a Provider must adhere to the following requirements: (i) have defined performance period that can be tied to the applicable MLR reporting periods; (ii) the Provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCO; (iii) the physician incentive contract with the Provider must include a specific dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including an expected date of payment for meeting the required metrics; and (iv) the physician incentive contracts with the Provider must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e. defined and linked to an applicable MLR reporting period or periods). [42 438.608(e); 42 CFR 438.3(i)(3) and (4)]

29. Modify Exhibit B, Section 4.16.1.11, to read:

    4.16.1.11 The MCO shall implement and maintain arrangements or procedures for prompt reporting within 30 calendar days of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste or Abuse, to the Department. [42 CFR 438.608(a)(2)]

30. Modify Exhibit B, Section 4.18.8.2.1, by adding Sections 4.18.8.2.1.1 through 4.18.8.2.1.1.3 to read:

    4.18.8.2.1. Effective July 1, 2026, implement and maintain a Patient Access Application Programming Interface (API) required in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the MCO, and:

        4.18.8.2.1.1. Include all encounter data, including encounter data from any network providers compensated by the MCO based on capitation payments and adjudicated claims and encounter data from any Subcontractors.

        4.18.8.2.1.2 Exclude covered outpatient drugs as defined in section 1927(k)(2) of the Act.

        4.18.8.2.1.3 Report metrics specified in 42 CFR 431.60(f) (total members whose data are transferred to an API and total members whose data were transferred more than once). [42 CFR 438.242(b)(5)]

31. Modify Exhibit B, Section 5.3.2.2.5, to read:

    5.3.2.2.5 A provision for the prompt reporting within 30 calendar days of all Overpayments identified and recovered, specifying the Overpayments due to potential F

Initial GMV

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CFR 438.608(a)(2)]

32. Modify Exhibit B, Section 5.3.3.6, to read:

5.3.3.6 The Department may recover Overpayments that are not recovered by or returned to the MCO within ninety (90) calendar days of the end of the appeal timeframe unless the MCO has a recovery agreement with the Provider, or is actively recovering through claims recoupment. The Department will notify MCO if the Department has plans to pursue recovery.

33. Modify Exhibit B, Section 5.3.6.4.2, to read:

5.3.6.4.2 The MCO shall report at least annually to the Department and as otherwise required by this Agreement on all Overpayments identified and recovered. 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

34. Modify Exhibit B, by adding Section 5.4.8, to read:

5.4.8 In accordance with RSA 126-A:3, the Department will seek to implement an outpatient procedure incentive program beginning as early as January 1, 2026, subject to review and approval from the fiscal committee of the general court.

35. Modify Exhibit B, Section 6.2.16.9, to read:

6.2.16.9 Beginning for services effective January 1, 2025, for the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each of three (3) new kick payments to cover juveniles and adults who are incarcerated to comply with new service requirements as part of the implementation of the expansion of its Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance Treatment and Recovery Access 1115 Demonstration Waiver

36. Modify Exhibit B, Section 6.3.4.2.11.1.3, to read:

6.3.4.2.11.1.3 For the July 1, 2025 through June 30, 2026 rating period, the capitation rates reflect an average target MLR, which measures the projected medical service costs as a percentage of the total at-risk capitation rates. The minimum MLR will limit MCO gains if the actual MLR is lower than the minimum MLR. The maximum MLR will limit MCO losses if the actual MLR is higher than the maximum MLR. The average target MLR for at-risk services is 91.2% for Standard Medicaid and 90.3% for GAHCP based on the SFY 2026 projected enrollment distribution. The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs for the rating period, the minimum MLR will be 88.7% for the Standard Medicaid population and 87.8% for the GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCO will have a maximum loss of 2%. Based on the target MLRs for the rating period, the average maximum MLR will be 94.7% for the Standard Medicaid population and 93.8% for the GAHCP population.

37. Modify Exhibit B, Section 6.4. by adding Section 6.4.1.1, to read:

6.4.1.1 For both Medicare Part A and Part B Claims, if the Member responsibility amount is “0” then the MCO shall make no payment.

38. Modify Exhibit B, Section 6.3.4.2.10, to read:

6.3.4.2.10 The MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available. At the Department’s discretion, a final rev[illegible] settlement calculation may occur upon completion of an MLR audit for t[illegible].

Initial GMV

if applicable, to consider any adjustments identified during the MLR audit impacting the final MLR settlement calculation.

39. Modify Exhibit B, Section 6.4.2.3, to read:

    6.4.2.3 Intentionally left blank.

40. Modify Exhibit B, Section 6.4.4, to read:

    6.4.4 For all claims (medical and pharmacy) with other insurance or Medicare Advantage plans, the MCO shall follow coordination of benefits processes described in the entirety of this Section 6.4, unless otherwise stipulated in this Agreement.

41. Modify Exhibit B, Section 6.4.4.2, to read:

    6.4.4.2 Beginning March 1, 2026, the MCO shall pay as primary payer for Medicare Part A and Part B claims when the provider is not enrolled with Medicare on the Date of service.

42. Modify Exhibit B, Section 6.4. by adding Section 6.4.4.3, to read:

    6.4.4.3 Beginning March 1, 2026, the MCO is responsible for Member Cost Sharing, (e.g., Copayment, deductible) (excluding Medicare Part D medications), as applicable, when other insurance, Medicare Part A or Part B, or Medicare Advantage pays as primary for a Covered Service via an automated crosswalk table or other methodology to effectuate payment regardless of whether the primary payer uses a different billing code for the same Covered Service.

43. Modify Exhibit B, Section 6.4. by adding Section 6.4.5, to read:

    6.4.5 The MCO shall not pay Member Cost Sharing for Medicare Part D covered medications regardless of whether the Member has one or both Medicare Part A and/or Medicare Part B.

44. Modify Exhibit B, Section 6.10.11.4, to read:

    6.10.11.4 The MCO shall have five (5) months from the original paid date to bill private insurance. The MCO shall have six (6) years to recover funds with the following exceptions:

45. Modify Exhibit B, Section 6.10.11.4 by adding Section 6.10.11.4.3, to read:

    6.10.11.4.3 The Department may directly bill and recover the private insurance amount paid by the MCO if the MCO has not billed the private insurance within five (5) months from the MCO original paid date. The Department shall inform the MCO in writing of any claims in which the Department plans to pursue Pay and Case recovery and retain any recovered funds.

46. Modify Exhibit C Payment Terms, Amendment #3 by replacing it in its entirety with Exhibit C Payment Terms, Amendment #4, which is attached hereto and incorporated by reference herein.

47. Modify Exhibit N Liquidated Damages Matrix, Amendment #2 by replacing it in its entirety with Exhibit N Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

48. Modify Exhibit O: Quality and Oversight Reporting Requirements, Amendment #3 by replacing it in its entirety with Exhibit O: Quality and Oversight Reporting Requirements Liquidated Damages Matrix, Amendment #4, which is attached hereto and incorporated by reference herein.

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 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

12/5/2025
Date

DocuSigned by:
Henry D. Lipman
CF5D44D4F70D4E4...

Name: Henry D. Lipman
Title: Medicaid Director

Granite State Health Plan, Inc. d/b/a New Hampshire Healthy Families

12/5/2025
Date

Signed by:
Geraldine M. Vaughan
F239D0F99B594D8...

Name: Geraldine M. Vaughan
Title: Plan President and CEO

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/5/2025
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:

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Medicaid Care Management

EXHIBIT B – AMENDMENT #4

SCOPE OF SERVICES

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

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1 INTRODUCTION

1.1 Purpose

1.1.1. This Medicaid Care Management Agreement is a comprehensive full risk prepaid capitated Agreement that sets forth the terms and conditions for the Managed Care Organization's (MCO's) participation in the New Hampshire (NH) Medicaid Care Management (MCM) program.

1.2 Term

1.2.1. The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed MCM Agreement or, if the MCO 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 MCO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.1.1 If the MCO 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 MCO.

1.2.2. The Program Start Date shall begin September 1, 2024, and the Agreement term shall continue through August 31, 2029.

1.2.3. The MCO's participation in the MCM program is contingent upon approval by the Governor and Executive Council, the MCO'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.

1.2.4. The MCO is solely responsible for the cost of all work during the Readiness Review and undertakes the work at its sole risk.

1.2.5. If at any time the Department determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, at its sole discretion, the Department may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.

2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 Abuse

2.1.1.1. Practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program or in reimbursement for goods services that are not medically necessary or that fail to meet professionally recognized standards for care; or recipient practices that result in unnecessary cost to the Medicaid program.

2.1.2 Adults with Special Health Care Needs

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2.1.2.1. 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.

2.1.2.2. This includes but is not limited to Members diagnosed 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**

2.1.3.1. 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**

2.1.4.1. 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 MCO to act on a grievance or an appeal within the time limits defined in this Agreement.

2.1.5 **Affordable Care Act**

2.1.5.1. The Patient Protection and Affordable Care Act, P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted on March 30, 2010.

2.1.6 **Agreement**

2.1.6.1. This entire written Agreement between the Department and the MCO duly executed and legally binding.

2.1.7 **Alternative Payment Model (APM)**

2.1.7.1. A payment approach that gives added incentive payments to provide high-quality cost-efficient care.

2.1.8 **Alternative Payment Model Implementation Plan**

2.1.8.1. A MCO's plan for meeting the APM requirements described in this Agreement.

2.1.9 **American Society of Addiction Medicine (ASAM) Criteria**

2.1.9.1. The National set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

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2.1.10 Americans with Disabilities Act (ADA)

2.1.10.1. The civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

2.1.11 Area Agency

2.1.11.1. An entity established as a nonprofit corporation in the State of New Hampshire which is established by rules adopted by the Commissioner to provide services to developmentally disabled persons in the area as defined in RSA 171-A:2.

2.1.12 ASAM Level of Care

2.1.12.1. The standard nomenclature for describing the continuum of recovery-oriented addiction services. With the continuum, clinicians are able to conduct multidimensional assessments that explore individual risks and needs, and recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs.

2.1.13 Assertive Community Treatment (ACT)

2.1.13.1. The evidence-based practice of delivering comprehensive and effective services to Members with SMI by a multidisciplinary team primarily in Member homes, communities, and other natural environments.

2.1.14 Automatic Assignment (or Auto-Assign)

2.1.14.1. The enrollment of an eligible Medicaid recipient, for whom enrollment is mandatory, in a MCO chosen by the Agency or its agent, and/or the assignment of a new enrollee to a PCP chosen by the MCO. In addition, Auto-Assignment may occur based on MCO performance as described in Section 4.3.4 (Auto-Assignment).

2.1.15 Auxiliary Aids

2.1.15.1. Services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy, the benefits of programs or activities conducted by the MCO.

2.1.15.2. Such aids include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDDs), certified medical interpreters, note takers, written materials, and other similar services and devices.

2.1.16 Behavioral Health Services

2.1.16.1. Mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.17 Bright Futures

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2.1.17.1. A National health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.18 **Capitation Payment**

2.1.18.1. The monthly payment by the Department to the MCO for each Member enrolled in the MCO's plan for which the MCO provides Covered Services under this Agreement.

2.1.18.2. Capitation payments are made only for Medicaid-eligible Members and retained by the MCO 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]

2.1.19 **Care Coordination**

2.1.19.1. A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a Member's physical, behavioral health and psychosocial needs using communication, closed-loop referral processes, and all available resources to promote quality cost-effective outcomes.

2.1.20 **Care Management**

2.1.20.1. Direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.21 **Care Manager**

2.1.21.1. A qualified and trained individual who is primarily responsible for providing Member supportive services as defined by this Agreement.

2.1.22 **Care Plan**

2.1.22.1. A document prepared and updated by a Member's Provider and interdisciplinary Care Team with input from the Member which summarizes the Member's health conditions, specific care needs, and current treatments. The Care Plan outlines what is needed to manage the Member's care needs and helps organize and prioritize care and treatment, including referrals relative to health-related social needs as defined in this Agreement.

2.1.23 **Care Team**

2.1.23.1. Chosen and/or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships. The care team shall include the PCP.

2.1.24 **Case Management**

2.1.24.1. Service provided for supervising or coordinating care on behalf of Members, including gaining access to needed waivers and other Medicaid

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State Plan services, as well as monitoring the continuity of patient care services. 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.

2.1.25 **Centers for Medicare & Medicaid Services (CMS)**

2.1.25.1. The federal agency within the United States Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare programs.

2.1.26 **Certified Community Behavioral Health Clinic (CCBHC)**

2.1.26.1. [Amendment #2:] A state certified clinic that is responsible for providing all required CCBHC services in a manner that meets or exceeds CCBHC criteria. CCBHCs must either directly or through its Designated Collaborating Organizations (DCOs) provide, in a manner reflecting person-centered and family-centered care: crisis services; screening, assessment, and diagnosis; person-centered and family-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management services; psychiatric rehabilitation services; peer supports and family/caregiver supports; and community care for uniformed service members and veterans. CCBHCs may also be a CMH Program if authorized to deliver the comprehensive array of services described in He-M 426, and is designated to cover a region as described in He-M 425.

2.1.27 **Children with Special Health Care Needs**

2.1.27.1. Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

2.1.27.2. [Amendment #1:] This includes, but is not limited to, children or infants; infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children, Youth and Families (DCYF), including those in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.28 **Children's Health Insurance Program (CHIP)**

2.1.28.1. A program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.29 **Choices for Independence (CFI)**

2.1.29.1. Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors

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and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

2.1.29.2. 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.

2.1.30 **Chronic Condition**

2.1.30.1. A physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.31 **Clean Claim**

2.1.31.1. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a health plan's claims system. 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).

2.1.32 **Cold Call Marketing**

2.1.32.1. Any unsolicited personal contact by the MCO or its designee, with a potential Member or a Member with another contracted MCO for the purposes of Marketing. [42 CFR 438.104(a)]

2.1.33 **Community Mental Health Services**

2.1.33.1. The mental health services provided by a Community Mental Health Program (“CMH Program”) or Community Mental Health Provider (“CMH Provider”) to eligible Members as defined under He-M 426.

2.1.34 **Community Mental Health Program (“CMH Program”)**

2.1.34.1. Synonymous with Community Mental Health Center, means a program established and administered by the State of New Hampshire, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, Case Management, and psychotherapy services, [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.35 **Community Mental Health Provider (“CMH Provider”)**

2.1.35.1. The Medicaid Provider of Community Mental Health Services that has been previously approved by the DHHS Commissioner to provide specific mental health services pursuant to He-M 426 [He-M 426.02: (g)]. The distinction between a CMH Program and a CMH Provider is that a CMH Provider offers a more limited range of services.

2.1.36 **Comprehensive Assessment**

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2.1.36.1. A person-centered assessment to help identify a Member's health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.37 **Comprehensive Medication Review (CMR)**

2.1.37.1. A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber.

2.1.37.2. The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other qualified individual, such as a prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve a patient's knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements; identify, and address problems or concerns the patient may have, and empower them to self-manage their medications and health conditions.

2.1.38 **Confidential Information and Confidential Data**

2.1.38.1. The definition for this term is located in Exhibit K: DHHS Information Security Requirements.

2.1.39 **Consumer Assessment of Health Care Providers and Systems (CAHPS®)**

2.1.39.1. Family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of health care.

2.1.40 **Continuity of Care**

2.1.40.1. Provision of continuous care for chronic or acute medical conditions through Member transitions between: facilities and home; facilities; Providers; service areas; managed care contractors; Marketplace, Medicaid fee-for-service (FFS) or private insurance and managed care arrangements. Continuity of Care occurs in a manner that prevents unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.41 **Continuous Quality Improvement (CQI)**

2.1.41.1. Systematic process of identifying, describing, and analyzing strengths and weaknesses and then testing, implementing, learning from, and revising solutions.

2.1.42 **Copayment**

2.1.42.1. Monetary amount that a Member pays directly to a Provider at the time a Covered Service is rendered.

2.1.43 **Corrective Action Plan (CAP)**

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2.1.43.1. Plan that the MCO 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.

2.1.44 **Cost Sharing**

2.1.44.1. A monetary amount that a Member pays directly to a Provider at the time a Covered Service is rendered.

2.1.45 **Covered Services**

2.1.45.1. Health care services as defined by the Department and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, including authorized In Lieu of Services and Value-Added Services and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.46 **Cultural Competence**

2.1.46.1. The level of knowledge-based skills required to provide effective clinical care to members of particular ethnic or racial groups.

2.1.47 **Data**

2.1.47.1. 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.

2.1.48 **Data Breach**

2.1.48.1. The definition for this term is located in Attachment 2 – Exhibit K: DHHS Information Security Requirements.

2.1.49 **Designated Receiving Facility (DRF)**

2.1.49.1. A hospital-based psychiatric unit or a non-hospital-based residential treatment program designated by the Commissioner to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system as defined in He-M 405. A DRF may also provide care for persons admitted to the facility voluntarily.

2.1.50 **Determinants of Health/Health-related Social Needs**

2.1.50.1. 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.

2.1.51 **Disenrollment**

2.1.51.1. 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.

2.1.52 **Data Certification**

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2.1.52.1. Encounter Data submitted to the Department, which must be certified by one of the following: MCO's CEO, CFO, or an individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO [42 CFR 438.604; 42 CFR 438.606(a)].

2.1.53 **Dual-Eligible Members**

2.1.53.1. Members who are eligible for both Medicare and Medicaid.

2.1.54 **Emergency Medical Condition**

2.1.54.1. 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)]

2.1.54.2. With respect to a pregnant woman, an emergency medical condition exists when:

2.1.54.2.1 There is inadequate time to effect safe transfer to another Provider prior to delivery;

2.1.54.2.2 Transfer may pose a threat to the health and safety of the patient or fetus; or

2.1.54.2.3 There is evidence of onset of uterine contractions or rupture of the membranes.

2.1.55 **Emergency Services**

2.1.55.1. 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)]

2.1.56 **Encounter Data**

2.1.56.1. A record of Covered Services provided to a MCO Member. An "encounter" is an interaction between a patient and a provider (MCO, 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.

2.1.57 **Enrollment**

2.1.57.1. The process by which a person becomes a Member of the MCO's plan through the Department.

2.1.58 **Equal Access**

2.1.58.1. All Members have the same access to all Providers and Covered Services.

2.1.59 **Evidence-Based Supported Employment (EBSE)**

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2.1.59.1. The provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by Dartmouth Medical School to promote successful competitive employment in the community.

2.1.60 **Exclusion Lists**

2.1.60.1. 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).

2.1.61 **External Quality Review (EQR)**

2.1.61.1. 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 MCO or its Subcontractors furnish to Medicaid recipients.

2.1.62 **Facility**

2.1.62.1. Any premises (a) owned, leased, used, or operated directly or indirectly by or for the MCO or its affiliates for purposes related to this Agreement; or (b) maintained by a Subcontractor to provide Covered Services on behalf of the MCO.

2.1.63 **Family Planning Services**

2.1.63.1. Services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include: Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

2.1.63.2. Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

2.1.63.3. Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

2.1.63.4. Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

2.1.63.5. Immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine.

2.1.64 **Federally Qualified Health Centers (FQHCs)**

2.1.64.1. 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.

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2.1.65 **Fraud**

2.1.65.1. 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.

2.1.66 **Granite Advantage Members**

2.1.66.1. 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.

2.1.67 **Grievance Process**

2.1.67.1. The procedure for addressing Member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.68 **Home and Community Based Services (HCBS)**

2.1.68.1. 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 (IHS) waiver program.

2.1.69 **Hospital-Acquired Conditions and Provider Preventable Conditions**

2.1.69.1. 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.

2.1.70 **Implementation**

2.1.70.1. The process for making the System fully operational for processing the Data.

2.1.71 **In Lieu of Services**

2.1.71.1. An alternative medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan. The utilization and

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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. A Member cannot be required by the MCO to use the alternative service or setting.

2.1.72 **Incomplete Claim**

2.1.72.1. A claim that is denied for the purpose of obtaining additional information from the Provider.

2.1.73 **Indian Health Care Provider (IHCP)**

2.1.73.1. 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)]

2.1.74 **Integrated Care**

2.1.74.1. The systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.[1]

2.1.75 **Licensed**

2.1.75.1. 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.

2.1.76 **Limited English Proficiency (LEP)**

2.1.76.1. Member's primary language is not English and the Member may have limited ability to read, write, speak or understand English.

2.1.77 **List of Excluded Individuals and Entities (LEIE)**

2.1.77.1. 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.

2.1.78 **Long Term Services and Supports (LTSS)**

2.1.78.1. 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).

2.1.79 **Managed Care Information System (MCIS)**

2.1.79.1. A comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides

[1] SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?"

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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.

2.1.80 **Managed Care Organization (MCO)**

2.1.80.1. 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 MCM program.

2.1.81 **Marketing**

2.1.81.1. Any communication from the MCO to a potential Member, or Member who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the Member to enroll with the MCO or to either not enroll, or disenroll from another the Department contracted MCO. [42 CFR 438.104(a)]

2.1.82 **Marketing Materials**

2.1.82.1. Materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as Marketing to potential Members.

2.1.83 **MCO Formulary or Prescription Drug List (PDL)**

2.1.83.1. List of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the Department-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.84 **MCO Quality Assessment and Performance Improvement (QAPI) Program**

2.1.84.1. An ongoing and comprehensive program for the services the MCO furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program. [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]

2.1.85 **MCO Utilization Management Program**

2.1.85.1. “MCO Utilization Management Program” means a program developed, operated, and maintained by the MCO that meets the criteria contained in this Agreement related to Utilization Management. The MCO Utilization Management Program shall include defined structures, policies, and procedures for Utilization Management.

2.1.86 **Medicaid Director**

2.1.86.1. The State Medicaid Director of NH DHHS.

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2.1.87 **Medicaid Management Information System (MMIS)**

2.1.87.1. 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.

2.1.88 **Medicaid State Plan**

2.1.88.1. 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 establishes 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.

2.1.89 **Medical Loss Ratio (MLR)**

2.1.89.1. 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) for the application of the minimum federal loss ratio provision.

2.1.90 **Medically Necessary**

2.1.90.1. 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:

2.1.90.1.1 Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the Member's illness, injury, disease, or its symptoms;

2.1.90.1.2 Not primarily for the convenience of the Member or the Member's family, caregiver, or health care Provider;

2.1.90.1.3 No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the Member's illness, injury, disease, or its symptoms; and

2.1.90.1.4 Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].

2.1.90.2. [Amendment #1:] For Members under twenty-one (21) years of age in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, any service that is included within the categories of

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mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.91 **Medication Assisted Treatment (MAT)**

2.1.91.1. The use of medications in combination with treatment planning, counseling and behavioral therapies or referral thereto for the treatment of Substance Use Disorder.

2.1.92 **Member**

2.1.92.1. An individual who is enrolled in managed care through an MCO having an Agreement with the Department. [42 CFR 438.2]

2.1.93 **Member Advisory Board**

2.1.93.1. A group of Members that represents the Member population, established and facilitated by the MCO. The Member Advisory Board shall adhere to the requirements set forth in this Agreement.

2.1.94 **Member Appeal Process**

2.1.94.1. 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.

2.1.95 **Member Encounter Confidential Data (Encounter Data)**

2.1.95.1. The information relating to the receipt of any item(s) or service(s) by a Member, under this Agreement, between the Department and an MCO that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

2.1.96 **Member Handbook**

2.1.96.1. A handbook based upon the Model Member Handbook developed by the Department and published by the MCO that enables the Member to understand how to effectively use the MCM program in accordance with this Agreement and 42 CFR 438.10(g).

2.1.97 **National Committee for Quality Assurance (NCQA)**

2.1.97.1. The organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

2.1.98 **NCQA Health Plan Accreditation**

2.1.98.1. MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.99 **Neonatal Abstinence Syndrome (NAS)**

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2.1.99.1. A constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.

2.1.100 **Non-Covered Service**

2.1.100.1. A service that is not a benefit under either the Medicaid State Plan or the MCO.

2.1.101 **Non-Emergency Medical Transportation (NEMT)**

2.1.101.1. Transportation services arranged by the MCO and provided free of charge to Members who are unable to pay for the cost of transportation to Provider offices and facilities for Medically Necessary care and services covered by the Medicaid State Plan, regardless of whether those Medically Necessary services are covered by the MCO.

2.1.102 **Non-Participating Provider**

2.1.102.1. A person, health care Provider, practitioner, facility or entity acting within their scope of practice or licensure, that does not have a written Agreement with the MCO to participate in the MCO's Provider network, but provides health care services to Members under appropriate scenarios (e.g., a referral approved by the MCO).

2.1.103 **Non-Symptomatic Office Visits**

2.1.103.1. Office visits available from the Member's Primary Care Provider (PCP) or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

2.1.104 **Non-Urgent, Symptomatic Office Visits**

2.1.104.1. Routine care office visits available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention, but that require monitoring.

2.1.105 **Ongoing Special Condition**

2.1.105.1. 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; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.106 **Overpayments**

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2.1.106.1. 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.

2.1.107 **Participating Provider**

2.1.107.1. A person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the MCO to provide services to Members under the terms of this Agreement.

2.1.108 **Pay and Chase**

2.1.108.1. Recovery of claims paid in which the Standard Medicare, Medicare Advantage plan or private insurance was not known at the time the claim was adjudicated.

2.1.109 **Peer Recovery Program**

2.1.109.1. "Peer Recovery Program" means a program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or another accrediting body approved by the Department, is under contract with the Department's contracted facilitating organization, or is under contract with the Department's Bureau of Drug and Alcohol Services to provide Peer Recovery Support Services (PRSS).

2.1.110 **Performance Improvement Project (PIP)**

2.1.110.1. 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)].

2.1.111 **Physician Group**

2.1.111.1. 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.

2.1.112 **Physician Incentive Plan**

2.1.112.1. Any compensation arrangement between the MCO and Providers that apply to federal regulations found at 42 CFR 422.208 and 42 CFR 422.210, as applicable to Medicaid managed care on the basis of 42 CFR 438.3(i).

2.1.113 **Post-Stabilization Services**

2.1.113.1. 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]

2.1.114 **Practice Guidelines**

2.1.114.1. Evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health

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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.

2.1.115 **Prescription Drug Monitoring Program (PDMP)**

2.1.115.1. The program operated by the Department that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in New Hampshire.

2.1.116 **Primary Care**

2.1.116.1. All health services and laboratory services, including periodic examinations, preventive health care services and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care by the PCP, record maintenance, and initiation and coordination of closed loop referrals to specialty providers, including but not limited to Behavioral Health Service providers, and collaboration with such providers, for maintaining continuity of the Member's care and to collaboratively support achievement of the Member's whole-person health care goals.

2.1.117 **Primary Care and Prevention Focused Care Model**

2.1.117.1. Model of Care as described in Section 4.10 of this Agreement.

2.1.118 **Primary Care Provider (PCP)**

2.1.118.1. A Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the Continuity of Member Care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All federal requirements applicable to primary care physicians shall also be applicable to PCPs as the term is used in this Agreement.

2.1.119 **Prior Authorization**

2.1.119.1. The process by which the Department, the MCO, or another MCO participating in the MCM program, whichever is applicable, authorizes, in advance, the delivery of Covered Services based on factors, including but not limited to medical necessity, cost-effectiveness, and compliance with this Agreement.

2.1.120 **Program Start Date**

2.1.120.1. The date when the MCO is responsible for coverage of Covered Services to its Members in the MCM program, contingent upon Agreement approval by

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the Governor and Executive Council and the Department's determination of successful completion of the Readiness Review period.

2.1.121 **Post Payment Recovery**

2.1.121.1. The process of seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). Also known as "Cost Recovery" or "pay and chase".

2.1.122 **Provider Appeal Process**

2.1.122.1. The procedure for handling, processing, collecting and tracking Provider appeal requests in accordance with Section 4.6 (Provider Appeals) of this Agreement.

2.1.123 **Provider Directory**

2.1.123.1. Information on the MCO's Participating Providers for each of the Provider types covered under this Agreement, available in electronic form and paper form upon request to the Member in accordance with 42 CFR 438.10 and the terms of this Agreement.

2.1.124 **Psychiatric Boarding**

2.1.124.1. The continued presence of a Member experiencing a mental health crisis in a hospital emergency room while waiting for admission in a designated receiving facility.

2.1.125 **Qualified Bilingual/Multilingual Staff**

2.1.125.1. An employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that 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.

2.1.126 **Qualified Interpreter for a Member with a Disability**

2.1.126.1. An interpreter who, via a remote interpreting service or an on-site appearance, adheres to generally accepted interpreter ethics principles, including Member confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

2.1.126.2. Qualified interpreters can include, for example, sign language interpreters, oral transliterators (employees who represent or spell in the characters of another alphabet), and cued language transliterators (employees who represent or spell by using a small number of handshapes).

2.1.127 **Qualified Interpreter for a Member with LEP**

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2.1.127.1. 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.

2.1.128 **Qualified Translator**

2.1.128.1. 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]

2.1.129 **Qualifying APM**

2.1.129.1. 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.

2.1.130 **Quality**

2.1.130.1. The degree to which a MCO increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

2.1.131 **Quality Assessment and Performance Improvement (QAPI) Program**

2.1.131.1. An ongoing and comprehensive program for the Covered Services the MCO furnishes to Members consistent with the requirements of this Agreement.

2.1.132 **Quality Improvement (QI)**

2.1.132.1. The process of monitoring that the delivery of oral, behavioral, and physical health care services are available, accessible, timely, and medically necessary. The MCO 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 health care outcomes for Members.

2.1.133 **Readiness Review**

2.1.133.1. The review process through which the MCO demonstrates, to the Department's satisfaction, the MCO's 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) and the terms and conditions of this Agreement.

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2.1.134 **Recovery**

2.1.134.1. A process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.[2]

2.1.135 **Referral Provider**

2.1.135.1. A Provider, who is not the Member's PCP, to whom a Member is referred for Covered Services.

2.1.136 **Required Priority Population**

2.1.136.1. The population mandated by the Department for MCO-Delivered Care Management services as described in this Agreement (Section 4.11.2). The MCO may provide Care Management services for other Members or populations at the plan's option.

2.1.137 **Rural Health Clinic (RHC)**

2.1.137.1. 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.

2.1.138 **Second Opinion**

2.1.138.1. The opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the MCO has permitted the Member to consult, at no cost to the Member. [42 CFR 438.206(b)(3)]

2.1.139 **Health-related Social Needs**

2.1.139.1. 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.

2.1.140 **Software**

2.1.140.1. All Custom, Open Source, IaaS, SaaS and/or COTS Software and/or applications provided by the Contractor under the Agreement.

2.1.141 **Specifications**

2.1.141.1. Refer to Contract Exhibit P-37: General Provisions Section 12 – Assignment, Delegation, Subcontracts.

2.1.142 **State**

2.1.142.1. The State of New Hampshire and any of its agencies.

2.1.143 **State Data**

[2] SAMHSA, "Recovery and Recovery Support".

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2.1.143.1. 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

2.1.144 **Subcontract**

2.1.144.1. 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.

2.1.145 **Subcontractor**

2.1.145.1. 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.

2.1.146 **Substance Use Disorder**

2.1.146.1. A cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in He-W 513.02.

2.1.147 **Substance Use Disorder Provider**

2.1.147.1. All Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.

2.1.148 **System**

2.1.148.1. All Software, specified hardware, and interfaces and extensions, integrated and functioning together in accordance with the Specifications.

2.1.149 **Term**

2.1.149.1. The duration of this Agreement.

2.1.150 **Third Party Liability (TPL)**

2.1.150.1. 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.

2.1.150.2. 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.

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2.1.150.3. 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.

2.1.151 **Transitional Care Management**

2.1.151.1. The responsibility of the MCO 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.

2.1.151.2. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.152 **Transportation**

2.1.152.1. An appropriate means of conveyance furnished to a Member to obtain Covered Services.

2.1.153 **Transitional Health Care**

2.1.153.1. Care that is available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

2.1.154 **Transitional Home Care**

2.1.154.1. Care that is available with a home care nurse, a licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or specialty care Provider or as part of the discharge plan.

2.1.155 **Trauma Informed Care**

2.1.155.1. A program, organization, or system that realizes the widespread impact of trauma and understands potential paths for Recovery; recognizes the signs and symptoms of trauma in Members, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization

2.1.156 **Urgent, Symptomatic Office Visits**

2.1.156.1. Office visits available from the Member's PCP or another Provider within forty-eight (48) hours, for the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

2.1.157 **Utilization Management**

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2.1.157.1. The criteria of evaluating the necessity, appropriateness, and efficiency of Covered Services against established guidelines and procedures.

2.1.158 **Value-Added Services**

2.1.158.1. Services not included in the Medicaid State Plan that the MCO elects to purchase and provide to Members at the MCO's discretion and expense to improve health and reduce costs. Value-Added Services are not included in capitation rate calculations.

2.1.159 **Verification**

2.1.159.1. Supports the confirmation of authority to enter a computer system application or network.

2.1.160 **Waste**

2.1.160.1. The thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

2.1.161 **Wellness Visit**

2.1.161.1. A PCP visit that includes health risk and social determinant of health needs assessments, evaluation of the Member's physical and behavioral health, including screening for depression, mood, suicidality, and Substance Use Disorder.

2.1.162 **Willing Provider**

2.1.162.1. A Provider credentialed as a qualified treatment provider according to the requirements of the Department and the MCO, who agrees to render Covered Services as authorized by the MCO and in compliance with terms of the MCO's Provider Agreement, including reimbursement rates and policy manual.

2.1.163 **Withhold**

2.1.163.1. [Amendment #3:] The actuarially sound amount retained as a percent of the MCO's risk adjusted total Capitation ~~for a rating period~~ which is withheld ~~annually~~ from the applicable rating period and ~~may be~~ made available for distribution to the MCO ~~in future contract years~~ through the Quality Withhold Program and upon meeting specific quality performance criteria.

2.1.164 **Work Plan**

2.1.164.1. Documentation that details the activities for the Project created in accordance with the Agreement. 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.

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2.2 Acronym List

2.2.1 AAP means American Academy of Pediatrics.
2.2.2 ABD means Acquired Brain Disorder.
2.2.3 ACT means Assertive Community Treatment.
2.2.4 ADA means Americans with Disabilities Act.
2.2.5 ADL means Activities of Daily Living.
2.2.6 ADT means Admission, Discharge and Transfer.
2.2.7 AIDS means Acquired Immune Deficiency Syndrome.
2.2.8 ANSA means Adult Needs and Strengths Assessment.
2.2.9 APM means Alternative Payment Model.
2.2.10 ARNP means Advanced Registered Nurse Practitioner.
2.2.11 ASAM means American Society of Addiction Medicine.
2.2.12 ASC means Accredited Standards Committee.
2.2.13 ASFRA means Assisted Suicide Funding Restriction Act.
2.2.14 ASL means American Sign Language.
2.2.15 BCCP means Breast and Cervical Cancer Program.
2.2.16 CAHPS means Consumer Assessment of Healthcare Providers and Systems.
2.2.17 CANS means Child and Adolescent Needs and Strengths Assessment.
2.2.18 CAP means Corrective Action Plan.
2.2.19 CAPRSS means Council on Accreditation of Peer Recovery Support Services.
2.2.20 CARC means Claim Adjustment Reason Code.
2.2.21 CCBHC means Certified Community Behavioral Health Clinic
2.2.22 CEO means Chief Executive Officer.
2.2.23 CFI means Choices for Independence.
2.2.24 CFO means Chief Financial Officer.
2.2.25 CHIP means Children's Health Insurance Program.
2.2.26 CHIS means Comprehensive Health Care Information System.
2.2.27 CMH means Community Mental Health.
2.2.28 CMO means Chief Medical Officer.
2.2.29 CMR means Comprehensive Medication Review.
2.2.30 CMS means Centers for Medicare & Medicaid Services.
2.2.31 COB means Coordination of Benefits.
2.2.32 COBA means Coordination of Benefits Agreement.

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2.2.33 CPT means Current Procedural Terminology.

2.2.34 CQI means Continuous Quality Improvement.

2.2.35 DBT means Dialectical Behavioral Therapy.

2.2.36 DCO means Designated Collaborating Organization.

2.2.37 DCYF means New Hampshire Division for Children, Youth and Families.

2.2.38 DD means Developmental Disability.

2.2.39 DEA means Drug Enforcement Administration.

2.2.40 DHHS means New Hampshire Department of Health and Human Services.

2.2.41 DME means Durable Medical Equipment.

2.2.42 DOB means Date of Birth.

2.2.43 DOD means Date of Death.

2.2.44 DOJ means (New Hampshire or United States) Department of Justice.

2.2.45 DRA means Deficit Reduction Act.

2.2.46 DSM means Diagnostic and Statistical Manual of Mental Disorders.

2.2.47 DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.

2.2.48 DUR means Drug Utilization Review.

2.2.49 EBSE means Evidence-Based Supported Employment.

2.2.50 ECI means Elderly and Chronically Ill.

2.2.51 ED means Emergency Department.

2.2.52 EDI means Electronic Data Interchange.

2.2.53 EFT means Electronic Funds Transfer.

2.2.54 EOB means Explanation of Benefits.

2.2.55 EPSDT means Early and Periodic Screening, Diagnostic and Treatment.

2.2.56 EQR means External Quality Review.

2.2.57 EQRO means External Quality Review Organization.

2.2.58 ERISA means Employees Retirement Income Security Act of 1974.

2.2.59 EST means Eastern Standard Time.

2.2.60 ETL means Extract, Transformation and Load.

2.2.61 FAR means Federal Acquisition Regulation.

2.2.62 FCA means False Claims Act.

2.2.63 FDA means Food and Drug Administration for the United States Department of Health and Human Services.

2.2.64 FFATA means Federal Funding Accountability & Transparency Act.

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2.2.65 FFS means Fee-for-Service.

2.2.66 FPL means Federal Poverty Level.

2.2.67 FQHC means Federally Qualified Health Center.

2.2.68 HEDIS means Healthcare Effectiveness Data and Information Set.

2.2.69 HCBS means Home and Community Based Services.

2.2.70 HCBS-I means Home and Community Based Services In Home Supports.

2.2.71 HCPCS means Health Care Common Procedure Coding System.

2.2.72 HCQI means Health Care Quality Improvement.

2.2.73 HHS means United States Department of Health and Human Services.

2.2.74 HIPAA means Health Insurance Portability and Accountability Act.

2.2.75 HIPP means Health Insurance Premium Payment.

2.2.76 HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.

2.2.77 HIV means Human Immunodeficiency Virus.

2.2.78 HMO means Health Maintenance Organization.

2.2.79 HRSA means Health Resources and Services Administration for the United States Department of Health and Human Services.

2.2.80 I/T/U means Indian Tribe, Tribal Organization, or Urban Indian Organization.

2.2.81 IADL means Instrumental Activities of Daily Living.

2.2.82 IBNR means Incurred But Not Reported.

2.2.83 ICF means Intermediate Care Facility.

2.2.84 ID means Intellectual Disabilities.

2.2.85 IEA means Involuntary Emergency Admission.

2.2.86 IHCP means Indian Health Care Provider.

2.2.87 IHS means Indian Health Service.

2.2.88 IMD means Institution for Mental Disease.

2.2.89 IVR means Interactive Voice Response.

2.2.90 LEIE means List of Excluded Individuals & Entities.

2.2.91 LEP means Limited English Proficiency.

2.2.92 LTSS means Long-Term Services and Supports.

2.2.93 MACRA means Medicare Access and CHIP Reauthorization Act of 2015.

2.2.94 MAT means Medication Assisted Treatment.

2.2.95 MCIS means Managed Care Information System.

2.2.96 MCM means Medicaid Care Management.

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2.2.97 MCO means Managed Care Organization.

2.2.98 MED means Morphine Equivalent Dosing.

2.2.99 MFCU means Medicaid Fraud Control Unit, Office of Attorney General.

2.2.100 MLADCs means Masters Licensed Alcohol and Drug Counselors.

2.2.101 MLR means Medical Loss Ratio.

2.2.102 MMIS means Medicaid Management Information System.

2.2.103 NAS means Neonatal Abstinence Syndrome.

2.2.104 NCPDP means National Council for Prescription Drug Programs.

2.2.105 NCQA means National Committee for Quality Assurance.

2.2.106 NEMT means Non-Emergency Medical Transportation.

2.2.107 NH means New Hampshire.

2.2.108 NHID means New Hampshire Insurance Department.

2.2.109 NPI means National Provider Identifier.

2.2.110 NPPES means National Plan and Provider Enumeration System.

2.2.111 OB/GYN means Obstetrics/Gynecology or Obstetricians/ Gynecologists.

2.2.112 OIG means Office of the Inspector General for the United States Department of Health and Human Services.

2.2.113 OTP means Opioid Treatment Program.

2.2.114 PBM means Pharmacy Benefits Manager.

2.2.115 PCA means Personal Care Attendant.

2.2.116 PCP means Primary Care Provider.

2.2.117 PDL means Preferred Drug List.

2.2.118 PDMP means Prescription Drug Monitoring Program.

2.2.119 PHI means Protected Health Information.

2.2.120 PI means Personal Information.

2.2.121 PIP means Performance Improvement Plan.

2.2.122 POS means Point of Service.

2.2.123 PRSS means Peer Recovery Support Services.

2.2.124 QAPI means Quality Assessment and Performance Improvement.

2.2.125 QI means Quality Improvement.

2.2.126 QM means Quality Management.

2.2.127 QOS means Quality of Service.

2.2.128 RARC means Reason and Remark Codes.

2.2.129 RFP means Request for Proposal.

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2.2.130 RHC means Rural Health Clinic.

2.2.131 SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.

2.2.132 SBIRT means Screening, Brief Intervention, and Referral to Treatment.

2.2.133 SED means Serious Emotional Disturbance.

2.2.134 SFY means State Fiscal Year.

2.2.135 SHIP means State's Health Insurance Assistance Program.

2.2.136 SIU means Special Investigations Unit.

2.2.137 SMART means Specific, Measurable, Attainable, Realistic, and Time Relevant.

2.2.138 SMDL means State Medicaid Director Letter.

2.2.139 SMI means Severe Mental Illness.

2.2.140 SNF means Skilled Nursing Facility.

2.2.141 SPMI means Severe or Persistent Mental Illness.

2.2.142 SSADMF means Social Security Administration Death Master File.

2.2.143 SSAE means Statement on Standards for Attestation Engagements.

2.2.144 SSI means Supplemental Security Income.

2.2.145 SSN means Social Security Number.

2.2.146 TAP means Technical Assistance Publication.

2.2.147 TDD means Telecommunication Device for Deaf Persons.

2.2.148 TPL means Third Party Liability.

2.2.149 TTY means Teletypewriter.

2.2.150 UAT means User Acceptance Testing.

2.2.151 Utilization Management means Utilization Management.

2.2.152 UDS means Urine Drug Screenings.

2.2.153 VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO.

3.1.1.2 The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and

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delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 **Representation and Warranties**

3.1.2.1 The MCO represents and warrants that it 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 MCO acknowledges that, in being awarded this Agreement, the Department has relied upon all representations and warrants made by the MCO in its response to the Department's Request for Proposal (RFP) as referenced in Exhibit M: The MCM Proposal by Reference including any addenda, with respect to delivery of Medicaid managed care services and affirms all representations made therein.

3.1.2.3 The MCO 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 MCO shall not take advantage of any errors and/or omissions in the RFP or the resulting Agreement and amendments.

3.1.2.5 The MCO 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 MCO shall develop and submit a Program Management Plan for the Department's review and approval.

3.1.3.2 The MCO 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.

3.1.3.3 The Program Management Plan shall:

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3.1.3.3.1 Elaborate on the general concepts outlined in the MCO's Proposal and the section headings of the Agreement;

3.1.3.3.2 Describe how the MCO 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;

3.1.3.3.3 Describe how the MCO shall ensure timely notification to the Department regarding:

3.1.3.3.3.1. Expected or unexpected interruptions or changes that impact MCO policy, practice, operations, Members or Providers,

3.1.3.3.3.2. Correspondence received from the Department on emergent issues and non-emergent issues; and

3.1.3.3.3.3. Outline the MCO integrated organizational structure including NH-based resources and its support from its parent company, affiliates, or Subcontractors.

3.1.3.3.3.4. On an annual basis, the MCO 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.

3.1.4 Key Personnel Contact List

3.1.4.1 The MCO shall submit a Key Personnel Contact List to the Department that includes the positions and associated information indicated in Section 3.11.1. (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program.

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3.1.4.2 Thereafter, the MCO shall submit an updated Contact List immediately upon any Key Personnel staff changes.

3.2 Agreement Elements

3.2.1 [Amendment #1:] The Agreement between the parties shall consist of the following, including subsequent Amendments:

3.2.1.1. General Provisions, Form Number P-37

3.2.1.2. [Amendment #1:] Exhibit A: ~~Revisions to Standard Agreement~~ Special Provisions

3.2.1.3. Exhibit B: Scope of Services

3.2.1.4. Exhibit C: Payment Terms

3.2.1.5. [Amendment #1:] Exhibit D: ~~Certification Regarding Drug Free Workplace Requirements~~Federal Requirements

3.2.1.6. [Amendment #1:] Exhibit E: ~~Certification Regarding Lobbying~~DHHS Information Security Requirements

3.2.1.7. [Amendment #1:] Exhibit F: ~~Certification Regarding Debarment, Suspension, and Other Responsibility Matters~~Business Associate Agreement

3.2.1.8. [Amendment #1:] Exhibit G: ~~Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections~~Additional Requirements

3.2.1.9. [Amendment #1:] ~~Exhibit H: Certification Regarding Environmental Tobacco Smoke~~Reserved

3.2.1.10. [Amendment #1:] ~~Exhibit I: Health Insurance Portability Act Business Associate Agreement~~Reserved

3.2.1.11. [Amendment #1:] Exhibit J: ~~Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance~~Vendor Risk Assessment Report (VRAR)

3.2.1.12. [Amendment #1:] Exhibit K: ~~DHHS Information Security Requirements~~ Technical Requirements Workbook

3.2.1.13. Exhibit L: MCO Implementation Plan

3.2.1.14. Exhibit M: MCO Proposal submitted in response to RFP, by reference

3.2.1.15. Exhibit N: Liquidated Damages Matrix

3.2.1.16. Exhibit O: Quality and Oversight Reporting Requirements

3.2.1.17. Exhibit P: MCO Program Oversight Plan

3.2.1.18. [Amendment #1:] Exhibit Q: ~~DoIT Technical Requirements Workbook~~Reserved

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3.3 **Delegation of Authority**

3.3.1 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.

3.4 **Authority of the New Hampshire Insurance Department**

3.4.1 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 MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.4.2 The MCO 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 New Hampshire Insurance Department (NHID); and the NH Comprehensive Health Care Information System (CHIS) Confidential Data reporting submission under NHID rules and/or bulletins.

3.5 **Time of the Essence**

3.5.1 In consideration of the need to ensure uninterrupted and continuous services under the MCM program, time is of the essence in the performance of the MCO's obligations under the Agreement.

3.6 **CMS Approval of Agreement and Any Amendments**

3.6.1 This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to and contingent upon the approval of CMS.

3.6.2 This Agreement submission shall be considered complete for CMS's approval if:

3.6.2.1 All pages, appendices, attachments, etc. were submitted to CMS; and

3.6.2.2 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.

3.6.3 As part of this Agreement, the Department shall submit to CMS for review and approval the MCO rate certifications concurrent with the review and approval process for this Agreement. [42 CFR 438.7(a)]

3.6.4 The Department shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement

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initiatives based on the Department's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.7 **Cooperation with Other Vendors and Prospective Vendors**

3.7.1 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 MCO 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.

3.7.2 The MCO 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 MCO, its subcontractor or a Provider.

3.7.3 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.

3.7.4 The MCO's notification shall be to a member of senior management of the Department such as the Commissioner, Deputy Commissioner, Associate Commissioner, Medicaid Director, or Deputy Medicaid Director.

3.8 **Renegotiation and Re-Procurement Rights**

3.8.1 **Renegotiation of Agreement**

3.8.1.1. Notwithstanding anything in the Agreement to the contrary, the Department may at any time during the Term exercise the option to notify the MCO that the Department has elected to renegotiate certain terms of the Agreement.

3.8.1.2. Upon the MCO's receipt of any Department notice pursuant to this section to renegotiate this Agreement, the MCO 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.

3.8.2 **Re-Procurement of the Services or Procurement of Additional Services**

3.8.2.1. Notwithstanding anything in the Agreement to the contrary, whether or not the Department has accepted or rejected MCO'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 MCO under the Agreement.

3.8.2.2. The Department shall give the MCO ninety (90) calendar days' notice of intent to replace another MCO participating in the MCM program or to add an additional MCO or other contractors to the MCM program.

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3.8.2.3. 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 MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.9 Organization Requirements

3.9.1 General Organization Requirements

3.9.1.1. As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by 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.

3.9.1.2. As a condition to entering into this Agreement, and during the entire Agreement Term, the MCO 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.

3.9.1.3. The MCO shall not be located outside of the United States. [42 CFR 438.602(i)] The MCO is prohibited from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.

3.9.1.4. At the Department's discretion and at a Member effective date to be determined, the MCO shall initiate a Centers for Medicare and Medicaid Services defined application process to implement a highly integrated dual eligible special needs plan (HIDE SNP) or an alternate dual-eligible special needs plan (D-SNP) as defined at 42 CFR 422.2.

3.9.2 Articles

3.9.2.1. The MCO shall provide, by the beginning of each Agreement year and at the time of any substantive changes, written assurance from MCO's legal counsel that the MCO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.9.3 Ownership and Control Disclosures

3.9.3.1. The MCO 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 MCO that:

3.9.3.1.1 Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO's equity;

3.9.3.1.2 Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO's assets; or

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3.9.3.1.3 Is an officer or director of an MCO organized as a corporation or is a partner in an MCO organized as a partnership. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

3.9.3.2. The submission shall include for each person or entity, as applicable:

3.9.3.2.1 The address, including the primary business address, every business location, and P.O. Box address, for every entity;

3.9.3.2.2 The date of birth (DOB) and social security number (SSN) of any individual;

3.9.3.2.3 Tax identification number(s) of any corporation;

3.9.3.2.4 Information on whether an individual or entity with an ownership or control interest in the MCO is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.9.3.2.5 Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.9.3.2.6 The name of any other disclosing entity, as such term is defined in 42 CFR 455.101, in which an owner of the MCO has an ownership or control interest;

3.9.3.2.7 The name, address, DOB, and SSN of any managing employee of the MCO, as such term is defined by 42 CFR 455.101; and

3.9.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.9.3 (Ownership and Control Disclosures) to the Department is accurate to the best of his or her information, knowledge, and belief.

3.9.3.3. The MCO shall disclose the information set forth in this Section 3.9.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to the Department at the following times:

3.9.3.3.1 At the time of Agreement execution;

3.9.3.3.2 When the Provider or disclosing entity submits a Provider application;

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3.9.3.3.3 When the Provider or disclosing entity executes a Provider agreement with the Department;

3.9.3.3.4 Upon request of the Department during the revalidation of the Provider enrollment; and

3.9.3.3.5 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)]

3.9.3.4. The Department shall review the ownership and control disclosures submitted by the MCO and any Subcontractors. [42 CFR 438.602(c); 42 CFR 438.608(c)]

3.9.3.5. The MCO shall be fined in accordance with Exhibit N: Liquidated Damages Matrix for any failure to comply with ownership disclosure requirements detailed in this Section.

3.9.4 Change in Ownership or Proposed Transaction

3.9.4.1. The MCO 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 MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO shall receive prior written approval from the Department and the NHID prior to taking such action.

3.9.5 Prohibited Relationships

3.9.5.1. Pursuant to Section 1932(d)(1)(A) of the Social Security Act (42 USC 1396u-2(d)(1)(A)), the MCO shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the MCO's equity who has been, or is affiliated with 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]

3.9.5.2. The MCO shall not have an individual:

3.9.5.2.1 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

3.9.5.2.2 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-

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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

3.9.5.2.3 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

3.9.5.2.4 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

3.9.5.2.5 Has been excluded from participation under a program under title XVIII or under a State health care program; or

3.9.5.2.6 Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act.

3.9.5.3. The MCO shall retain any data, information, and documentation regarding the above described relationships for a period of no less than ten (10) years.

3.9.5.4. Within five (5) calendar days of discovery, the MCO shall provide written disclosure to the Department, and Subcontractors shall provide written disclosure to the MCO, 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]

3.9.5.5. If the Department learns that the MCO has a prohibited relationship with an individual or entity that (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCO has relationship with an individual who is an affiliate of such an individual; (ii) is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, the Department may:

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3.9.5.5.1 Terminate the existing Agreement with the MCO;

3.9.5.5.2 Continue an existing Agreement with the MCO unless the HHS Secretary directs otherwise;

3.9.5.5.3 Not renew or extend the existing Agreement with the MCO unless the HHS Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation. [42 CFR 438.610(d)(2)-(3); 42 CFR 438.610(a); 42 CFR 438.610(b); Exec. Order No. 12549]

3.9.6 **Background Checks**

3.9.6.1. The MCO shall perform criminal history record checks on its owners, directors, and managing employees, as such terms are defined in 42 CFR 455.101 and clarified in applicable subregulatory guidance such as the Medicaid Provider Enrollment Compendium.

3.9.6.2. The MCO 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 MCO and Subcontractors do not employ or contract with any individual or entity, in accordance with Prohibited Relationship provisions in Section 3.9.5 of this Agreement, on an Exclusion List who are:

3.9.6.2.1 Convicted of crimes described in Section 1128(b)(8) of the Social Security Act;

3.9.6.2.2 Debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and/or

3.9.6.2.3 Is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. [[42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b); SMDL 6/12/08; SMDL 1/16/09; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]

3.9.6.3. In addition, the MCO or its Subcontractor shall conduct screenings upon hire and monthly of its employees (except its directors and officers), and contractors and MCO Subcontractors' contractor employees (except its directors and officers) to ensure that none of them appear on:

3.9.6.3.1 HHS-OIG's List of Excluded Individuals/Entities;

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3.9.6.3.2 The System of Award Management;

3.9.6.3.3 The list maintained by the Office of Foreign Assets Control; and

3.9.6.3.4 To the extent applicable, NPPES (collectively, these lists are referred to as the "Exclusion Lists").

3.9.6.4. The MCO 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 MCO nor its Subcontractors, including contractor employees of MCO Subcontractors, have any employees, directly or indirectly, with:

3.9.6.4.1 Any individual or entity excluded from participation in the federal health care program;

3.9.6.4.2 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;

3.9.6.4.3 Any individual or entity excluded from Medicare, Medicaid or NH participation by the Department per the Department system of record;

3.9.6.4.4 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

3.9.6.4.5 Any individual entity appearing on any of the Exclusion Lists.

3.9.6.5. In the event that the MCO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.9.6 (Background Checks) or Section 3.9.3 (Ownership and Control Disclosures) above, then the MCO 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.

3.9.6.6. The MCO shall maintain documentation to ensure screenings have been completed by Subcontractors and reviewed by the MCO monthly.

3.9.7 Conflict of Interest

3.9.7.1. The MCO 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 MCO shall report transactions between the MCO and parties in interest to the Department

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and any other agency as required, and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.9.7.2. The MCO 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 MCO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

3.9.7.2.1 Any sale or exchange, or leasing of any property between the MCO and such a party;

3.9.7.2.2 Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and

3.9.7.2.3 Any lending of money or other extension of credit between the MCO and such a party. [Section 1903(m)(4)(A) of the Social Security Act; Section 1318(b) of the Social Security Act]

3.9.8 **Compliance with State and Federal Laws**

3.9.8.1. General Requirements

3.9.8.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.9.8 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement.

3.9.8.1.2 The MCO 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)]

3.9.8.1.3 The MCO shall comply, at a minimum, with the following:

3.9.8.1.3.1. 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;

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3.9.8.1.3.2.	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);
3.9.8.1.3.3.	CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397aa; Regulations promulgated thereunder: 42 CFR 457;
3.9.8.1.3.4.	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;
3.9.8.1.3.5.	State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;
3.9.8.1.3.6.	State administrative rules and laws pertaining to confidentiality;
3.9.8.1.3.7.	American Recovery and Reinvestment Act;
3.9.8.1.3.8.	Title VI of the Civil Rights Act of 1964;
3.9.8.1.3.9.	The Age Discrimination Act of 1975;
3.9.8.1.3.10.	The Rehabilitation Act of 1973;
3.9.8.1.3.11.	Title IX of the Education Amendments of 1972 (regarding education programs and activities);
3.9.8.1.3.12.	The ADA;

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3.9.8.1.3.13. 42 CFR Part 2; and

3.9.8.1.3.14. Section 1557 of the Affordable Care Act. [42 CFR438.3(f)(1); 42 CFR 438.100(d)]

3.9.8.1.4 The MCO shall provide, by the beginning of each Agreement year and at the time of any substantive changes, written assurance from MCO's legal counsel that the MCO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.9.8.1.5 The MCO shall comply with all aspects of the Department Sentinel Event Reporting and Review Policy PO.1003, and any subsequent versions and/or amendments;

3.9.8.1.6 The MCO shall cooperate with review of any reported sentinel event, and provide any additional reporting information requested by the Department, and participate in a Department sentinel event review, if requested;

3.9.8.1.7 The MCO 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 MCO's responsibility to notify the appropriate authority if the MCO suspects a crime has occurred;

3.9.8.1.8 The MCO shall comply with all statutorily mandated reporting requirements, including but not limited to, RSA 161-F:42-54 and RSA 169-C:29;

3.9.8.1.9 In instances where the time frames detailed in the Agreement conflict with those in the Department Sentinel Event Policy, the policy requirements will prevail.

3.9.9 Non-Discrimination

3.9.9.1. The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.9.8 (Compliance with State and Federal Laws) 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)]

3.9.10 Reporting Discrimination Grievances

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3.9.10.1. The MCO 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 MCO.

3.9.10.2. 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).

3.9.11 **Americans with Disabilities Act**

3.9.11.1. The MCO shall have written policies and procedures that ensure compliance with requirements of the ADA, and a written plan to monitor compliance to determine the ADA requirements are being met.

3.9.11.2. 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.

3.9.11.3. 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.

3.9.11.4. 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.

3.9.11.5. The MCO shall require Participating Providers and Subcontractors to comply with the requirements of the ADA. In providing Covered Services, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid Members who are qualified individuals with disabilities covered by the provisions of the ADA.

3.9.11.6. The MCO 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 MCO and shall be available for inspection by the Department.

3.9.11.7. [Amendment #1:] The MCO shall, in accordance with Exhibit ~~G~~D (Federal Requirements ~~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 3.9.11 (Americans with Disabilities Act) of the Agreement, and that it

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has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.9.11.8. The MCO 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 MCO to be in compliance with the ADA.

3.9.11.9. Where applicable, the MCO shall abide by the provisions of Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. Section 794, regarding access to programs and facilities by people with disabilities.

3.9.12 **Non-Discrimination in Employment**

3.9.12.1. The MCO shall not discriminate against any employee or applicant for employment because of age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.9.12.2. The MCO 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.

3.9.12.3. 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.

3.9.12.4. The MCO agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

3.9.12.5. The MCO shall, in all solicitations or advertisements for employees placed by or on behalf of the MCO, 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.

3.9.12.6. The MCO 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 MCO's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.9.12.7. The MCO 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.

3.9.12.8. The MCO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and

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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.

3.9.12.9. The MCO shall include the provisions described in this Section 3.9.12 (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.

3.9.12.10. The MCO 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 MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.9.13 Non-Compliance

3.9.13.1. In the event of the MCO's noncompliance with the non-discrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and the MCO may be declared ineligible for further government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.9.14 Changes in Law

3.9.14.1. The MCO shall implement appropriate program, policy or system changes, as required by changes to State and federal laws or regulations or interpretations thereof.

3.10 Subcontractors

3.10.1 MCO Obligations

3.10.1.1. The MCO shall maintain ultimate responsibility for adhering to, and otherwise fully complying with the terms and conditions of this Agreement, notwithstanding any relationship the MCO may have with the Subcontractor, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by the MCO.

3.10.1.2. For the purposes of this Agreement, such work performed by any Subcontractor shall be deemed performed by the MCO. [42 CFR 438.230(b)]

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3.10.1.3. 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.

3.10.1.4. The MCO, regardless of its written agreements with any Subcontractors, maintains ultimate responsibility for complying with this Agreement.

3.10.1.5. The MCO shall have oversight of all Subcontractors' policies and procedures for compliance with the False Claims Act (FCA) and other State and federal laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

3.10.2 **Contracts with Subcontractors**

3.10.2.1. The MCO shall have a written agreement between the MCO and each Subcontractor which includes, but shall not be limited to:

3.10.2.1.1 Full disclosure of the method and amount of compensation or other consideration received by the Subcontractor;

3.10.2.1.2 Amount, duration, and scope of services to be provided by the Subcontractor;

3.10.2.1.3 Term of the agreement, methods of extension, and termination rights;

3.10.2.1.4 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);

3.10.2.1.5 Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement; and

3.10.2.1.6 In accordance with Prohibited Relationship provisions in Section 3.9.5.

3.10.2.1.7 Requirements for the Subcontractor

3.10.2.1.7.1. Provided that the Department makes timely payments to the MCO 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 MCO;

3.10.2.1.7.2. 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.

3.10.2.1.8 Requirements that provide that:

3.10.2.1.8.1. The MCO, 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 to audit, evaluate, and inspect, and that it shall make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under this Agreement; [42 CFR 438.230(c)(3)(i) & (ii); 42 CFR 438.3(k)]

3.10.2.1.8.2. 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

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438.230(c)(3)(iii); 42 CFR 438.3(k)]

3.10.2.1.8.3. The MCO, the Department, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit 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)]

3.10.2.1.8.4. Subcontractor's agreement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority;

3.10.2.1.8.5. Require Subcontractor to submit ownership and controlling interest information as required by Section 3.9.3 (Ownership and Control Disclosures);

3.10.2.1.8.6. Require Subcontractors to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs and who is [42 CFR 455.106(a)]:

3.10.2.1.8.6.1 A person who has an ownership or control interest in the

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Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)];

3.10.2.1.8.6.2 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)];

3.10.2.1.8.6.3 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

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		day-to-day operation of, the Subcontractor or Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)];
3.10.2.1.8.6.4		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 MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved

waiver program;

3.10.2.1.8.6.5 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;

3.10.2.1.8.6.6 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;

3.10.2.1.8.6.7 A provision for revoking delegation of activities or obligations, or imposing

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other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the MCO or the Department;

3.10.2.1.8.6.8 Subcontractor's agreement to comply with the ADA, as required by Section 3.9.11 (Americans with Disabilities Act) above;

3.10.2.1.8.6.9 Include provisions of this Section 3.10.2 (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.

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11246 of September 24, 1965;

3.10.2.1.8.6.10 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as 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;

3.10.2.1.8.6.11 Require any Subcontracto

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r 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

3.10.2.1.8.6.12 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]

3.10.2.2. The MCO 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.

3.10.2.3. If any of the MCO's activities or obligations under this Agreement are delegated to a Subcontractor:

3.10.2.3.1 The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCO and the Subcontractor; and

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3.10.2.3.2 The contract or written arrangement between the MCO 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 MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i)-(iii); 42 CFR 438.3(k)]

3.10.2.4. [Amendment #3:] Any Subcontractor performing utilization review must comply with the licensure or certification requirements set forth in this Agreement. ~~Subcontractors or any other party performing utilization review are required to be licensed in New Hampshire~~.

3.10.3 **Subcontractor Agreement Notification**

3.10.3.1. The MCO shall submit all Subcontractor agreements and Subcontractor Provider agreements to the Department for review at least sixty (60) calendar days prior to the agreement's anticipated implementation date, or change in scope or terms, of the Subcontractor agreement.

3.10.3.2. The MCO remains responsible for ensuring that all Agreement requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.10.3.3. The MCO 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.

3.10.3.4. Review and authorization by the Department of a Subcontractor agreement does not relieve the MCO from any obligation or responsibility regarding the Subcontractor or its Subcontractor oversight, and does not imply any obligation by the Department regarding the Subcontractor or Subcontractor agreement.

3.10.3.5. The Department may grant a written exception to the notice requirements of this Section 3.10.3 (Subcontractor Agreement Notification) if, in the Department's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.10.3.6. The MCO shall notify the Department within five (5) business days of receiving notice from a Subcontractor of its intent to terminate a Subcontractor agreement.

3.10.3.7. The MCO shall notify the Department of any material breach by Subcontractor of an agreement between the MCO and the Subcontractor that may result in the MCO being non-compliant with or violating this Agreement within one (1) business day of validation that such breach has occurred.

3.10.3.8. The MCO shall take any actions directed by the Department to cure or remediate said breach by the Subcontractor.

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3.10.3.9. In the event of breach or termination of a Subcontractor agreement between the MCO and a Subcontractor, the MCO's notice to the Department shall include a transition plan for the Department's review and approval.

3.10.4 **MCO Oversight of Subcontractors**

3.10.4.1. The MCO shall provide its Subcontractors with training materials regarding preventing Fraud, waste and abuse and shall require the MCO's hotline to be publicized to Subcontractors' staff who provide services to the MCO.

3.10.4.2. The MCO shall oversee and be held accountable for any functions and responsibilities that it delegates to any Subcontractor in accordance with 42 CFR 438.230 and 42 CFR Section 438.3, including:

3.10.4.2.1 Prior to any delegation, the MCO shall evaluate the prospective Subcontractor's ability to perform the Social Security activities to be delegated;

3.10.4.2.2 The MCO shall audit the Subcontractor's compliance with its agreement with the MCO and the applicable terms of this Agreement, at least annually and when there is a substantial change in the scope or terms of the Subcontractor agreement; and

3.10.4.2.3 The MCO shall identify deficiencies or areas for improvement, if any. The MCO shall prompt the Subcontractor to take corrective action.

3.10.4.3. The MCO shall develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and this Agreement.

3.10.4.4. If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the MCO shall notify the Department within seven (7) calendar days and require the Subcontractor to develop a CAP. The MCO 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]

3.11 **Staffing**

3.11.1 **Key Personnel**

3.11.1.1. The MCO shall commit key personnel to the MCM program on a full-time basis. Positions considered to be key personnel, along with any specific requirements for each position, include:

3.11.1.1.1 CEO/Executive Director: Individual shall have clear authority over the general administration and day-to-day business activities of this Agreement.

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3.11.1.1.2 Finance Officer: Individual shall be responsible for accounting and finance operations, including all audit activities.

3.11.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures.

3.11.1.1.3.1. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the Department's Medical Director.

3.11.1.1.3.2. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).

3.11.1.1.3.3. The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

3.11.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.11.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with the Department and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.11.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement.

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3.11.1.1.5.1. The Compliance Officer shall report directly to the NH-based CEO or the executive director thereof.

3.11.1.1.6 Network Management Director: Individual shall be responsible for development and maintenance of the MCO's Participating Provider network.

3.11.1.1.7 Provider Relations Manager: Individual shall be responsible for provision of all MCO Provider services activities.

3.11.1.1.7.1. The Provider Relations Manager shall have prior experience with individual physicians, Provider groups and facilities.

3.11.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities.

3.11.1.1.8.1. The Member Services Manager shall have prior experience with Medicaid populations.

3.11.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities.

3.11.1.1.9.1. [Amendment #3:] The UM Director shall be under the direct supervision of the Medical Director. and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

3.11.1.1.9.2. [Amendment #3:] As soon as possible, but no later than January 1, 2026, the MCO shall ensure any person, including Subcontractors, performing medical necessity determinations must hold an active professional license issued by the applicable board or committee of the New Hampshire Office of Professional Licensure and

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Certification for such person's applicable scope of practice. ~~The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.~~

3.11.1.1.10 Systems Director/Manager: Individual shall be responsible for all MCO information systems supporting this Agreement, including but not limited to continuity and integrity of operations, continuity flow of records with the Department's information systems and providing necessary and timely reports to the Department.

3.11.1.1.11 Encounter Manager: Individual shall be responsible for and qualified by training and experience to oversee encounter submittal and processing to ensure the accuracy, timeliness, and completeness of encounter reporting.

3.11.1.1.12 Claims Manager: Individual shall be responsible for and qualified by training and experience to oversee claims processing and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

3.11.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and shall have a minimum of five (5) years pharmacy experience as a practicing pharmacist.

3.11.1.1.13.1. The Pharmacy Manager shall be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.12.24 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

3.11.1.1.14 Substance Use Disorder Physician: Individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine and participate under the terms of this Agreement.

3.11.1.1.14.1. The SUD Physician's responsibilities shall include, but are not limited to:

3.11.1.1.14.1.1 In-person and in-state presence for greater than .50 FTE to meet with SUD Providers and PCPs to help expand SUD services. Discussion subjects shall include, but are not limited to, appropriate prescribing of medications for the treatment of opioid use disorder (MOUD);

3.11.1.1.14.1.2 In person and in-state to educate SUD Providers regarding appropriate treatment plans, and documentation, and billing practices;

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3.11.1.1.14.1.3 Responsibility for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for Members who visit an ED or are hospitalized for an overdose;

3.11.1.1.14.1.4 Active meeting participation, and at least yearly, meetings with organizations that support persons with a substance use disorder, including OTPs,

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hospitals, harm reduction organizations, The Doorway program sites, CMHCs, sober living homes, and other non-profit and for-profit organizations assisting persons with substance use disorder; and

3.11.1.1.14.1.5 Provide consultative support for the MCM program on a routine basis, including but not limited to, clinical policy related to Substance Use Disorders and individual Member cases, as needed.

3.11.1.2. MCO coordinators, also considered key personnel, shall be responsible for overseeing Care Coordination and Care Management activities, and also serve as liaisons to Department staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis unless otherwise specified:

3.11.1.2.1 Special Needs Coordinator at the Department's option: Individual shall have a minimum of a Master's Degree from a recognized college or university with

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major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.1.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

3.11.1.2.1.2. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.11.1.2.1.3. The Developmental Disability and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.1.3.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the Special Needs and Developmental Disabilities Coordinator positions may be either consolidated or established as individual

part-time positions.

3.11.1.2.2 [Amendment #1:] Developmental Disability Coordinator at the Department's option: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.2.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

3.11.1.2.2.2. The Developmental Disability Coordinator shall be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.11.1.2.2.3. The Developmental Disability and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.2.3.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the

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Developmental Disabilities and Special Needs Coordinator positions may be either consolidated or established as individual part-time positions.

3.11.1.2.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability.

3.11.1.2.3.1. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.11.1.2.3.2. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services.

3.11.1.2.3.3. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and

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interpretation of clinical policies and procedures; and Health-related social needs Health-related social needs and community-based resources.

3.11.1.2.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues.

3.11.1.2.4.1. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder.

3.11.1.2.4.2. The individual shall have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders.

3.11.1.2.4.3. The individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases.

3.11.1.2.4.4. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management;

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Provider relations; and Health-related social needs health-related social needs and community-based resources.

3.11.1.2.5 Long Term Care Coordinator at the Department's option: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs.

3.11.1.2.5.1. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

3.11.1.2.5.2. [Amendment #3:] [Amendment #1:] For the period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~, the Long Term Care Coordinator position is not required.

3.11.1.2.6 Grievance Coordinator: Individual shall be responsible for overseeing the MCO's Grievance System.

3.11.1.2.7 Fraud, Waste, and Abuse Coordinator: Individual shall be responsible for tracking, reviewing, monitoring, and reducing Fraud, waste and abuse.

3.11.1.2.8 Transportation Coordinator: Individual shall oversee the delivery of NEMT services to Members to ensure that there is a single point of oversight and accountability for all transportation and NEMT services.

3.11.1.2.8.1. The Transportation Coordinator shall be the primary individual responsible for ensuring the MCO's NEMT program is

operating effectively, and shall be expected to proactively identify and propose operational improvements.

3.11.1.2.8.1.1 The Transportation Coordinator shall be the primary individual responsible for identifying, securing, and maintaining transportation for Members, including but not limited to overseeing the MCO's NEMT Subcontractor and shall have the authority to take any action warranted to resolve an NEMT issue.

3.11.1.2.8.2. The Transportation Coordinator is responsible for ensuring the integration of transportation services into Member Care Plans.

3.11.1.2.8.3. The Transportation Coordinator shall ensure that the NEMT Subcontractor meets all NEMT requirements, including requirements as described in Section 4.1.9 (Non-Emergency Medical Transportation (NEMT)) and Exhibit O: Quality and

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Oversight Reporting Requirements of this Agreement as well as all other requirements in guidance provided by the Department.

3.11.1.2.8.4. The Transportation Coordinator shall be responsible for providing resolution to issues requiring immediate attention, including:

3.11.1.2.8.4.1 Resolution of complaints made by Members and transportation Providers.

3.11.1.2.8.4.2 Service delivery failures, including real-time assistance with rescheduling service appointments and/or transportation

3.11.1.2.8.5. The Transportation Coordinator shall have a minimum of four (4) years' experience relevant to the oversight of transportation services for vulnerable populations.

3.11.1.2.9 Housing Coordinator at the Department's option: The individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options. The Housing Coordinator shall:

3.11.1.2.9.1. Act as the MCO's central housing expert/resource,

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providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues.

3.11.1.2.9.2. Be a dedicated staff person whose primary responsibility is housing-related work.

3.11.1.2.9.3. Be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

3.11.1.2.9.4. At as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building.

3.11.1.2.9.5. Have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing.

3.11.1.2.9.6. [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~, the Housing Coordinator position is not required. ~~Be familiar with the relevant public and private housing resources and stakeholders.~~

3.11.1.2.10 Prior Authorization Coordinator: Individual shall be responsible for all MCO Utilization Management activities and shall work under the direct supervision of the Medical Director.

3.11.1.2.10.1. [Amendment #3:] The Prior Authorization Coordinator shall ensure that all staff performing prior authorization functions meet requirements for Section 3.11.1.1.9.2 and ~~have the necessary clinical backgrounds~~

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needed to apply established coverage criteria to and make appropriate decisions based on Mmedical Necessity. necessary.

3.11.1.2.10.2. The individual shall be licensed by the NH Board of Nursing and have a minimum of eight (8) years of demonstrated experience in both the provision of direct clinical services as well as progressively increasing levels of management responsibilities with a particular focus on performance of a variety of utilization functions including conducting inter-rater reliability quality audits.

3.11.1.2.11 Third Party Liability (TPL) Coordinator: Individual shall be responsible for ensuring the MCO and its subcontractors are performing all required TPL functions when processing claims, that MCOs are properly identifying and recovering on claims not cost avoided, that the MCO has a system in place to manage subrogation cases and comply with contract requirements, and act as liaison between the Department's TPL unit and the MCO. This person shall have claims experience and a financial background.

3.11.2 **Other MCO Required Staff**

3.11.2.1. Fraud, Waste, and Abuse Staff: The MCO shall establish a Special Investigations Unit (SIU), which shall be comprised of experienced Fraud, waste and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein.

3.11.2.1.1 At a minimum, the SIU shall have at least two (2) Fraud, waste and abuse investigators and one (1) Fraud, Waste and Abuse Coordinator.

3.11.2.1.2 The MCO shall adequately staff the SIU to ensure that the MCO meets Agreement provisions of Section 5.3.2 (Fraud, Waste and Abuse).

3.11.2.2. Behavioral Health Staff: The MCO shall designate one (1) or more staff who have behavioral health specific managed care experience to provide assistance to Members who are homeless and oversee:

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3.11.2.2.1 Behavioral health Care Management;

3.11.2.2.2 Behavioral health Utilization Management;

3.11.2.2.3 Behavioral health network development; and

3.11.2.2.4 The behavioral health Subcontract, as applicable.

3.11.2.3. Any subcontracted personnel or entity engaged in decision-making for the MCO regarding clinical policies related to Substance Use Disorder or mental health shall have demonstrated experience working in direct care for Members with Substance Use Disorder or mental health.

3.11.3 **On-Site Presence**

3.11.3.1. The MCO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this section of the Agreement means that the MCO's full-time equivalent (1.0 FTE) personnel for each position identified below regularly reports to work in the State of New Hampshire unless otherwise specified:

3.11.3.1.1 CEO/Executive Director;

3.11.3.1.2 Medical Director;

3.11.3.1.3 Network Management Director;

3.11.3.1.4 Provider Relations Manager;

3.11.3.1.5 Pharmacy Manager;

3.11.3.1.6 Substance Use Disorder Physician;

3.11.3.1.7 Special Needs Coordinator (at Department's option);

3.11.3.1.8 Mental Health Coordinator;

3.11.3.1.9 Substance Use Disorder Coordinator

3.11.3.1.10 Developmental Disabilities Coordinator (at Department's option);

3.11.3.1.11 Long Term Care Coordinator (at Department's option);

3.11.3.1.12 Transportation Coordinator;

3.11.3.1.13 Housing Coordinator (at Department's option);

3.11.3.1.14 Grievance Coordinator; and

3.11.3.1.15 Fraud, Waste, and Abuse Coordinator

3.11.3.2. Upon the Department's request, MCO required staff who are not located in New Hampshire shall travel to New Hampshire for in-person meetings.

3.11.3.3. The MCO 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.

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3.11.3.4. The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by the Department, which approval shall not be unreasonably withheld.

3.11.3.5. The Department may grant a written exception to the notice requirements of this section if, in the Department's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.11.4 **General Staffing Provisions**

3.11.4.1. The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely manner as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, the Department may impose liquidated damages, in accordance with Section 5.5.2 (Liquidated Damages).

3.11.4.2. The MCO shall ensure that all staff receive appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement.

3.11.4.3. 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.

3.11.4.4. 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.

3.11.4.5. The MCO 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.

3.11.4.6. The MCO 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.

3.11.4.7. If a member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform 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.

3.11.4.8. The Staffing Transition Plan shall include, but is not limited to:

3.11.4.8.1 The allocation of resources to the Agreement during key personnel vacancy;

3.11.4.8.2 The timeframe for obtaining key personnel replacements within ninety (90) calendar days; and

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3.11.4.8.3 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 MCO shall provide and be responsible for the cost of managed care 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, and as required by newly enacted state and federal laws, rules and regulations including expanded eligibility coverage for the postpartum period, effective October 1, 2023 (RSA 167:68); lawfully residing pregnant women and children, effective January 1, 2024 (RSA 126-A:4-i); and 12 months of continuous eligibility for children, effective January 1, 2024 (section 5112 of the Consolidated Appropriations Act of 2023).

4.1.1.2. Members enrolled with the MCO who subsequently become ineligible for managed care during MCO enrollment shall be excluded from MCO participation. The Department shall, based on State or federal statute, regulation, or policy, exclude other Members as appropriate.

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Incarcerated individuals in the State's prison system eligible for participation in the Department's Community Reentry demonstration waiver	X	
Medicaid Children Funded through the Children's Health Insurance Program	X	
Medicaid for Employed Adults with Disabilities Non-Dual	X	
Medicaid for Employed Older Adults with Disabilities	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

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4.1.2.1. The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.12 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management).

4.1.2.2. The MCO 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 MCO shall cover services consistent with 45 CFR 92.207(b).

4.1.2.3. While the MCO 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 MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. The Department reserves the right to alter this list at any time by providing reasonable notice to the MCO. [42 CFR 438.210(a)(1)-(3), (4)(i), (5) (i)-(ii)(A)-(C) and (b).

4.1.2.4. Summary of Covered Services

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
[Amendment #2:] Certified Community Behavioral Health Clinic (CCBHC) Services[3]	X	
Certified Non-Nurse Midwife	X	

[3] [Amendment #2:] Effective January 1, 2025, ARPA compliant mobile crisis services provided by CCBHCs are carved out of the MCM Program. For additional information, refer to https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/nh-ccbhc-demonstration-application-v2.pdf.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT		X
[Amendment #1:] Community Mental Health Services[4]	X	
[Amendment #2:] Community Reentry Services[5]	X	
Crisis Intervention–Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services[6]		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage[7]	X	
Family Planning Services	X	
Freestanding Birth Centers	X	
Furnished Medical Supplies & Durable Medical Equipment	X	
Glencliff Home		X

[4] [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

[5] [Amendment #2:] Effective for dates of service January 1, 2025 through June 30, 2029, in accordance with 1115 Medicaid Demonstration authority for Community Reentry (CRE), the State's "Reentry Demonstration Initiative" approved by CMS on July 16, 2024, as part of the extension for the New Hampshire's Substance Use Disorder Serious Mental Illness (SMI) and Serious Emotional Disturbance (SUD) Treatment Recovery and Access Section 1115 Demonstration Waiver, as specified in separate guidance. Demonstration information is available at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-images/nh-sud-treatment-recovery-access-ext-appvl-06162024_0.pdf.

[6] Certain preventive, restorative, denture and other oral health services are carved-out of the MCM program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages are Covered Services under the MCM program.

[7] [Amendment #2:] Inclusion of anesthesia medical benefit services ancillary to pediatric oral health services covered under Medicaid fee-for-service.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Home Based Therapy–Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	
Hospice	X	
Home and Community-Based In Home Support Services		X
[Amendment #2:] Incarcerated Youth Services[8]	X	
Inpatient Hospital[5a]	X	
Inpatient Hospital Swing Beds, Intermediate Care		X
Inpatient Hospital Swing Beds, Skilled Nursing		X
Inpatient Psychiatric Facility Services Under Age Twenty-One (21)[9]	X	
[Amendment #3:] Inpatient Psychiatric Treatment in State-owned New Hampshire Hospital ~~and Hampstead Hospital,~~ and Other State Determined IMD for Mental Illness[10]	X	
Intensive Home and Community-Based Services–Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities (e.g., Cedarcrest)		X

[8] [Amendment #2:] Effective January 1, 2025, in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) as specified in separate guidance. [SHO #24-004]
As described under "Mandatory Requirements of Section 5121 of the CAA," and detailed in SMDL 21-002, section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old). As mentioned above, the term "eligible juveniles" is not used in the amendments to the CHIP statute effectuated by section 5121 of the CAA, 2023. However, under the section 5121 amendments to section 2102(d) of the Act, the same eligibility policies that apply to "eligible juveniles" in Medicaid also apply to targeted low-income children in CHIP.

[9] Under age 22 if individual admitted prior to age 21.

[10] [Amendment #3:] Medicaid managed care inpatient psychiatric treatment at State-owned New Hampshire Hospital ~~and Hampstead Hospital,~~ and other State determined IMD for mental illness are covered up to sixty (60) days for adults age 21-64 due to a primary diagnosis of mental illness.

[5a] Including coverage for inpatient long-term acute care services in a long-term care hospital.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X
Medical Services Clinic (e.g., Opioid Treatment Program)	X	
Mental health services (e.g., psychology, psychotherapy, psychological and neurological testing)	X	
[Amendment #2:] [Amendment #1:] Mobile Crisis Services	X[11]	X
Non-Emergency Medical Transportation[12]	X	
Occupational Therapy[13]	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital[14]	X	
[Amendment #4:] Psychiatric ~~Pediatric~~ Residential Treatment Facility Services		X
Personal Care Services	X	
Physical Therapy[15]	X	
Physicians Services	X	
Placement Services–Division for Children, Youth & Families		X
Podiatrist Services	X	

[11] [Amendment #2:] Effective January 1, 2025, non-ARPA compliant mobile crisis services are a MCO CCBHC Covered Service only when provided by a State certified CCBHC.
[12] Also includes mileage reimbursement for Medically Necessary travel.
[13] Services are limited to twenty (20) visits per benefit year for each type of therapy including combined habilitation services and outpatient rehabilitation services.
[14] Including facility and ancillary services for dental procedures.
[15] Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Prescribed Drugs	X	
Preventative Services (e.g., nicotine cessation, SBIRT, transitional care management, chronic care management)[16]	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children–Division for Children, Youth & Families		X
Psychology	X	
Qualified Residential Treatment Program Services		X
Rehabilitative Services Post Hospital Discharge	X	
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy[17]	X	
Substance Use Disorder Services (Per He-W 513), including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

[16] See Law of the State of New Hampshire 2023, Chapter79:203 (HB2) (authorizing preventative services which may include, but is not necessarily limited to those listed).
[17]Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services.

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4.1.3.1. Nothing in this Section 4.1.3 shall be construed to limit the MCO's ability to otherwise voluntarily provide any other services in addition to the Covered Services required to be provided under this Agreement.

4.1.3.2. The MCO 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 MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS.

4.1.3.4. The MCO shall adopt written policies and procedures to verify that Covered Services are actually provided. [42 CFR 455.1(a)(2)]

4.1.3.4.1 Covered services shall be consistent with State laws and regulations in effect.

4.1.3.5. In Lieu of Services

4.1.3.5.1 The MCO may provide Members with services or settings that are "In Lieu of" Services or settings with prior approval and in accordance with federal regulations.

4.1.3.5.2 The MCO may cover In Lieu of Services if:

4.1.3.5.2.1. The alternative service or setting is a medically appropriate and cost-effective substitute;

4.1.3.5.2.2. The Member is not required to use the alternative service or setting;

4.1.3.5.2.3. The In Lieu of Service has been authorized by the Department and/or CMS, as appropriate; and

4.1.3.5.2.4. The in Lieu of Service has been offered to Members at the option of the MCO. [42 CFR 438.3(e)(2)(i-iii)]

4.1.3.5.3 For the MCO to obtain approval for In Lieu of Services not previously authorized by the Department, the MCO shall submit an In Lieu of Service request to the Department for each proposed In Lieu of Service not yet authorized.

4.1.3.5.4 [Amendment #1:] The Department has authorized medical nutrition, partial hospitalization for eating

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disorders, alternative therapies for pain management, partial hospitalization for youth with behavioral health diagnoses, critical time intervention (CTI) services, and diabetes self-management, ~~and assistance in finding and keeping housing (not including rent),~~ as In Lieu of Services (subject to CMS approval, as appropriate). This list may be expanded upon or otherwise modified by the Department and with CMS approval, as appropriate, and incorporated into this Agreement.

4.1.3.5.5 The MCO shall monitor the cost-effectiveness of each approved In Lieu of Service in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.3.5.6 [Amendment #1:] The MCO shall utilize a consistent process to ensure that a Provider (either the MCO's clinical staff or network Provider) using their professional judgment determines and documents that the ~~ILOS~~ In Lieu of Service is medically appropriate for the specific enrollee, based on any defined target population eligible for the ~~ILOS~~ In Lieu of Service. The documentation may be included, for example, in a Member's Care Plan or medical record.

4.1.3.6. Telemedicine

4.1.3.6.1 The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Members in certain circumstances.

4.1.3.6.2 The MCO shall develop a telemedicine clinical coverage policy and submit the policy to the Department during Readiness Review for review. Covered telemedicine modalities shall comply with all local, State and federal laws including the HIPAA and record retention requirements, and Exhibit K: Information Security Requirements and the Exhibit Q: IT Requirements Workbook.

4.1.3.6.3 The clinical policy shall include security requirements which demonstrate how each covered telemedicine modality complies with Exhibit K, Information Security Requirements.

4.1.3.7. Non-Participating Indian Health Care Providers

4.1.3.7.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health Care Providers (IHCP)

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from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.7.2 The MCO 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)]

4.1.3.8. Moral and Religious Grounds

4.1.3.8.1 An MCO that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(a)(2)]

4.1.3.8.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO 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)]

4.1.3.8.3 If the MCO does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, the Department shall provide that information to potential Members upon request. [42 CFR 438.10(e)(2)(v)(C)]

4.1.3.9. [Amendment #2:] Community Reentry Services

4.1.3.9.1 [Amendment #2] For services effective January 1, 2025, MCO shall implement the incarcerated youth community re-entry benefit for Members in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328), CMS guidance, and Department guidance.

4.1.3.9.2 [Amendment #2:] Effective for dates of service January 1, 2025 through June 30, 2029, MCO shall implement the adult community re-entry benefit for Members in accordance with 1115 Medicaid Demonstration authority for Community Reentry

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(CRE), the State's "Reentry Demonstration Initiative" approved by CMS on July 16, 2024, as part of the extension for the New Hampshire's Substance Use Disorder (SUD), Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Treatment Recovery and Access Section 1115 Demonstration Waiver, Department guidance, and applicable CMS guidance.

4.1.3.9.3 [Amendment #2:] Effective for dates of service beginning on or after January 1, 2025, for Members eligible for both the (i) adult community re-entry benefit in accordance with 1115 Medicaid Demonstration authority for Community Reentry (CRE), and (ii) incarcerated youth community re-entry benefit in accordance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328), the MCO shall integrate and make available both adult and youth CRE program Covered Services to such Members.

4.1.4 **Cost Sharing**

4.1.4.1. 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.

4.1.4.2. With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) 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:

4.1.4.2.1 [Amendment #4:] A Copayment of four dollars ($4.00) ~~one dollar ($1.00)~~ shall be required for each preferred prescription drug and each refill of a preferred prescription drug; and

4.1.4.2.2 [Amendment #4:] A Copayment of four dollars ($4.00) ~~two dollars ($2.00)~~ shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug~~, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug shall be one dollar ($1.00)~~;

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4.1.4.2.3 [Amendment #4:] Intentionally left blank. ~~A Copayment of one dollar ($1.00) shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and~~

4.1.4.2.4 [Amendment #4:] [Amendment #3:] ~~Intentionally left blank. A Copayment of one dollar ($1.00) for each preferred prescription drug to two dollars ($2.00) for each non-preferred prescription drug or such other amount(s) as required by state law or the applicable New Hampshire State Plan Amendment.~~

4.1.4.3. The following services are exempt from cost-sharing:

4.1.4.3.1 Emergency services,

4.1.4.3.2 Family planning services,

4.1.4.3.3 Preventive services provided to children,

4.1.4.3.4 Pregnancy-related services,

4.1.4.3.5 Services resulting from potentially preventable events, and,

4.1.4.3.6 Cloraril (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.3.7 [Amendment #4:] Recommended medications, services, and items graded A or B by the U.S. Preventive Services Task Force, including nicotine cessation products and oral and injectable formulations of Pre-Exposure Prophylaxis (PrEP) for persons who are at high risk of HIV acquisition.

4.1.4.4. Members are exempt from Copayments when:

4.1.4.4.1 The Member falls under the designated income threshold (one hundred percent (100%) or below the FPL);

4.1.4.4.2 The Member is under eighteen (18) years of age;

4.1.4.4.3 The Member is in a nursing facility or in an ICF for Members with IDs;

4.1.4.4.4 The Member participates in one (1) of the HCBS waiver programs;

4.1.4.4.5 The Member is pregnant and receiving services related to their pregnancy or any other medical condition that might complicate the pregnancy;

4.1.4.4.6 [Amendment #4:] The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within twelve (12)

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months ~~sixty (60) calendar days~~ after the month the pregnancy ended;

4.1.4.4.6.1. The Member is in the Breast and Cervical Cancer Treatment Program;

4.1.4.4.6.2. The Member is receiving hospice care; or

4.1.4.4.6.3. The Member is an American Indian/Alaska Native.

4.1.4.5. 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]

4.1.5 **Emergency Services**

4.1.5.1. The MCO shall cover and pay for Emergency Services at rates that are no less than the equivalent Department FFS rates if the Provider that furnishes the services has an agreement with the MCO. [Section 1932(b)(2)(A) of the Social Security Act; 42 CFR 438.114(b)]

4.1.5.2. If the Provider that furnishes the Emergency Services does not have an agreement with the MCO, the MCO shall cover and pay for the Emergency Services in compliance with Section 1932(b)(2)(D) of the Social Security Act, 42 CFR 438.114(c)(1)(i), and the SMDL 3/20/98.

4.1.5.3. The MCO shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating Provider.

4.1.5.4. The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the 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]

4.1.5.5. The MCO shall not deny treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition.

4.1.5.6. The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A-B)].

4.1.5.7. The MCO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

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4.1.5.8. The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or 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)]

4.1.5.9. The MCO may not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. [42 CFR 438.114(d)(2)]

4.1.5.10. 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)]

4.1.6 **Post-Stabilization Services**

4.1.6.1. Post-Stabilization Services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for medically necessary Post-Stabilization Services:

4.1.6.1.1 Obtained within or outside the MCO that are pre-approved by a Participating Provider or other MCO representative;

4.1.6.1.2 Obtained within or outside the MCO that are not pre-approved by a Participating Provider or other MCO representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services; and/or

4.1.6.1.3 Administered to maintain, improve or resolve the Member's stabilized condition without pre-authorization, and regardless of whether the Member obtains the services within the MCO network if:

4.1.6.1.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

4.1.6.1.3.2. The MCO cannot be contacted; or

4.1.6.1.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is not available for consultation. In this situation, the MCO shall give the treating

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physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

4.1.6.2. The MCO shall limit charges to Members for Post-Stabilization Services to an amount no greater than what the organization would charge the Member if the Member had obtained the services through the MCO. [[42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)]

4.1.6.3. The MCO's financial responsibility for Post-Stabilization Services, if not pre-approved, ends when:

4.1.6.3.1 The MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

4.1.6.3.2 The MCO physician assumes responsibility for the Member's care through transfer;

4.1.6.3.3 The MCO representative and the treating physician reach an agreement concerning the Member's care; or

4.1.6.3.4 The Member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i-iv)]

4.1.7 **Value-Added Services**

4.1.7.1. The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2. Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The MCO shall submit to the Department an annual list of the Value-Added Services being provided.

4.1.8 **Early and Periodic Screening, Diagnostic, and Treatment**

4.1.8.1. The MCO shall provide the full range of preventive, screening, diagnostic and treatment services including all medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions for EPSDT eligible beneficiaries ages birth to twenty-one in accordance with 1905(r) of the Social Security Act. [42 CFR 438.210(a)(5)]

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4.1.8.2. The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

4.1.8.3. Upon conclusion of an individualized review of medical necessity, the MCO shall cover all Medically Necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. Section 1396d(a), regardless of whether such services are covered under the Medicaid State Plan and regardless of whether the request is labeled as such, with the exception of all services excluded from the MCO.

4.1.8.4. The MCO may provide Medically Necessary services in the most economic mode possible, as long as:

4.1.8.4.1 The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;

4.1.8.4.2 The determination process does not delay the delivery of the needed service; and

4.1.8.4.3 The determination does not limit the Member's right to a free choice of Participating Providers within the MCO's network.

4.1.8.5. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria.

4.1.8.6. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

4.1.8.7. The MCO shall not require Prior Authorization for Non-Symptomatic Office Visits (early and periodic screenings/Wellness Visits) for Members less than twenty-one (21) years of age. The MCO may require Prior Authorization for other diagnostic and treatment products and services provided under EPSDT.

4.1.8.8. The MCO shall conduct Prior Authorization reviews using current clinical documentation, and shall consider the individual clinical condition and health needs of the child Member. The MCO shall not make an adverse benefit determination on a service authorization request for a Member less than twenty-one (21) years of age until the request is reviewed per EPSDT criteria.

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4.1.8.9. While an EPSDT request is under review, the MCO may suggest alternative services that may be better suited to meet the Member's needs, engage in clinical or educational discussions with Members or Providers, or engage in informal attempts to resolve Member concerns as long as the MCO makes clear that the Member has the right to request authorization of the services he or she wants to request.

4.1.8.10. The MCO shall develop effective methods to ensure that Members less than twenty-one (21) years of age receive all elements of preventive health screenings recommended by the AAP in the Academy's most currently published Bright Futures preventive pediatric health care periodicity schedule using a validated screening tool. The MCO shall be responsible for requiring in contracts that all Participating Providers that are PCPs perform such screenings.

4.1.8.11. The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening:

4.1.8.11.1 Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders;

4.1.8.11.2 Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool;

4.1.8.11.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.11.4 Comprehensive, unclothed physical examination;

4.1.8.11.5 All appropriate immunizations, in accordance with the schedule for pediatric vaccines, laboratory testing (including blood lead screening appropriate for age and risk factors); and

4.1.8.11.6 Health education and anticipatory guidance for both the child and caregiver.

4.1.8.12. The MCO shall include the following information related to EPSDT in the Member Handbook:

4.1.8.12.1 The benefits of preventive health care;

4.1.8.12.2 Services available under the EPSDT program and where and how to obtain those services;

4.1.8.12.3 That EPSDT services are not subject to cost-sharing; and

4.1.8.12.4 That the MCO shall provide scheduling and transportation assistance for EPSDT services upon request by the Member.

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4.1.8.13. The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis.

4.1.8.13.1 The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.14. The MCO shall submit its EPSDT plan for the Department's review and approval as part of its Readiness Review and in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.1.9 **Non-Emergency Medical Transportation (NEMT)**

4.1.9.1. The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO.

4.1.9.1.1 The MCO shall deem NEMT Medically Necessary for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

4.1.9.2. The MCO shall provide the most cost-effective and least expensive mode of transportation to secure Covered Services for its Members. However, the MCO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The MCO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements.

4.1.9.3. The MCO shall ensure that each vehicle providing NEMT Covered Services meets the following requirements:

4.1.9.3.1 Has a valid vehicle registration;

4.1.9.3.2 [Amendment #4:] Has undergone a satisfactory safety inspection in accordance with the mutually agreed comprehensive safety checklist at the time of transportation provider enrollment into the Subcontractor's network, at least annually thereafter, and when a safety issue is reported for the transportation provider vehicle ~~laws of the state of New Hampshire~~; and

4.1.9.3.3 Has no apparent need for maintenance that affects safety including, but not limited to, visible holes in the body of the vehicle, defective brakes, worn or underinflated tires, leaking fluids, or illuminated check engine light.

4.1.9.4. The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family

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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:

4.1.9.4.1 Does not have a valid driver's license;

4.1.9.4.2 Does not have a working vehicle available in the household;

4.1.9.4.3 Is unable to travel or wait for services alone; or

4.1.9.4.4 Has a physical, cognitive, mental or developmental limitation.

4.1.9.5. The Family and Friends mileage reimbursement rate shall be 62.5 cents per mile. The MCO shall create incentive programs to encourage the utilization of the Family and Friends Program with a target of fifty percent (50%) utilization.

4.1.9.6. If no car is owned or available, the Member shall use public transportation if:

4.1.9.6.1 The Member lives less than one half mile from a bus route;

4.1.9.6.2 The Provider is less than one half mile from the bus route; and

4.1.9.6.3 The Member is an adult under the age of sixty-five (65).

4.1.9.7. Exceptions the above public transportation requirement are:

4.1.9.7.1 The Member has two (2) or more children under age six (6) who shall travel with the parent;

4.1.9.7.2 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

4.1.9.7.3 The Member has at least one (1) of the following conditions:

4.1.9.7.3.1. Pregnant or up to six (6) weeks post-partum;

4.1.9.7.3.2. Moderate to severe respiratory condition with or without an oxygen dependency;

4.1.9.7.3.3. Limited mobility (walker, cane, wheelchair, amputee, etc.);

4.1.9.7.3.4. Visually impaired;

4.1.9.7.3.5. Developmentally delayed;

4.1.9.7.3.6. Significant and incapacitating degree of mental illness; or

4.1.9.7.3.7. Other exception by Provider approval only.

4.1.9.8. If public transportation is not an option, the MCO shall ensure that the Member is provided transportation from a transportation Subcontractor.

4.1.9.8.1 For NEMT driver services, excluding public transit drivers, the MCO shall ensure:

4.1.9.8.1.1. Background checks are performed for all NEMT drivers;

4.1.9.8.1.2. 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;

4.1.9.8.1.3. Each such individual driver has a valid driver's license;

4.1.9.8.1.4. Each such provider has in place a process to address any violation of a State drug law;

4.1.9.8.1.5. 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];

4.1.9.8.1.6. Each such individual driver consistently utilizes a Global Positioning System device (GPS) to document the date, time and location for each pick up and drop off to track on-time

performance and ensure that trips take place as scheduled;

4.1.9.8.1.7. All vehicles utilized in the delivery of NEMT services shall be compliant with all federal and state safety requirements during the provision of the NEMT ride; and

4.1.9.8.1.8. Once a ride has been confirmed for a Member, the ride shall be provided unless cancelled by the Member.

4.1.9.8.1.9. [Amendment #4:] Any vehicles used for the purpose of transporting individuals with disabilities must meet the requirements set forth in the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles. [49 CFR 38]

4.1.9.8.2 The Department may require the procurement of an independent evaluator to measure and report on how NEMT services are being provided.

4.1.9.8.3 The Department reserves the right to reject, suspend, or terminate any Transportation Provider and/or individual driver from participation in the NEMT Program.

4.1.9.8.4 The MCO shall submit a weekly issue log for NEMT services as specified in Exhibit O: Quality and Oversight Reporting Requirements, and guidance issued by the Department.

4.1.9.8.4.1. NEMT Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement. In addition the MCO shall submit data on one hundred (100%) percent of the outcomes of scheduled NEMT trips, including, but not limited to trips delivered on-time, delivered late, rescheduled, rescued,

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cancelled, to the Department through NEMT Encounter Data or other means and schedule specified by the Department.

4.1.9.8.5 The Transportation Coordinator shall ensure there are no disruptions to Covered Services due to NEMT issues which shall be subject to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.1.9.8.5.1. The MCO, 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 or shall otherwise be subject to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.1.9.9. The Department reserves the right to require the use of a single transportation Subcontractor.

4.1.9.9.1 The MCO shall subcontract with and provide remuneration to the single transportation Subcontractor designated by the Department for NEMT services. The Department has the sole discretion to establish the subcontract terms.

4.1.9.9.2 The MCO shall not make amendments to the single transportation contract without prior written approval from the Department.

4.1.9.10. Failure of the MCO to meet any of these requirements shall subject the MCO to liquidated damages as specified in Exhibit N: Liquidated Damages Matrix.

4.1.9.11. The MCO 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.

4.1.9.12. [Amendment #1:] The MCO shall perform monitoring and oversight activities of trips provided to Members, including Family and Friends Program reimbursement, to ensure transportation Providers and Members are in compliance with the requirements of the NEMT Medicaid State Plan, including all State and federal regulations.

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4.2 Pharmacy Management

4.2.1 General

4.2.1.1. The Department reserves the right to require the use of a single Pharmacy Benefits Manager (PBM) starting in Year 3 or Year 4 of this Agreement.

4.2.1.1.1 The MCO shall subcontract with and provide remuneration to the Single PBM designated by the Department for pharmacy claims payment and administrative services. The Department has the sole discretion to establish the subcontract terms.

4.2.1.1.2 The MCO shall not make amendments to the Single PBM subcontract without prior written approval from the Department.

4.2.2 MCO and DHHS Covered Prescription Drugs

4.2.2.1. The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which the Department provides coverage as defined in Section 1927(k)(2) of the Social Security Act [42 CFR 438.3(s)(1)]. The MCO shall not include drugs by manufacturers not participating in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) Medicaid rebate program on the MCO formulary without the Department's consent.

4.2.2.2. [Amendment #3:] The Department shall include a High-Cost Pharmacy Risk Pool (HCPRP) for purposes of risk mitigation as described in Section 6.3.4.1.1~~6.3.5.1.1~~ of this Agreement.

4.2.2.3. The MCO shall pay for all prescription drugs, including specialty and office administered drugs consistent with the MCO's formulary, pharmacy edits and Prior Authorization criteria reviewed and approved by the Department, and are consistent with the Department's Preferred Drug List (PDL) as described in Section 4.2.3 (MCO Formulary) below.

4.2.2.4. Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO.

4.2.2.5. The MCO shall pay for, when Medically Necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

4.2.2.6. The MCO shall ensure Members diagnosed with opioid use disorder, Substance Use Disorder, and behavioral health conditions treated at Community Mental Health Programs, FQHCs, FQHC look-alikes, and Doorway network facilities with integrated on-site pharmacies have immediate access to covered specialty drugs to treat related conditions.

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4.2.3 **MCO Formulary**

4.2.3.1. The Department shall establish the PDL and shall be the sole party responsible for negotiating rebates for drugs on the PDL.

4.2.3.1.1. [Amendment #4:] In addition to the MCO's PDL compliance obligations under this Agreement, the MCO shall achieve Department specified minimum adherence targets for specific Department identified drugs' initial adherence targets measured from January 1, 2026 through June 30, 2026. The Department may update adherence targets annually and shall be maintained by the MCO annually thereafter as described in separate guidance.

4.2.3.1.2. [Amendment #4:] The MCO shall provide quarterly reporting on MCO's adherence targets in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.2.3.1.3. [Amendment #4:] Failure to meet adherence to targets will subject the MCO to liquidated damages in accordance with Exhibit N: Liquidated Damages Matrix.

4.2.3.2. The MCO shall use the Department's PDL and shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs on the PDL.

4.2.3.3. The Department shall be responsible for invoicing any pharmaceutical manufacturers for federal rebates mandated under federal law and for PDL supplemental rebates negotiated by the Department.

4.2.3.4. The MCO shall develop a formulary that adheres to the Department's PDL for drug classes included in the PDL and is consistent with Section 4.2.2 (MCO and DHHS Covered Prescription Drugs). In the event that the Department makes changes to the PDL, the Department shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.3.5. Negative changes shall apply to new starts within thirty (30) calendar days of notice from the Department. The MCO shall have ninety (90) calendar days to notify Members and prescribers currently utilizing medications that are to be removed from the PDL if current utilization is to be transitioned to a preferred alternative.

4.2.3.6. For any drug classes not included in the Department's PDL, the MCO shall determine the placement on its formulary of products within that drug class, provided the MCO covers all products for which a federal manufacturer rebate is in place and the MCO is in compliance with all Department requirements in this Agreement.

4.2.3.7. The Department shall maintain a uniform review and approval process through which the MCO may submit additional information and/or requests for the inclusion of additional drug or drug classes on the Department's PDL. The Department shall invite the MCO's Pharmacy Manager to attend meetings of the NH Medicaid DUR Board.

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4.2.3.8. The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary shall be available to Members and Participating Providers electronically, in a machine-readable file and format, and shall, at minimum, contain information related to:

4.2.3.8.1 Which medications are covered, including whether it is the generic and/or the brand drug; and

4.2.3.8.2 What tier each medication is on. [42 CFR 438.10(i)(1-3)]

4.2.3.9. The MCO shall adhere to all relevant State and federal law, including without limitation, with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, laws of 2004, Senate Bill 383-FN, Section IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

4.2.3.9.1 Allergy to all medications within the same class on the PDL;

4.2.3.9.2 Contraindication to or drug-to-drug interaction with all medications within the same class on the PDL;

4.2.3.9.3 History of unacceptable or toxic side effects to all medications within the same class on the PDL;

4.2.3.9.4 Therapeutic failure of all medications within the same class on the PDL;

4.2.3.9.5 An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal FDA-approved indication;

4.2.3.9.6 An age-specific indication;

4.2.3.9.7 Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or;

4.2.3.9.8 Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

4.2.3.10. [Amendment #1:] Through September 30, 20243, the cost of COVID-19 at-home test kits, vaccines, and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

4.2.4 **Pharmacy Clinical Policies and Prior Authorizations**

4.2.4.1. The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and

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complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.8.1.6 (Prior Authorization).

4.2.4.1.1 The MCO's clinical pharmacy team shall periodically review drug Prior Authorization denials issued by any Subcontractor(s) to ensure the denial is appropriate. This does not include Prior Authorization requests denied because the authorization request is incomplete or does not contain enough information to determine Medical Necessity.

4.2.4.2. The MCO's pharmacy Prior Authorization criteria, including any pharmacy policies and programs, shall be submitted to the Department prior to the implementation of this Agreement, shall be subject to the Department's approval, and shall be submitted to the Department prior to the MCO's implementation of a modification to the criteria, policies, and/or programs.

4.2.4.3. The MCO's pharmacy Prior Authorization criteria shall be no more restrictive than the Prior Authorization criteria of the Fee for Service (FFS) program's medically accepted indication(s) for a covered outpatient drug in accordance with 1927(k)(6).

4.2.4.4. The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.12.34.3 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.4.4.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship.

4.2.4.4.2 The MCO shall conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT.

4.2.4.4.3 The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, Vivitrol®, etc.).

4.2.4.5. The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the Department-approved modification effective date.

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4.2.4.6. Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the Department -approved modification effective date.

4.2.4.7. The MCO shall implement and operate a DUR program that shall be in compliance with Section 1927(g) of the Social Security Act, address Section 1004 provisions of the SUPPORT for Patient and Communities Act, and include:

4.2.4.7.1 Prospective DUR;

4.2.4.7.2 Retrospective DUR;

4.2.4.7.3 An educational program for Participating Providers, including prescribers and dispensers; and

4.2.4.7.4 DUR program features in accordance with Section 1004 provisions of the SUPPORT for Patient and Communities Act, including:

4.2.4.7.4.1. Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.2.4.7.4.2. Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.2.4.7.4.3. A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.2.4.7.4.4. A program to monitor and manage the appropriate use of antipsychotic medications by all

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children including foster children enrolled under the State Plan;

4.2.4.7.4.5. Fraud and abuse identification processes that identifies potential Fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies; and

4.2.4.7.4.6. Operate like the State's Fee-for-Service DUR program. [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)].

4.2.4.8. The MCO shall submit to the Department a detailed description of its DUR program prior to the implementation of this Agreement and, if the MCO's DUR program changes, annually thereafter.

4.2.4.9. In accordance with Section 1927 (d)(5)(A) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization one hundred percent (100%) of the time and reimburse for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation when Prior Authorization cannot be obtained. [42 CFR 438.210(d)(3)]

4.2.4.10. The MCO shall develop and/or participate in other State of New Hampshire pharmacy-related quality improvement initiatives, as required by the Department and in alignment with the MCO's QAPI, further described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.2.4.11. For the HEDIS Measure "Use of Opioids from Multiple Providers", the MCO shall achieve performance that is less than or equal to the average rate of New England HMO Medicaid health plans as reported by NCQA Quality Compass for the previous calendar year.

4.2.4.12. The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed by the Department, and complies with requirements included in Section 4.12.34.3 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from the Department, implement Lock-In Programs for other medical services.

4.2.4.13. Members shall not be required to change covered prescription drugs more than once per calendar year, with the following exceptions:

4.2.4.13.1 When a Member is new to Medicaid, or switches from one Medicaid MCO to another Medicaid MCO;

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4.2.4.13.2 When a covered prescription drug change is initiated by the Member's provider;

4.2.4.13.3 When a biosimilar becomes available to the market;

4.2.4.13.4 When FDA boxed warnings or new clinical guidelines are recognized by CMS;

4.2.4.13.5 When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and

4.2.4.13.6 When a covered prescription is not available due to a supply shortage.

4.2.5 **Pharmacy Systems, Data, and Reporting Requirements**

4.2.5.1. Systems Requirements

4.2.5.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to:

4.2.5.1.1.1. Systems maintenance,

4.2.5.1.1.2. Software upgrades, and

4.2.5.1.1.3. National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP).

4.2.5.1.2 Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.5.2. Pharmacy Data and Reporting Requirements

4.2.5.2.1 To demonstrate its compliance with the Department PDL, the MCO shall submit to the Department information regarding its PDL compliance rate.

4.2.5.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, the Department shall be responsible for collecting OBRA 90 CMS rebates, inclusive of supplemental, from drug manufacturers on MCO pharmacy claims.

4.2.5.2.3 The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the

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Encounter Data file within fourteen (14) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement.

4.2.5.2.4 The drug utilization information reported to the Department shall, at a minimum, include information on:

4.2.5.2.4.1. The total number of units of each dosage form,

4.2.5.2.4.2. Strength, and

4.2.5.2.4.3. Package size by National Drug Code of each covered outpatient drug dispensed, per Department encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.5.2.5 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to the Department. [42 CFR 438.3(s)(3)]

4.2.5.2.6 The MCO shall implement a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program.

4.2.5.2.7 The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for Members for medications covered by other payers.

4.2.5.2.8 The MCO shall adhere to federal regulations with respect to providing pharmacy data required for the Department to complete and submit to CMS the Annual Medicaid DUR Report. [42 CFR 438.3(s)(4),(5)]

4.2.5.2.9 The MCO shall provide the Department reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.2.5.2.10 [Amendment #1:] The MCO shall provide to the Department a detailed plan describing the exchange of Member pharmacy and medical record information between the PCP, behavioral health Provider, and other appropriate parties for the purpose of medication management. This information shall be provided in a streamlined manner across the MCOs ~~prescribed by the Department~~ as permitted by State and federal law.

4.2.5.2.10.1. All Member medical records and other medication management information exchanged between parties shall be shared with the Member's PCP in an easily identifiable format.

4.2.5.2.10.2. The MCO shall retain oversight and accountability of the medication management program, including data exchanges between parties.

4.2.5.2.10.3. The MCO shall submit its medication management plan for the Department's review and authorization at time of readiness, and prior to implementation when changes to the MCO's medication management program are proposed.

4.2.5.2.10.4. [Amendment #1:] The MCO shall have all processes and systems in place for related information sharing of data between parties no later than December 1, 2024.

4.2.6 **Medication Management**

4.2.6.1. Medication Management for All Members

4.2.6.1.1 Polypharmacy criteria for Members are defined as follows:

4.2.6.1.1.1. Child Members dispensed four (4) or more maintenance drugs based on GPI 10 or an equivalent product identification code (such as HICL) over a rolling sixty (60) day period, each

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drug filled for at least ninety (90) days duration, allowing each drug up to one fifteen (15) day gap between fills;

4.2.6.1.1.2. Adult Members dispensed five (5) or more maintenance drugs based on Generic Product Identifier (GPI) 10 or an equivalent product identification code (such as HICL) over a rolling sixty (60) day period; and

4.2.6.1.1.3. Brand and equivalent generics (or similar relationship such as reference product and biosimilar) within same GPI or equivalent product identification code shall not be counted as separate drugs within the five (5) maintenance drugs.

4.2.6.2. The MCO shall support medication management for Members meeting Polypharmacy criteria, and for other Members requesting medication review to ensure the PCP, pharmacist, or other qualified health care individual pharmacist has the information necessary to conduct Polypharmacy and medication management for child/adolescent and adult Members.

4.2.6.3. Comprehensive Medication Review (CMR) is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. This systematic process shall be used for each CMR.

4.2.6.3.1 [Amendment #1:] The MCO is responsible to ensure that a Member receives at least one Comprehensive Medication Review (CMR) from the PCP, community pharmacist or other qualified individual within six (6) months from the date~~/quarter~~ in which the Member was identified as meeting Polypharmacy criteria and the MCO shall be responsible for providing medication history to the PCP, pharmacist or other qualified individual.

4.2.6.3.2 [Amendment #1:] The PCP, community pharmacist, or other qualified individual shall participate in Polypharmacy and medication management.

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4.2.6.3.3 [Amendment #1:] The PCP, community pharmacist or other qualified individual shall provide counseling with any Member or authorized representative upon request, as described in this section, and in Exhibit O: Quality Oversight Reporting Requirements.

4.2.6.3.4 [Amendment #1:] The MCO shall report to the Department on a quarterly basis the total number of CMRs completed, including total number of counselling interactions with any Member, the Member names, and Provider (PCP, community pharmacist, or other qualified health care provider) who performed the CMR and/or counselling interaction with the Member or authorized representative.

4.2.6.3.5 The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the Member, authorized representative, and the PCP, pharmacist and/or other qualified individual with the intent to improve a Member's knowledge of their prescriptions, over-the-counter medications, herbal therapies, and dietary supplements; identify, and address problems or concerns the patient may have; and empower them to self-manage their medications and health conditions. These items shall be addressed for each Member during each CMR counselling interaction.

4.2.6.3.6 [Amendment #1:] Intentionally left blank. ~~In the event a Member identified for Polypharmacy does not participate in such review offered by a PCP, pharmacist, or other qualified individual at least once annually, the MCO shall offer CMR and counseling at least monthly until the Member actively accepts or denies receipt of CMR services.~~

4.2.6.3.6.1. [Amendment #1:] Intentionally left blank. ~~When the Member does not engage with the PCP, pharmacist, or other qualified individual for the purpose of satisfying medication management requirements of this Agreement, the MCO may subcontract with an appropriately credentialed and licensed professional or entity to support such engagement with~~

~~prior approval from the Department.~~

4.2.6.4. The MCO shall routinely monitor and address the appropriate use of behavioral health medications in children by encouraging the use of, and reimbursing for consultations with, child psychiatrists.

4.2.6.5. The MCO shall provide to the qualified individual conducting CMR contact information for at least five (5) in-network child/adolescent psychiatrists for the purpose of peer-to-peer consulting whenever a child/adolescent Member is identified for Polypharmacy and is prescribed behavioral health prescriptions.

4.2.6.6. The MCO shall monitor Members who meet criteria for Polypharmacy three (3), six (6), and twelve (12) months after the CMR is completed to see if the member continues to meet criteria for Polypharmacy, or if it has been resolved. The MCO shall report the number of members who continue to meet criteria for Polypharmacy, and the number of members who no longer meet criteria on a quarterly basis.

4.2.7 **Medication Management for Children with Special Health Care Needs**

4.2.7.1. [Amendment #1:] The MCO shall be responsible to ensure~~for~~ active and comprehensive medication management for Children with Special Health Care Needs. In the event the PCP, community pharmacist or other qualified individual has not completed a CMR, t~~T~~he MCO shall offer to Members, their parents, and/or caregivers, comprehensive medication management services for Children with Special Health Care Needs. If comprehensive medication management services are accepted by the Member or authorized representative, the MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that shall include, but not be limited to, the following:

4.2.7.1.1 Performing or obtaining necessary health assessments;

4.2.7.1.2 [Amendment #1:] Formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the Member, parent and/or caregiver with a special focus on safe prescribing of psychotropic medications;

4.2.7.1.3 Selecting, initiating, modifying, recommending changes to, or administering medication therapy;

4.2.7.1.4 Monitoring, which could include lab assessments and evaluating the Member's response to therapy;

4.2.7.1.5 Consulting with social service agencies on medication management services;

4.2.7.1.6 [Amendment #1:] Initial and on-going CMR to prevent medication-related problems and address drug

reconciliation, including adverse drug events, followed by targeted medication reviews, including peer-to-peer when requested;

4.2.7.1.7 [Amendment #1:] Requesting medical records, d~~D~~ocumenting and communicating information about care delivered by~~to~~ other appropriate health care Providers;

4.2.7.1.8 [Amendment #1:] Member and/or authorized representative education to enhance understanding and appropriate use of medications; and

4.2.7.1.9 Coordination and integration of medication therapy management services with broader health Care Management services to ensure access to Medically Necessary medications wherever Member is placed, including access to out of network pharmacies.

4.2.7.2. Review of medication use shall be based on the following:

4.2.7.2.1 Pharmacy claims;

4.2.7.2.2 Provider progress reports;

4.2.7.2.3 Comprehensive Assessments and Care Plans;

4.2.7.2.4 Contact with the Member's Providers;

4.2.7.2.5 Current diagnoses;

4.2.7.2.6 Current behavioral health functioning;

4.2.7.2.7 [Amendment #1:] Information from the family, placement p~~P~~rovider, the Department, and residential or other treatment entities or Providers; and

4.2.7.2.8 [Amendment #1:] For infants, children and youth who are involved in the State's protective services and juvenile justice system, and Division for Children Youth and Families (DCYF), including those in foster care who meet red flag criteria[18]: ~~Information shared with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship, to the extent permissible by State and federal law.~~

4.2.7.2.8.1. [Amendment #1:] Information shared with DCYF around oversight, monitoring and managing the use of

[18] [Amendment #1:] SafeRx: Psychotropic Medication Oversight, available on March 27,2023 at https://www.dhhs.nh.gov/programs-services/child-protection-juvenile-justice/foster-care-health-mental-health-programs-0

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psychotropic medications, including activity that occurs after identifying the criteria, how to document the activity, and the action plan that will be initiated and monitored to the extent permissible by State and federal law.

4.2.7.2.8.2. [Amendment #1:] The MCO shall provide to DCYF a written behavioral health CMR for each child and youth meeting red flag criteria in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1. 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 MCM program. The MCO shall comply with eligibility decisions made by the Department.

4.3.1.2. The MCO and its Subcontractors shall ensure that ninety-nine percent (99%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. The MCO shall make the Department aware, within one (1) business day, of unsuccessful uploads that go beyond twenty-four (24) hours.

4.3.1.3. The Accredited Standards Committee (ASC) X12 834 enrollment file shall limit enrollment history to eligibility spans reflective of any assignment of the Member with the MCO.

4.3.1.4. To ensure appropriate Continuity of Care, the Department shall provide up to six (6) months (as available) of all FFS paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all FFS Medicaid Members assigned to the MCO. For Members transitioning from another MCO, the Department shall also provide such claims Confidential Data as well as available encounter information regarding the Member supplied by other Medicaid MCOs, as applicable.

4.3.1.5. The MCO 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)]

4.3.1.6. In accordance with separate guidance, the MCO shall outreach to Members forty-five (45) calendar days prior to each Member's Medicaid

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eligibility expiration date to assist the Member with completion and submission of required paperwork. The MCO shall submit their outbound call protocols for the Department's review during the Readiness Review process.

4.3.1.6.1 The MCO shall not conduct outreach to address the backlog of pending Medicaid eligibility cases to Members in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits. [CMS State Health Official Letter].

4.3.2 Enrollment

4.3.2.1. Pursuant to 42 CFR 438.54, Members who do not select an MCO as part of the Medicaid application process shall be auto-assigned to an MCO. All newly eligible Medicaid Members shall be given ninety (90) calendar days to either remain in the assigned MCO or select another MCO, if they choose. Members may not change from one (1) MCO to another outside the ninety (90) day plan selection period unless they meet the "cause" criteria as described in Section 4.3.5 (Disenrollment) of this Agreement.

4.3.2.2. The MCO shall accept all Members who are assigned to the MCO by the Department. The MCO shall accept for automatic re-enrollment Members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less. [42 CFR 438.56(g)]

4.3.2.2.1 [Amendment #1:] The MCO shall accept temporarily auto re-enrolled Members into their managed care plan after the individual's loss of Medicaid coverage for a period of 120 days or less. The temporary auto re-enrollment mechanism shall remain effective until the later of December 31, 2024 or expiration of the State's 1902(e)(14) in accordance with CMS guidance. [Section 1902(e)(14) of the Act]

4.3.2.3. The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not

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select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member.

4.3.2.4. When assigning a PCP, the MCO shall include the following methodology in selecting a PCP for the Member, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.3 Non-Discrimination

4.3.3.1. The MCO shall accept new enrollment from individuals in the order in which they apply, without restriction, unless authorized by CMS. [42 CFR 438.3(d)(1)]

4.3.3.2. The MCO shall not discriminate against eligible persons or Members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions. [42 CFR 438.3(d)(3)]

4.3.3.3. The MCO 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)]

4.3.3.4. The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has a discriminatory effect. [42 CFR 438.3(d)(4)] [RSA 354-A]

4.3.4 Auto-Assignment

4.3.4.1. In its sole discretion, the Department shall use the following factors for auto-assignment in an order to be determined by the Department:

4.3.4.1.1 Preference to an MCO with which there is already a family affiliation;

4.3.4.1.2 Previous MCO enrollment, when applicable;

4.3.4.1.3 Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438 54(d)(7);

4.3.4.1.4 Any members earned through the Performance-Based Auto-Assignment Program; and

4.3.4.1.5 Equitable distribution among the MCOs as determined appropriate solely by the Department.

4.3.4.2. The Performance-Based Auto-Assignment Program determined solely by the Department and communicated to the MCO in guidance issued by the Department, rewards one or more MCOs that demonstrate exceptional performance on one (1) or more key dimensions of performance determined at the Department's sole discretion.

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4.3.4.2.1 High-performing MCO(s) may be rewarded with preferential auto-assigned membership in accordance with separate guidance. Such an award would potentially precede any equitable distribution of Members who do not self-select an MCO across.

4.3.5 Disenrollment

4.3.5.1. Member Disenrollment Request

4.3.5.1.1 A Member may request disenrollment "with cause" to the Department at any time during the coverage year when:

4.3.5.1.1.1. The Member moves out of state;

4.3.5.1.1.2. 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;

4.3.5.1.1.3. 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

4.3.5.1.1.4. When the MCO does not cover the service the Member seeks because of moral or religious objections. [42 CFR 438.56(d)(2)(i-ii)].

4.3.5.1.2 For Member disenrollment requests "with cause" as described in in this section of the Agreement, the Member shall first seek redress through the MCO's grievance system.

4.3.5.1.3 A Member may request disenrollment "without cause" at the following times:

4.3.5.1.3.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into

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the MCO or the date of the Department Member notice of the initial auto-assignment/enrollment, whichever is later;

4.3.5.1.3.2. When Members have an established relationship with a PCP that is only in the network of a non-assigned MCO, the Member can request disenrollment during the first twelve (12) months of enrollment at any time and enroll in the non-assigned MCO;

4.3.5.1.3.3. Once every twelve (12) months;

4.3.5.1.3.4. During enrollment related to renegotiation and re-procurement;

4.3.5.1.3.5. 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

4.3.5.1.3.6. When the Department imposes a sanction on the MCO. [42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i-iii)]

4.3.5.1.4 The MCO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period. The notice shall include an explanation of all of the Member's disenrollment rights as specified in this Agreement. [42 CFR 438.56(f)]

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4.3.5.1.5 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)]

4.3.5.1.6 The MCO 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.

4.3.5.1.7 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.

4.3.5.1.8 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)]

4.3.5.2. MCO Disenrollment Request

4.3.5.2.1 The MCO shall submit involuntary disenrollment requests to the Department with proper documentation for the following reasons:

4.3.5.2.1.1. Member has established out of state residence;

4.3.5.2.1.2. Member death;

4.3.5.2.1.3. Determination that the Member is ineligible for enrollment due to being deemed part of an excluded population;

4.3.5.2.1.4. Fraudulent use of the Member identification card; or

4.3.5.2.1.5. In the event of a Member's threatening or abusive behavior that jeopardizes the health or safety of Members, staff, or Providers. [42 CFR 438.56(b)(1); 42 CFR 438.56(b)(3)]

4.3.5.2.2 The MCO shall not request disenrollment because of:

4.3.5.2.2.1. An adverse change in the Member's health status;

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4.3.5.2.2.2. The Member's utilization of medical services;

4.3.5.2.2.3. The Member's diminished mental capacity;

4.3.5.2.2.4. The Member's uncooperative or disruptive behavior resulting from their special needs (except when their continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either the particular Member or other Members); or

4.3.5.2.2.5. The Member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse. [Section 1903(m)(2)(A)(v) of the Social Security Act; 42 CFR 438.56(b)(2)]

4.3.5.2.3 If an MCO is requesting disenrollment of a Member, the MCO shall:

4.3.5.2.3.1. Specify the reasons for the requested disenrollment of the Member; and

4.3.5.2.3.2. Submit a request for involuntary disenrollment to the Department along with documentation and justification, for review.

4.3.5.2.3.3. 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 MCO files the request.

4.3.5.2.3.4. If the Department fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e)]

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4.4 Member Services

4.4.1 Member Information

4.4.1.1. The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members.

4.4.2 PCP Information

4.4.2.1. The MCO shall send a letter to a Member upon initial enrollment, and anytime the Member requests a new PCP, confirming the Member's PCP and providing the PCP's name, address, and telephone number.

4.4.3 Member Identification Card

4.4.3.1. The MCO shall issue a hardcopy identification card to all New Members 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.

4.4.3.2. 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:

4.4.3.2.1 The Member's name;

4.4.3.2.2 The Member's Medicaid identification number assigned by the Department at the time of eligibility determination;

4.4.3.2.3 The name of the MCO;

4.4.3.2.4 The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO;

4.4.3.2.5 The toll-free telephone number for transportation; and

4.4.3.2.6 How to file an appeal or grievance.

4.4.3.3. The MCO shall reissue a Member identification card if:

4.4.3.3.1 A Member reports a lost card;

4.4.3.3.2 A Member has a name change; or

4.4.3.3.3 Any other reason that results in a change to the information disclosed on the identification card.

4.4.3.4. [Amendment #2:] Effective July 1, 2026, the MCO shall assign and exclusively use unique Medicaid-specific Bank Identification Number (BIN) and Processor Control Number (PCN) combination, and group number identifiers for all Member identification cards for pharmacy benefits. [42 CFR 438.3(s)(7)]

4.4.4 Member Handbook

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4.4.4.1. The MCO shall publish and provide Member information in the form of a Member Handbook at the time of Member enrollment in the plan and, at a minimum, on an annual basis thereafter. The Member Handbook shall be based upon the model Member Handbook developed by the Department. [42 CFR 438.10(g)(1), 45 CFR 147.200(a); 42 CFR 438.10(c)(4)(ii)]

4.4.4.2. The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other Department initiatives. The MCO 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.

4.4.4.3. The Member Handbook shall be in easily understood language, and include, but not be limited to, the following information:

4.4.4.3.1 General information;

4.4.4.3.2 A table of contents;

4.4.4.3.3 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)];

4.4.4.3.4 The Department developed definitions, including but not limited to: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

4.4.4.3.5 The medical necessity definitions used in determining whether services will be covered;

4.4.4.3.6 A reminder to report to the Department any change of address, as Members may be liable for premium payments paid during period of ineligibility;

4.4.4.3.7 Information and guidance as to how the Member can effectively use the managed care program [42 CFR 438.10(g)(2)];

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4.4.4.3.8 Appointment procedures;

4.4.4.3.9 How to contact 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;

4.4.4.3.10 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the MCO's toll-free telephone line and website, the toll-free telephone number for Member Services, the toll-free telephone number for Medical Management, and the toll-free telephone number for any other unit providing services directly to Members [42 CFR 438.10(g)(2)(xiii-xvi)];

4.4.4.3.11 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;

4.4.4.3.12 The policies and procedures for disenrollment;

4.4.4.3.13 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];

4.4.4.3.14 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];

4.4.4.3.15 A description of utilization review policies and procedures used by the MCO;

4.4.4.3.16 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];

4.4.4.3.17 Information on how to report suspected Fraud or abuse [42 CFR 438.10(g)(2)(xiii-xvi)];

4.4.4.3.18 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];

4.4.4.3.19 Non-Participating Providers and cost-sharing on any benefits carved out and provided by the Department [42 CFR 438.10(g)(2)(i-ii)];

4.4.4.3.20 How to exercise Advance Directives [42 CFR 438.10(g)(2)(xii), 42 CFR 438.3(j)];

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4.4.4.3.21 Advance Directive policies which include a description of current State law. [42 CFR 438.3(j)(3)];

4.4.4.3.22 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.12.19. (Parity);

4.4.4.3.23 Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi-vii)]

4.4.4.3.24 Benefits:

4.4.4.3.24.1. How and where to access any benefits provided, including Maternity services, Family Planning Services and NEMT services [42 CFR 438.10(g)(2)(i-ii), (vi-vii)];

4.4.4.3.24.2. Detailed information regarding the amount, duration, and scope of all available benefits so that Members understand the benefits to which they are entitled [42 CFR 438.10(g)(2)(iii-iv)];

4.4.4.3.24.3. How to access EPSDT services and component services if Members under age twenty-one (21) entitled to the EPSDT benefit are enrolled in the MCO;

4.4.4.3.24.4. How and where to access EPSDT benefits delivered outside the MCO, if any [42 CFR 438.10(g)(2)(i-ii)];

4.4.4.3.24.5. 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)];

4.4.4.3.24.6. Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO shall inform Members that the

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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)];

4.4.4.3.24.7. A description of pharmacy policies and pharmacy programs; and

4.4.4.3.24.8. How emergency care is provided, including:

4.4.4.3.24.8.1 The extent to which, and how, after hours and emergency coverage are provided;

4.4.4.3.24.8.2 What constitutes an Emergency Service and an Emergency Medical Condition; The extent to which, and how, after hours and emergency coverage are provided;

4.4.4.3.24.8.3 The fact that Prior Authorization is not required for Emergency Services; and

4.4.4.3.24.8.4 The Member's

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right to use a hospital or any other setting for emergency care. [42 CFR 438.10(g)(2)(v)]

4.4.4.3.25 Service Limitations:

4.4.4.3.25.1. An explanation of any service limitations or exclusions from coverage;

4.4.4.3.25.2. An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider [42 CFR 438.10(g)(2)(vii)];

4.4.4.3.25.3. A description of all pre-certification, Prior Authorization criteria, or other requirements for treatments and services;

4.4.4.3.25.4. Information regarding Prior Authorization in the event the Member chooses to transfer to another MCO and the Member's right to continue to utilize a Provider specified in a Prior Authorization for a period of time regardless of whether the Provider is participating in the MCO network;

4.4.4.3.25.5. The policy on referrals for specialty care and for other Covered Services not furnished by the Member's PCP [42 CFR 438.10(g)(2)(iii-iv)];

4.4.4.3.25.6. Information on how to obtain services when the Member is out-of-state and for after-hours coverage [42 CFR 438.10(g)(2)(v)]; and

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4.4.4.3.25.7. A notice stating that the MCO shall be liable only for those services authorized by or required of the MCO.

4.4.4.3.26 Rights and Responsibilities:

4.4.4.3.26.1. Member rights and protections, outlined in Section 4.4.8 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i-vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)]

4.4.4.3.27 Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.4.3.27.1. The right to file grievances and appeals;

4.4.4.3.27.2. The requirements and timeframes for filing grievances or appeals;

4.4.4.3.27.3. The availability of assistance in the filing process for grievances and appeals;

4.4.4.3.27.4. The right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and

4.4.4.3.27.5. The right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however, if the Member receives an adverse decision then the Member may be required to pay for the cost of service(s) furnished while the appeal or State fair hearing is pending. [42 CFR 438.10(g)(2)(xi)(A-E)]

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4.4.5 Member Handbook Dissemination

4.4.5.1. The MCO 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)]

4.4.5.2. The MCO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information. The MCO shall provide the Member Handbook information by email after obtaining the Member's agreement to receive the information electronically. [42 CFR 438.10(g)(3)(i-iv)]

4.4.5.3. The MCO shall notify all Members, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the MCO's website. [42 CFR 438.10(g)(3)(i) - (iv)] The Member information appearing on the website (also available in paper form) shall include the following, at a minimum:

4.4.5.3.1 Information contained in the Member Handbook;

4.4.5.3.2 Information on how to file grievances and appeals;

4.4.5.3.3 Information on the MCO's Provider network for all Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

4.4.5.3.3.1. Names and any group affiliations;

4.4.5.3.3.2. Street addresses;

4.4.5.3.3.3. Office hours;

4.4.5.3.3.4. Telephone numbers;

4.4.5.3.3.5. Website (whenever web presence exists);

4.4.5.3.3.6. Specialty (if any),

4.4.5.3.3.7. Description of accommodations offered for people with disabilities;

4.4.5.3.3.8. The cultural and linguistic capabilities of Participating Providers, including languages

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(including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office;

4.4.5.3.3.9. Gender of the Provider;

4.4.5.3.3.10. Identification of Providers that are not accepting new Members; and

4.4.5.3.3.11. Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi-vii)]

4.4.5.4. The MCO shall produce a revised Member Handbook, or an insert, informing Members of changes to Covered Services, upon the Department's notification of any change in Covered Services, and at least thirty (30) calendar days prior to the effective date of such change. This includes notification of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the Member can access those services. [42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)]

4.4.5.5. The MCO 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 MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. The MCO shall utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.6 Provider Directory

4.4.6.1. The MCO shall publish a Provider Directory that shall be reviewed by the Department prior to initial publication and distribution. The MCO shall submit the draft Provider Directory and all substantive changes to the Department for review.

4.4.6.2. [Amendment #2:] The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers (including CCBHCs), FQHCs, RHCs):

4.4.6.2.1 Names and any group affiliations;

4.4.6.2.2 Street addresses;

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4.4.6.2.3 Office hours;

4.4.6.2.4 Telephone numbers;

4.4.6.2.5 Website (whenever web presence exists);

4.4.6.2.6 Specialty (if any),

4.4.6.2.7 Gender;

4.4.6.2.8 Description of accommodations offered for people with disabilities;

4.4.6.2.9 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;

4.4.6.2.10 Hospital affiliations (if applicable);

4.4.6.2.11 Board certification (if applicable);

4.4.6.2.12 Identification of Participating Providers that are not accepting new patients; and

4.4.6.2.13 Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(h)(1)(i-viii); 42 CFR 438.10(h)(2)]

4.4.6.3. The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from 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 MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request and free of charge.

4.4.6.4. The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2 (Practice Guidelines and Standards). [42 CFR 438.236(c)]

4.4.6.5. The MCO shall notify all Members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the MCO's website in a machine readable file and format as specified by CMS.

4.4.6.6. The MCO shall update the paper copy of the Provider Directory at least monthly if the MCO does not have a mobile-enabled electronic directory, or quarterly, if the MCO has a mobile-enabled, electronic provider directory; and shall update an electronic directory no later than thirty (30) calendar days after the MCO receives updated provider information. [42 CFR 438.10(h)(3-4)]

4.4.6.7. The MCO shall post on its website a searchable list of all Participating Providers. At a minimum, this list shall be searchable by Provider name, specialty, location, and whether the Provider is accepting new Members.

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4.4.6.8. The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory.

4.4.6.9. 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 MCO 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 MCO shall submit the final website Provider Directory.

4.4.6.10. Upon the termination of a Participating Provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify Members who received their primary care from, or was seen on a regular basis by, the terminated Provider. [42 CFR 438.10(f)(1)]

4.4.7 Language and Format of Member Information

4.4.7.1. The MCO shall have in place mechanisms to help potential Members and Members understand the requirements and benefits of the MCO. [42 CFR 438.10(c)(7)]

4.4.7.2. The MCO shall use the Department developed definitions consistently in any form of Member communication. The MCO shall develop Member materials utilizing readability principles appropriate for the population served.

4.4.7.3. The MCO shall provide all enrollment notices, information materials, and instructional materials relating to Members and potential Members in a manner and format that may be easily understood and readily accessible in a font size no smaller than twelve (12) point. [42 CFR 438.10(c)(1), 42 CFR 438.10(d)(6)(i-iii)]

4.4.7.4. The MCO's written materials shall be developed in compliance with all applicable communication access requirements at the request of the Member or prospective Member at no cost.

4.4.7.5. 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.

4.4.7.6. The MCO shall inform Members that information is available in alternative formats and how to access those formats. [42 CFR 438.10(d)(3), 42 CFR 438.10(d)(6)(i-iii)]

4.4.7.7. The MCO shall make all written Member information available in English, Spanish, and any other state-defined prevalent non-English languages of MCM Members. [42 CFR 438.10(d)(1)]

4.4.7.8. 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 Members, to explain the availability of written translation or oral interpretation, and include

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the toll-free and teletypewriter (TTY/TDD) telephone number of the MCO's Member Services Center. [42 CFR 438.10(d)(3)]

4.4.7.9. 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 MCO 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)]

4.4.7.10. Written Member information shall include at a minimum:

4.4.7.10.1 Provider Directories;

4.4.7.10.2 Member Handbooks;

4.4.7.10.3 Appeal and grievance notices; and

4.4.7.10.4 Denial and termination notices.

4.4.7.11. The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that 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)]

4.4.7.12. The MCO shall notify Members that oral interpretation is available for any language and written information is available in languages prevalent among MCM Members; the MCO shall notify Members of how to access those services. [42 CFR 438.10(d)(4), 42 CFR 438.10(d)(5)(i-iii)]

4.4.7.13. The MCO shall provide Auxiliary Aids such as TTY/TDD and ASL interpreters free of charge to Members or potential Members who require these services. [42 CFR 438.10(d)(4)]

4.4.7.14. The MCO shall take into consideration the special needs of Members or potential Members with disabilities or LEP. [42 CFR 438.10(d)(5)(i)-(iii)]

4.4.8 Member Rights

4.4.8.1. The MCO shall have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:

4.4.8.1.1 Receive information on the MCM program and the MCO to which the Member is enrolled;

4.4.8.1.2 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;

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4.4.8.1.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

4.4.8.1.4 Participate in decisions regarding his/her health care, including the right to refuse treatment;

4.4.8.1.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

4.4.8.1.6 Request and receive a copy of his/her medical records free of charge, and to request that they be amended or corrected;

4.4.8.1.7 Request and receive any MCO's written Physician Incentive Plans;

4.4.8.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers;

4.4.8.1.9 Request and receive a Second Opinion; and

4.4.8.1.10 Exercise these rights without the MCO or its Participating Providers treating the Member adversely. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)-(vi)]; 42 CFR 438.100(c); 42 CFR 438.10(f)(3); 42 CFR 438.10(g)(2)(vi)-(vii); 42 CFR 438.10(g)(2)(ix); 42 CFR 438.3(i)]

4.4.9 Member Communication Supports

4.4.9.1. During the Readiness Review period, the MCO shall provide a blueprint of its website, including Member portal, for review by the Department.

4.4.9.2. [Amendment #1:] The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal.

4.4.10 Member Call Center

4.4.10.1. The MCO shall operate a toll-free Member Call Center Monday through Friday, and be operational on all days the Department Customer Service Center is open.

4.4.10.2. The MCO shall ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.4 (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:

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4.4.10.2.1 Two (2) days per week: eight (8:00) am Eastern Standard Time (EST) to five (5:00) pm EST;

4.4.10.2.2 Three (3) days per week: eight (8:00) am EST to eight (8:00) pm EST; and

4.4.10.2.3 During major program transitions, additional hours and capacity shall be accommodated by the MCO.

4.4.10.3. The Member Call Center shall meet the following minimum standards, which the Department reserves the right to modify at any time:

4.4.10.3.1 Call Abandonment Rate: Fewer than five percent (5%) of calls shall be abandoned;

4.4.10.3.2 Average Speed of Answer: Eighty-five percent (85%) of calls shall be answered with live voice within thirty (30) seconds; and

4.4.10.3.3 Voicemail or answering service messages shall be responded to no later than the next business day.

4.4.10.4. The MCO shall coordinate its Member Call Center with the Department Customer Service Center, and community-based and statewide crisis lines, and at a minimum, include the development of a warm transfer protocol for Members.

4.4.11 Welcome Call

4.4.11.1. The MCO shall make a welcome call or an interactive voice recognition (IVR) call to each new Member within ninety (90) calendar days of the Member's enrollment in the MCO, and include a means for the Member to request immediate live MCO representative support during the welcome call.

4.4.11.2. In accordance with applicable law, the MCO may communicate with Members by text, email, phone or other digital or electronic communications.

4.4.11.3. The welcome call shall, at a minimum:

4.4.11.3.1 Assist the Member in selecting a PCP or confirm selection of a PCP;

4.4.11.3.2 [Amendment #1:] ~~Arrange~~ Assist with scheduling ~~for~~ a Wellness Visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs)~~., which shall include:~~

4.4.11.3.2.1. [Amendment #1:] Initial screening ~~Assessments~~ of both physical and behavioral health, including identification of urgent health care needs;

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4.4.11.3.2.2. [Amendment #1:] Initial sScreening for depression, mood, suicidality, and Substance Use Disorder;

4.4.11.3.2.3. Support development of a Member's plan of care with the PCP;

4.4.11.3.2.4. Arrange for the completion of a HRA Screening in accordance with the terms of this Agreement and Section 4.10.2 (Health Risk Assessment (HRA) Screening).

4.4.11.3.2.5. [Amendment #1:] Initial sScreening for adverse health needs, special needs, physical and behavioral health, and services of the Member. The MCO shall share the results of screening findings with the Member's PCP to support the Member's plan of care with the Provider;

4.4.11.3.2.6. [Amendment #1:] Answer any ~~other~~ Member questions about the MCO;

4.4.11.3.2.7. Ensure Members can access information in their preferred language; and

4.4.11.3.2.8. Remind Members to report to the Department any change of address, as Members shall be liable for premium payments paid during period of ineligibility.

4.4.11.3.3 Regardless of the completion of the welcome call by the MCO, the PCP shall complete HRA Screenings as stipulated in Section 4.10.2 (Health Risk Assessment (HRA) Screening), and documented by a claim encounter.

4.4.12 Member Hotline

4.4.12.1. The MCO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays.

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4.4.12.2. 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.

4.4.12.3. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day.

4.4.12.4. The MCO may substitute a live answering service in place of an automated system.

4.4.13. Program Website

4.4.13.1. The MCO shall develop a website, in compliance with Section 7.7 (Website and Social Media) in this Agreement, to provide general information about the MCO's program, its Participating Provider network, its formulary, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance Process and Member Appeal Process.

4.4.13.2. The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit N (Liquidated Damages Matrix).

4.4.13.3. If the MCO chooses to provide required information electronically to Members, it shall:

4.4.13.3.1 Be in a format and location that is prominent and readily accessible;

4.4.13.3.2 Be provided in an electronic form which can be electronically retained and printed;

4.4.13.3.3 Be consistent with content and language requirements;

4.4.13.3.4 Notify the Member that the information is available in paper form without charge upon request; and

4.4.13.3.5 Provide, upon request, information in paper form within five (5) business days. [42 CFR 438.10(c)(6)(i-v)]

4.4.13.4. The MCO program content included on the website shall be:

4.4.13.4.1 Written in English and Spanish;

4.4.13.4.2 Culturally appropriate;

4.4.13.4.3 Appropriate to the reading literacy of the population served; and

4.4.13.4.4 Geared to the health needs of the enrolled MCO program population.

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4.4.13.5. The MCO's website shall be compliant with the federal DOJ "Accessibility of State and Local Government Websites to People with Disabilities."

4.4.13.6. [Amendment #4:] Beginning March 31, 2026 and annually thereafter, the MCO shall report prior authorization data from the prior calendar year in accordance with Exhibit O: Quality and Oversight Reporting Requirements, excluding any and all drugs covered by the MCO. In addition, the MCO shall make this data accessible by posting the information on its website. [42 CFR 210(f)]

4.4.14. Marketing

4.4.14.1. The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The MCO shall submit all MCO Marketing material to the Department for approval before distribution.

4.4.14.2. 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 MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i-ii), 42 CFR 438.104(b)(1)(iv-v)]

4.4.14.3. The MCO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

4.4.14.4. The MCO Marketing Materials shall not contain false or materially misleading information. The MCO shall not offer other insurance products as inducement to enroll.

4.4.14.5. The MCO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or the Department. The MCO's Marketing Materials shall not contain any written or oral assertions or statements that:

4.4.14.5.1 The recipient shall enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

4.4.14.5.2 The MCO is endorsed by CMS, the State or federal government, or a similar entity. [42 CFR 438.104(b)(2)(i-ii)]

4.4.14.6. The MCO shall distribute Marketing Materials to the entire State. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO 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)]

4.4.15. Member Engagement Strategy

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4.4.15.1. The MCO shall develop and facilitate an active Member Advisory Board that is composed of Members who represent its Member population.

4.4.16 Member Advisory Board

4.4.16.1. Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program.

4.4.16.2. The Member Advisory Board shall meet at least four (4) times per year.

4.4.16.3. 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 MCO's QAPI program changes (as further described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.4.16.4. All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.17 Regional Member Meetings

4.4.17.1. The MCO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the MCO can ask questions and obtain feedback from Members.

4.4.17.2. Regional meetings shall be held at least twice each Agreement year in demographically different locations in New Hampshire. The MCO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the MCO shall use alternate technologies as available for all meetings.

4.4.18. Cultural and Accessibility Considerations

4.4.18.1. The MCO 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)]

4.4.18.2. The MCO shall ensure that Participating Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities. [42 CFR 438.206(c)(3)]

4.4.19 Cultural Competency Plan

4.4.19.1. In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and linguistically competent manner to all Members, including those with LEP or a disability, using qualified staff, medical interpreters, and translators in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.4.19.2. The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity.

4.4.19.3. The MCO shall work with the Department Office of Health Equity to address cultural and linguistic considerations.

4.4.20 Communication Access

4.4.20.1. To ensure equitable access to benefits and services for all of the MCO's Members, the MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

4.4.20.2. The MCO shall develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking Members' needs for communication assistance for health encounters including preferred spoken language for all encounters, need for interpreter, and preferred language for written information.

4.4.20.3. The MCO 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.

4.4.20.4. The MCO shall ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. For any Member who requires interpretation or translation services, the MCO shall not::

4.4.20.4.1 Require a Member with LEP or a disability to provide their own interpreter or translator;

4.4.20.4.2 Rely on an adult accompanying a Member with LEP or a Member with a Disability to interpret or facilitate communication, except:

4.4.20.4.2.1. In an emergency involving an imminent threat to the safety or welfare of the Member or the public where the MCO has attempted to obtain a Qualified Interpreter for the Member with LEP or Qualified Interpreter for the Member with a Disability, as applicable, and no Qualified

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Interpreter for the Member with LEP or Qualified Interpreter for the Member with a Disability is immediately available. In such cases, the MCO shall continue to make good faith attempts at obtaining a Qualified Interpreter for the Member with a Disability or Qualified Interpreter for the Member with LEP, as applicable, to interpret or facilitate communication for the Member where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.20.4.2.2. Rely on a minor to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of a Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.20.4.2.3. Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.101(b)(2)]

4.4.20.5. The MCO shall ensure services provided by Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services, exclusive of inpatient services.

4.4.20.6. The MCO shall recognize that no one interpreter, language, or assistive 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) or assistance will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.4.20.7. Accordingly, the MCO shall provide the most appropriate interpretation or assistive service possible under the circumstances. In all cases, the MCO shall provide interpreter services of Qualified Bilingual/Multilingual Staff, Qualified

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Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators when deemed clinically necessary by the Provider of the encounter service.

4.4.20.8. The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, or Qualified Translators are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.20.8.1 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;

4.4.20.8.2 A sharply delineated image that is large enough to display the Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, or Qualified Translator's face and the participating Member's face regardless of the Member's body position;

4.4.20.8.3 A clear, audible transmission of voices; and

4.4.20.8.4 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)]

4.4.20.9. The MCO shall bear the cost of interpretive services and communication access including SSL, ASL, Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translator interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

4.4.20.10. The MCO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.4.20.11. If the Member declines free interpretation services offered by the MCO, the MCO 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.

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4.4.20.12. Interpreter services shall be offered by the MCO at every new contact. Every declination requires new documentation by the MCO of the offer and decline.

4.4.20.13. The MCO 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 MCO from discriminating on the basis of race, color, or national origin.

4.4.20.14. 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 MCO shall take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

4.4.20.15. Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The MCO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the MCO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.4.20.16. [Amendment #1:] Digital, video, and phone interpretation services must comply with Exhibit EK: Information Security Requirements and Exhibit KQ: ITTechnical Requirements Workbook.

4.5. **Member Grievances and Appeals**

4.5.1. General Requirements

4.5.1.1. The MCO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The MCO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, State law as applicable, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.5.1.2. The MCO 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.

4.5.1.3. The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a

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Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement.

4.5.1.4. In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

4.5.1.5. The MCO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The MCO shall:

4.5.1.5.1 Provide Members with all reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to, providing qualified or certified interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.5.1.5.2 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)];

4.5.1.5.3 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)];

4.5.1.5.4 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)];

4.5.1.5.5 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:

4.5.1.5.5.1. An appeal of a denial based on lack of medical necessity;

4.5.1.5.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

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4.5.1.5.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A-C); 42 CFR 438.228(a)]

4.5.1.5.6 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]

4.5.1.6. The MCO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

4.5.1.7. The MCO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contact or Subcontract. The information shall include, but is not limited to:

4.5.1.7.1 The Member's right to file grievances and appeals and requirements and timeframes for filing;

4.5.1.7.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.5.1.7.3 The availability of assistance with filing;

4.5.1.7.4 The toll-free numbers to file oral grievances and appeals;

4.5.1.7.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.5.1.7.6 The Provider's right to appeal the failure of the MCO to pay for or cover a service.

4.5.1.8. The MCO shall make available training to Providers in supporting and assisting Members in the Grievance System.

4.5.1.9. The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)]

4.5.1.10. 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)]

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4.5.1.11. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.5.1.12. The MCO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The MCO shall regularly review appeals Confidential Data for process improvement which should include but not be limited to reviewing:

4.5.1.12.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

4.5.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.13. The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.1.14. [Amendment #4:] Beginning March 31, 2026, the MCO shall report for the prior calendar year publicly accessible prior authorization data on its plan website, excluding data on any and all drugs covered by the MCO. [42 CFR 438.210].

4.5.2. **Member Grievance Process**

4.5.2.1. The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2. The MCO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3. The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

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4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4. The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance 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 MCO 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)]

4.5.2.5. The MCO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.5.2.5.1 If the Member requests the extension; or

4.5.2.5.2 If the MCO 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)]

4.5.2.6. If the MCO extends the timeline for a grievance not at the request of the Member, the MCO shall:

4.5.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.5.2.6.2 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)]

4.5.2.7. If the Member requests disenrollment, then the MCO 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)]

4.5.2.8. The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.9. Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3. **Member Appeal Process**

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4.5.3.1. The MCO shall develop, implement, and maintain an Member Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2. The MCO shall 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 MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3. The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4. The MCO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)]

4.5.3.5. [Amendment #4:] The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals ~~and confirm those inquires in writing, unless the Member or the authorized Provider requests expedited resolution~~. [42 CFR 438.406(b)(3)]

4.5.3.6. If the Department receives a request to appeal an action of the MCO, the Department shall forward relevant information to the MCO and the MCO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.7. The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.8. The MCO 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 MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.9. The MCO shall provide the Member and/or the Member's representative an opportunity to receive the Member's case file, free of charge prior to and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b-c)]

4.5.3.10. [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO may offer peer-to-peer review support with a like clinician who is actively licensed by the New Hampshire Office of Professional Licensure and Certification, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

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4.5.3.11. The MCO shall resolve ninety-eight percent (98%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.5.3.12. 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.

4.5.3.13. Members who believe the MCO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.5.3.14. If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.5.4. **Member Adverse Actions**

4.5.4.1. The MCO shall permit the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 Denial, in whole or in part, of payment for a service;

4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that the Department has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1) MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5. **Expedited Member Appeal**

4.5.5.1. The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

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4.5.5.2. The MCO 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)]

4.5.5.3. The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.5.5.4. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. The MCO shall also make reasonable efforts to provide oral notice. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)]

4.5.5.5. 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.

4.5.5.6. If the MCO extends the timeframes not at the request of the Member, it shall:

4.5.5.6.1 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 MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.6.2 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;

4.5.5.6.3 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)]

4.5.5.7. The MCO shall meet the timeframes above for ninety-eight percent (98%) of requests for expedited appeals.

4.5.5.8. The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.9. If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

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4.5.5.10. The Member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6. **Content of Member Appeal Notices**

4.5.6.1. The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.1.1 [Amendment #4:] Effective July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), in accordance with the timeframes established in 42 CFR 438.210(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.) as if such requirements applied directly to the MCO according to the decision timeframes in 42 CFR 438.210(d). [42 CFR 438.242(b)(8)]

4.5.6.2. The MCO shall utilize NCQA compliant Department model notices for all adverse actions and appeals. MCO 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:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b-c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request

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that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. [42 CFR 438.404(b)(6)]

4.5.6.3. The MCO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.5.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 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.

4.5.6.4. The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

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4.5.6.4.9 The transfer or discharge from a facility shall occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7. **Timing of Member Notices**

4.5.7.1. For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable Fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2. In accordance with 42 CFR 438.404(c)(2), the MCO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.5.7.3. [Amendment #4:] Beginning July 1, 2026, For standard service authorization decisions ~~denials or partial denials~~, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed seven (7) ~~fourteen (14)~~ calendar days following the date of receipt of 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 from the date of receipt of the request for service is permissible, if:

4.5.7.3.1 The Member, or the Provider, requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4. When the MCO extends the timeframe, the MCO 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 MCO 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)]

4.5.7.5. For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than

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seventy-two (72) hours after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7. The MCO 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)]

4.5.8. **Continuation of Member Benefits**

4.5.8.1. The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2. The intended effective date of the MCO's proposed action;

4.5.8.1.1.3. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.1.4. The services was ordered by an authorized Provider;

4.5.8.1.1.5. The authorization period has not expired;

4.5.8.1.1.6. The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

4.5.8.1.1.7. 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)]

4.5.8.2. If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

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4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1-3); 42 CFR 438.408(d)(2)]

4.5.8.3. If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4. A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9. **Resolution of Member Appeals**

4.5.9.1. The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it shall:

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4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2. [Amendment #4:] Under no circumstances may the MCO extend the appeal determination beyond forty-four (44) ~~forty-five (45)~~ calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3. The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.5.9.4. The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.5.9.5. For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6. For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision

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upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1-2)]

4.5.10. **State Fair Hearing for Member Appeals**

4.5.10.1. The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.5.10.2. The parties to the State fair hearing include the MCO as well as the Member and their representative or the representative of a deceased Member's estate.

4.5.10.3. The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.3.1 That Members shall exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with the Department; and

4.5.10.3.2 [Amendment #2:] That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the MCO's notice of the resolution of the appeal. [42 CFR 438.408(f)(2)]

4.5.10.4. If the Member requests a State fair hearing, the MCO shall provide to the Department and the Member, upon request, within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.5. 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:

4.5.10.5.1 The MCO adversely resolved the Member's appeal wholly or partially; or

4.5.10.5.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.6. If the Member requests an expedited State fair hearing, the MCO shall provide to the Department and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but

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not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.7. 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 MCO the case file and any other necessary information. [He-W 506.09(g)]

4.5.10.8. The MCO shall appear and defend its decision before the Department AAU. The MCO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to the Department for the duration of the appeal at no additional cost.

4.5.10.9. The Department AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11. **Effect of Adverse Decisions of Member Appeals and Hearings**

4.5.11.1. If the MCO 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 MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2. If the MCO or 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 MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12. **Survival of Member Appeals and Grievances**

4.5.12.1. The obligations of the MCO 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.

4.6. **Provider Appeals**

4.6.1. **General**

4.6.1.1. The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

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4.6.1.2. The MCO shall provide a complete written description of its Provider Appeals Process, including all policies and procedures, and notices and forms, for the Department's review and approval during the Readiness Review period.

4.6.1.3. Any proposed changes to the Provider Appeals Process shall be approved by the Department at least thirty (30) calendar days in advance of implementation.

4.6.1.4. The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference it in the Provider and Subcontractor agreements.

4.6.1.5. The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.6.1.5.2 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;

4.6.1.5.3 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

4.6.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

4.6.2. **Provider Adverse Actions**

4.6.2.1. [Amendment #1:] The Provider shall have the right to file an appeal with the MCO within sixty (60) calendar days of the date of the MCO's notice of adverse action to the Provider, and may utilize the Provider Appeals Process for any adverse action, ~~in accordance with RSA 126-A:5, VIII~~, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). ~~The Provider shall have the right to file an appeal within sixty (60) calendar days of the date of the MCO's notice of adverse action to the Provider.~~ Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when the Department, MFCU or other government agency has required the MCO to terminate such agreement;

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4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2. The MCO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.6.3. **Provider Appeal Process**

4.6.3.1. The MCO shall provide written notice, and electronic notice if available, 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.

4.6.3.2. Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within sixty (60) calendar days of:

4.6.3.2.1 The date of the MCO's written notice advising the Provider of the adverse action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3. The MCO shall be permitted to extend the decision deadline to issue the Resolution Notice by an additional sixty (60) calendar days to allow the Provider to submit additional evidence or supportive documentation, and for other good cause determined by the MCO.

4.6.3.4. The MCO shall ensure that all Provider Appeal Process decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider appeal.

4.6.3.5. [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO may offer peer-to-peer review support with a like clinician who is actively licensed by the New Hampshire Office of Professional Licensure and Certification, upon request, for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal Process or State fair hearing process.

4.6.3.6. The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

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4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7. If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Provider Appeal Process and may initiate a State fair hearing.

4.6.4. **MCO Resolution of Provider Appeals**

4.6.4.1. The MCO shall provide timely written notice of Provider appeal resolution (Resolution Notice) at a rate of ninety-five percent (95%) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.4.2. The Resolution Notice shall include, without limitation:

4.6.4.2.1 The MCO's decision;

4.6.4.2.2 The reasons for the MCO's decision;

4.6.4.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.4.2.4 For overturned appeals, the MCO shall take all steps to reverse the adverse action within ten (10) calendar days.

4.6.5. **State Fair Hearing for Provider Appeals**

4.6.5.1. The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.6.5.2. The parties to the State fair hearing include the MCO as well as the Provider.

4.6.5.3. The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing.

4.6.5.4. If a Participating Provider requests a State fair hearing, the MCO shall provide to the Department and the Participating Provider, upon request, within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.6.5.5. The MCO shall consult with the Department regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO

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shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.6.5.6. The MCO shall appear and defend its decision before the Department AAU. Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.5.7. [Amendment #2:] ~~The Department AAU shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.~~ The Department AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.6.5.8. The MCO shall:

4.6.5.8.1 Not object to the State intervening in any such appeal;

4.6.5.8.2 Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.5.8.3 Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.6.5.9. Reporting

4.6.5.9.1 The MCO 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)]

4.7. Access

4.7.1. Participating Provider Network

4.7.1.1. The MCO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2. The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its Participating Provider network, the MCO shall consider and address the following factors to ensure network adequacy for each Member:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH Medicaid population;

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4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Participating Providers limiting NH Medicaid patients' access to the Participating Provider or not accepting new or any NH Medicaid patients;

4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, in compliance with Exhibit K: Information Security Requirements and Exhibit Q: IT Requirements Workbook;

4.7.1.2.8 Adequacy of the primary care Participating Provider network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

4.7.1.2.9 Access standards identified in this Agreement; and

4.7.1.2.10 Required access standards set forth by the NHID, including RSA. 420-J; and N.H. Code of Administrative Rules Ins 2700

4.7.1.3. The MCO shall meet the Participating Provider network adequacy standards included in this Agreement in all geographic areas in which the MCO operates for all Provider types covered under this Agreement.

4.7.1.4. The MCO shall ensure that services are as accessible to Members in terms of timeliness, amount, duration and scope as those that are available to Members covered by the Department under FFS Medicaid within the same service area.

4.7.1.5. The MCO shall ensure Participating Providers comply with the accessibility standards of the ADA. Participating Providers 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)]

4.7.1.6. The MCO 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

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services. If Members are permitted by the MCO to access out-of-state IHCPs, or if this circumstance is deemed to be good cause for disenrollment, the MCO shall be considered to have met this requirement. [42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory, as specified in Section 4.4.6 (Provider Directory) of this Agreement.

4.7.2. **Assurances of Adequate Capacity and Services**

4.7.2.1. The MCO's Participating Provider network shall have Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all Covered Services to meet the geographic standards in Section 4.7.3 (Time and Distance Standards), the timely provision of services requirements in Section 4.7.5 (Timely Access to Service Delivery), Equal Access, and reasonable choice by Members to meet their needs [42 CFR 438.207(a)].

4.7.2.2. The MCO shall submit documentation to the Department, in the format and frequency specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, that fulfills the following requirements:

4.7.2.2.1 The MCO 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)]

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with the Department's requirements for availability, accessibility of services, and adequacy of the Participating Provider network including pediatric subspecialists as described in Section 4.7.5.11 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 [Amendment #2:] The MCO is complying with the Department's requirements for Behavioral Health Services, as specified in Section 4.12, including but not limited to Substance Use Disorder treatment services and recovery, Mental Health services,

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Community Mental Health services, CCBHC services, and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3. To permit the Department to determine if access to private duty nursing services is increasing, as indicated by the Department in Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide to the Department the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4. The MCO shall submit documentation to 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 MCO. [42 CFR 438.207(b-c)]

4.7.2.5. For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by the Department.

4.7.3. **Time and Distance Standards**

4.7.3.1. At a minimum, the MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members, subject to alternative CMS requirements. [42 CFR 438.68(b)(1)(i-viii); 42 CFR 438.68(b)(3)]

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Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
[Amendment #2] Certified Community Behavioral Health Clinics (CCBHC)	All certified CCBHCs in New Hampshire
Community Mental Health Programs	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
[Amendment #1:] Intentionally Left Blank~~Mobile Crisis Service Providers~~[19]	~~One (1) within sixty (60) driving minutes or forty-five (45) driving miles~~
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
Tertiary or Specialized Services (e.g., Trauma, Neonatal)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

[19] [Amendment #1:] Intentionally left blank~~Mobile crisis services are provided by CMH Programs but subject to a different Geographic Access Standard requirement pursuant to the Department's selected Mobile Crisis System model~~.

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Geographic Access Standards	
Provider/Service	Requirement
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupation-al Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2. The MCO 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.

4.7.3.3. 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 MCO regarding its Participating Provider network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.4. The MCO shall contract with qualified Substance Use Disorder Providers who request to join its Participating Provider network pending the Substance Use Disorder Provider's agreement to the terms of the MCO's contract.

4.7.3.5. Additional Behavioral Health Provider Standards

Provider/Service	Requirement
MLADCs	The MCO's Participating Provider network shall include seventy percent (70%) of all such Providers licensed and practicing in NH
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH
Buprenorphine Prescribers	The Participating Provider network shall include seventy-five percent (75%) of all such Providers actively prescribing Buprenorphine in their practice and licensed and practicing in NH
Residential Substance Use Disorder Treatment Programs	The MCO's Participating Provider network shall include fifty percent (50%) of all such Providers licensed and practicing in NH
Peer Recovery Programs	The MCO's Participating Provider network shall include one hundred percent (100%) of all such willing Programs in NH
Residential Programs for Serious Mental Illness	The MCO's Participating Provider network shall include 100% of all such Providers, located in NH, if they are operated by or under contract with Community Mental Health Programs, and 100% of all such Providers if they are otherwise under contract with the Department and are appropriately licensed or certified by the Department under He-P 800 or He-M 1000.

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Provider/Service	Requirement
[Amendment #3:] Intentionally left blank ~~Psychiatric Residential [Treatment Facilities~~	[Amendment #3:] Intentionally left blank ~~The MCO's Participating Provider network shall include 100% of all such Providers, located in NH, if they are owned or operated by, under contract with, or are otherwise determined or designated by the Department to provide this service, and are appropriately licensed or certified by the Department or a Department approved alternative certification entity.~~

4.7.4. **Standards for Geographic Accessibility**

4.7.4.1. The MCO may request reasonable exceptions from the Agreement's Participating Provider 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 MCO be unable to contract a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, with the assistance of the Department and after good faith negotiations, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days 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: Liquidated Damages Matrix shall apply.

4.7.4.3. Except within a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, after good faith negotiations with assistance of the Department, continue to be unable to meet geographic and timely access to service delivery standards the Department may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4. At any time the provisions of this section may apply, the MCO shall ensure Members have reasonable access to Covered Services.

4.7.4.5. The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6. Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the Participating Provider 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)]

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4.7.4.6.2 The Department may grant the MCO an exception in the event that:

4.7.4.6.2.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the Participating Provider network adequacy standards in this Agreement and as otherwise defined by the NHID and the Department;

4.7.4.6.2.2. The MCO demonstrates, to the satisfaction of the Department, that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.2.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

4.7.4.6.2.4. The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies

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reviewed and approved by the Department, but the MCO shall not use telemedicine to meet the Participating Provider network adequacy standards unless the Department has specifically approved a Request for Exception.

4.7.4.6.3 The MCO shall report on Participating Provider network adequacy and exception requests in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.5. **Timely Access to Service Delivery**

4.7.5.1. The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2. The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3. The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)]

4.7.5.4. The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5. The MCO's Participating Provider network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6. The MCO shall have in its Participating Provider network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., diagnostic, preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

4.7.5.6.2 A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

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4.7.5.6.3 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.4 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.5 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.6.6 Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.

4.7.5.6.7 Obstetrics and gynecological care shall be available within fifteen (15) calendar days from the date of the Member's appointment request.

4.7.5.7. The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards.

4.7.5.8. The MCO shall regularly monitor its Participating Provider 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.

4.7.5.9. The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.10. The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

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4.7.5.11. Access Standards for Children with Special Health Care Needs

4.7.5.11.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

4.7.5.11.2 In addition to the "specialty care" Participating Provider network adequacy requirements, the MCO shall contract with Providers who offer the following specialty services:

4.7.5.11.2.1. Pediatric Critical Care;

4.7.5.11.2.2. Pediatric Child Development;

4.7.5.11.2.3. Pediatric Genetics;

4.7.5.11.2.4. Pediatric Physical Medicine and Rehabilitation;

4.7.5.11.2.5. Pediatric Ambulatory Tertiary Care;

4.7.5.11.2.6. Neonatal-Perinatal Medicine;

4.7.5.11.2.7. Pediatrics-Adolescent Medicine; and

4.7.5.11.2.8. Pediatric Psychiatry.

4.7.5.11.3 The MCO shall have adequate Participating Provider networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.11.4 The MCO shall specify, in their listing of mental health and Substance Use Disorder Provider directories, which Providers specialize in children's services.

4.7.5.11.5 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.11.6 The MCO shall permit a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

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4.7.5.11.7 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.11.8 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.12. Access Standards for Behavioral Health

4.7.5.12.1 The MCO shall have in its Participating Provider network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.12.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its Participating Provider network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.12.2.1. Within six (6) hours for a non-life threatening emergency;

4.7.5.12.2.2. Within forty-eight (48) hours for urgent care; and

4.7.5.12.2.3. Within ten (10) business days for a routine office visit appointment.

4.7.5.12.3 American Society of Addiction Medicine (ASAM) Level of Care

4.7.5.12.3.1. The MCO shall ensure Members timely access to care through a network of Participating Providers in each ASAM Level of Care. During the Readiness

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Review process and in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.7.5.12.3.1.1 The MCO shall submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of Substance Use Disorder service Providers so that services are accessible without unreasonable delays; and

4.7.5.12.3.1.2 The MCO shall have a specified number of Providers able to provide services at each level of care required; if supply precludes compliance, the MCO shall notify the Department and, within

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thirty (30) calendar days, submit an updated plan that identifies the specific steps that shall be taken to increase capacity, including milestones by which to evaluate progress.

4.7.5.12.4 The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.

4.7.5.12.5 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.

4.7.5.12.6 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential

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services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.12.7 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider, and the ordering Provider does not make a referral for the Covered Service within three (3) business days from initial contact, then the MCO is responsible, in collaboration with the Member's care team, for making a closed loop referral for that type of service (for the identified level of care), and to the applicable Doorway Program location within three (3) business days thereafter. The MCO is responsible for ensuring that the Member has access to interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

4.7.5.12.8 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.12.9 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

4.7.5.12.9.1. Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching

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out to identify Providers on the behalf of the Member;

4.7.5.12.10 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

4.7.5.12.11 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6. **Women's Health**

4.7.6.1. The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services provide necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist. [42 CFR 438.206(b)(2)]

4.7.6.2. The MCO shall provide access to Family Planning Services to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3. Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

4.7.6.4. The MCO shall only provide for abortions in the following situations:

4.7.6.4.1 If the pregnancy is the result of an act of rape or incest; or

4.7.6.4.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.5. The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement.

4.7.7. **Access to Special Services**

4.7.7.1. The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the

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equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2. The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3. The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4. The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8. **Non-Participating Providers**

4.7.8.1. If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2. The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3. The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider,

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the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.3.3 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network. [42 CFR 438.206(b)(5)]

4.7.9. **Access to Providers During Transitions of Care**

4.7.9.1. The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 [Amendment #1:] In the case of a child or youth who qualifies as a target population~~with Special Health Care Needs as~~ defined in Section 4.11.2 (MCO-Delivered Care Management for Required Priority Populations).

4.7.9.2. The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with the Department) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, 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;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her

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Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3. The MCO shall permit that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4. The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing their Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5. The MCO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition plan shall describe how Members shall be identified by the MCO and how Continuity of Care shall be provided.

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4.7.9.6. The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7. The MCO shall make a good faith effort to give written notice of termination of a contracted Provider, as follows:

4.7.9.7.1 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

4.7.9.7.2 Written notice to each Member who received their care from, or was seen on a regular basis by, the terminated Provider, the later of:

4.7.9.7.2.1. Thirty (30) calendar days prior to the effective date of the termination; or

4.7.9.7.2.2. Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated Provider.

4.7.9.8. The MCO shall have a transition plan in place for affected Members described in this section within three (3) calendar days prior to the effective date of the termination.

4.7.9.9. In addition to notification of the Department of Provider terminations, the MCO shall provide reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.7.9.10. If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.9.11. If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.11.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.11.2 Explain that the Member shall be assigned to an alternative PCP if they do not actively select one; and

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4.7.9.11.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.12. If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.13. The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Management team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant.

4.7.9.14. To minimize disruptions in care, the MCO shall:

4.7.9.14.1 With the exception of Members in their second or third trimester of pregnancy, 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; and

4.7.9.14.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10. **Second Opinion**

4.7.10.1. The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook. [42 CFR 438.206(b)(3)]

4.7.11. **Provider Choice**

4.7.11.1. The MCO shall permit each Member to choose their Provider to the extent possible and appropriate. [42 CFR 438.3(l)]

4.7.12. [Amendment #4:] **Rural Health Care**

4.7.12.1. [Amendment #4:] Beginning as early as January 1, 2026, the MCO shall support the Department's Rural Health Care activities authorized through the 2025 federal budget reconciliation bill as described in separate guidance. [H.R. 1; P.L. 119-21]

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4.8. Utilization Management

4.8.1. Policies and Procedures

4.8.1.1. The MCO'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 MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3. Amount, Duration, and Scope

4.8.1.3.1 The MCO 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)]

4.8.1.3.2 The MCO shall also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services shall be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.3 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.3.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.3.2. Personal Care Attendant (PCA) authorizations shall be issued for no less that one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

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4.8.1.3.3.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

4.8.1.4. Written Utilization Management Policies

4.8.1.4.1 The MCO 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 MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (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

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(including health-related social needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.13.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs;

4.8.1.4.2.2. Pre-hospital admission certification;

4.8.1.4.2.3. Pre-inpatient service eligibility certification;

4.8.1.4.2.4. Concurrent hospital review to determine appropriate length of stay;

4.8.1.4.2.5. The process used by the MCO 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 MCO to the Department for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the MCO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

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4.8.1.4.6 The MCO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The MCO'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 MCO shall provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.66 (c)(7)]

4.8.1.5. Service Limits

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6. Prior Authorization

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4.8.1.6.1 The MCO 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. Any Prior Authorization for Substance Use Disorder shall comply with RSA 420-J:17 and RSA 420-J:18 as described in Section 4.12.34.3 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

4.8.1.6.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including health-related social needs and a subsequent person-centered planning process.

4.8.1.6.3 The MCO's Prior Authorization requirements shall comply with parity in mental health and Substance Use Disorder, as described in Section 4.12.19.4 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.4 The MCO shall use the NH MCM standard Prior Authorization form, as applicable. The MCO shall also 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.

4.8.1.6.5 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

4.8.1.6.7 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely

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because of the diagnosis, type of illness, or condition of the Member.

4.8.1.6.8 The MCO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.8.1. The MCO shall not deny service authorization requests based solely on cost.

4.8.1.6.9 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.1.6.10 The MCO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.1.6.11 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)]

4.8.1.6.12 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.1.6.13 The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.14 Upon receipt of Prior Authorization information from the Department, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.2 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.15 In the event that the Prior Authorization specifies a specific Provider, that MCO shall continue to utilize

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that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network.

4.8.1.6.16 The MCO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.17 [Amendment #3:] As soon as possible, but no later than January 1, 2026, t~~T~~he MCO shall ensure that medical necessity determinations by Subcontractors or any other party performing utilization review are made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease, and is actively licensed ~~are licensed in NH~~ in accordance with Section 3.10.2.4 (Contracts with Subcontractors) and Section 3.11.1.1.9.2 of this Agreement.

4.8.1.6.18 The MCO shall ensure that Subcontractors or any other party performing utilization reviews applicable to inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:

4.8.1.6.18.1. For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.

4.8.1.6.18.2. Reauthorization of the Member's continuous admission, shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.

4.8.2. **Practice Guidelines and Standards**

4.8.2.1. The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO shall:

4.8.2.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

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4.8.2.1.2 Consider the needs of the MCO's Members,

4.8.2.1.3 Be adopted in consultation with Participating Providers, and

4.8.2.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1-3); 42 CFR 438.236(b)(4)]

4.8.2.2. The MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

4.8.2.3. The MCO 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:

4.8.2.3.1 ASAM, as further described in Section 4.12.27 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.3.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adult, adolescent, and pediatric populations, rated A or B; as well as State specified requirements which include, but are not limited to, pediatric lead testing rates of fifty-five percent (55%) for 12-month olds and forty-four percent (44%) for 24 month olds in the first year of the Agreement, increasing by five percent 5% each year thereafter until the final year of the Agreement when the goals will be seventy-five percent (75%) for 12-month olds and sixty-four percent (64%) for 24-month olds.

4.8.2.3.3 The preventive services recommended by the AAP Bright Futures program; and

4.8.2.3.4 The Zero Suicide Consensus Guide for Emergency Departments.

4.8.2.4. The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is reviewed by the Department prior to implementation.

4.8.2.5. The MCO shall disseminate Practice Guidelines to the Department and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

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4.8.2.6. The MCO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3. **Medical Necessity Determination**

4.8.3.1. The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.3.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2. For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Section 2.1 (Definitions).

4.8.3.3. For Members under twenty-one (21) years of age, per EPSDT, "Medically Necessary" shall be as defined in Section 2.1 (Definitions).

4.8.4. **Notices of Coverage Determinations**

4.8.4.1. The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2. Urgent Determinations and Continued/Extended Services

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4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.4.2.1.2. In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request and shall advise the Member or Member's representative of the specific information necessary to make a coverage determination.

4.8.4.2.1.3. 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.

4.8.4.2.1.4. 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 MCO's receipt of the specified additional information; or the end of the period afforded the

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Member or Member's representative to provide the specified additional information.

4.8.4.2.1.5. 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.

4.8.4.3. All Other Determinations

4.8.4.3.1 [Amendment #4:] Beginning July 1, 2026,t~~T~~he determination of all other authorizations for pre-service benefits (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed seven (7) ~~fourteen (14)~~ calendar days for ninety-five percent (95%) of standard requests after the receipt of a request. [42 CFR 438.210(d)]

4.8.4.3.2 [Amendment #4:] Beginning July 1, 2026, An extension of up to fourteen (14) calendar days after receiving the request is permissible ~~for non-diagnostic radiology determinations~~ if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.3 [Amendment #4:] Intentionally left blank.~~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-~~

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~~five (45) calendar days from receipt of the notice within which to provide the specified information.~~

4.8.4.3.4 [Amendment #4:] Beginning July 1, 2026, Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than seven (7) ~~fourteen (14)~~ calendar days after the earlier of:

4.8.4.3.4.1. The MCO's receipt of the specified additional information; or

4.8.4.3.4.2. The end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.3.4.3. When the MCO extends the timeframe, the MCO 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 MCO 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.

4.8.4.3.5 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 MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.4.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.7 [Amendment #4:] Beginning July 1, 2026, ~~Whenever there is an adverse determination, the MCO shall~~

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~~notify the ordering Provider and the Member. For an adverse standard authorization decision,~~ the MCO shall notify the requesting provider, and give the enrollee written notice of any decision ~~provide written notification~~ as expeditiously as the Member's condition requires, but may not exceed seven (7) ~~within three (3)~~ calendar days after receiving the request for service ~~of the decision~~. [42 CFR 438.10(d)]

4.8.4.3.7.1. [Amendment #4:] Beginning July 1, 2026, if the MCO denies a prior authorization request (excluding a request for coverage of drugs as defined in 42 CFR 431.60(b)(6)), the MCO shall provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request to the MCO. [42 CFR 438.210(d)] Reasons may be communicated via portal (may include existing payer messaging portal), fax, email, mail, or phone. [42 CFR 438.242(b)(8)]

4.8.4.3.8 The MCO shall provide Utilization Management Confidential Data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.8.5. **Advance Directives**

4.8.5.1. The MCO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:20.

4.8.5.2. The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.

4.8.5.3. The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.

4.8.5.4. The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]

4.8.5.5. The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

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4.8.5.6. The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.7. The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.8. The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9. Member Education and Incentives

4.9.1. General Provisions

4.9.1.1. The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by the Department, including the National Diabetes Prevention Program. The MCO shall also participate in other public health initiatives at the direction of the Department.

4.9.1.2. The MCO shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. The MCO shall encourage Members to take an active role in shared decision-making.

4.9.1.3. The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. The Department shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2. Member Health Education

4.9.2.1. The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

4.9.2.2. The MCO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3. Member Cost Transparency

4.9.3.1. The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with

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clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2. The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to permit Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3. The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) of this Agreement.

4.9.4. **Member Incentive Programs**

4.9.4.1. The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this section of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives described in Section 4.15 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.2. For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 [Amendment #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), except as specified in separate guidance.

4.9.4.2.3 The MCO shall submit to the Department for review and approval all Member Incentive Program plan proposals prior to implementation.

4.9.4.3. Within the plan proposal, the MCO shall include adequate assurances, as assessed by the Department, that:

4.9.4.3.1 The program meets the requirements of the Social Security Act; and

4.9.4.3.2 The program meets the criteria determined by the Department as described in Section 4.9.4.5 (Healthy

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Behavior Incentive Programs) and Section 4.9.4.6 (Reference-Based Pricing Incentive Programs) of this Agreement.

4.9.4.4. The MCO 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:

4.9.4.4.1 The number of Members in the program's target population, as determined by the MCO;

4.9.4.4.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.4.4.3 The total value of the incentive payments;

4.9.4.4.4 An analysis of the statistically relevant results of the program; and

4.9.4.4.5 Identification of goals and objectives for the next year informed by the data.

4.9.4.5. Healthy Behavior Incentive Programs

4.9.4.5.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.4.5.1.1. Incorporate incentives for Members who complete a HRA Screening, in compliance with Section 4.10.2 of this Agreement;

4.9.4.5.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.9.4.5.1.3. Address obesity;

4.9.4.5.1.4. Prevent diabetes;

4.9.4.5.1.5. [Amendment #1:] Support nicotine~~smoking~~ cessation;

4.9.4.5.1.6. Increase lead screening rates in one- and two-year old Members; and/or

4.9.4.5.1.7. Other similar types of healthy behavior incentive programs in

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consultation with the collaboration with the Department's Division of Public Health New Hampshire Tobacco Cessation Program, Quitline.

4.9.4.6. Reference-Based Pricing Incentive Programs

4.9.4.6.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO and on its website in compliance with the Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.6.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5. **Collaboration with New Hampshire Tobacco Cessation Programs**

4.9.5.1. [Amendment #1:] The MCO shall enter into a Provider or Subcontractor agreement to cover the cost of nicotine cessation services for youth (13-17 years), and adults without Copayment, Prior Authorization, or annual limits with Department approved nicotine quitline(s). ~~The MCO shall promote and utilize the Department-approved tobacco treatment quitline, 1-800-QUITNOW (1-800-784-8669) to provide:~~

4.9.5.1.1 [Amendment #1:] Intentionally left blank. ~~Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;~~

4.9.5.1.2 [Amendment #1:] Intentionally left blank. ~~Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;~~

4.9.5.1.3 [Amendment #1:] Intentionally left blank. ~~The following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by the Department; and~~

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4.9.5.1.4 [Amendment #1:] Intentionally left blank. ~~Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.~~

4.9.5.2. [Amendment #1:] The MCO shall cover the cost of nicotine cessation, including counseling visits, in addition to the quitline without Copayment, Prior Authorization, or duration/frequency or annual limits. ~~The MCO shall provide tobacco cessation treatment to include, at a minimum~~:

4.9.5.2.1 [Amendment #1:] Intentionally left blank ~~Tobacco cessation coaching/counseling in addition to the quitline~~;

4.9.5.2.2 [Amendment #1:] Intentionally left blank ~~In addition to the quitline, the following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by the Department~~;

4.9.5.2.3 [Amendment #1:] Intentionally left blank ~~In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release; and~~

4.9.5.2.4 [Amendment #1:] Intentionally left blank ~~Covered FDA-approved tobacco cessation prescription medications that qualify for rebates under the Medicaid Prescription Drug Rebate Program, including~~:

4.9.5.2.5 [Amendment #1:] Intentionally left blank ~~Non-nicotine prescription medications; and~~

4.9.5.2.6 [Amendment #1:] Intentionally left blank ~~Inhalers and nasal sprays.~~

4.9.5.3. [Amendment #1:] The MCO shall promote through its website and membership mailings the nicotine cessation quitlines: QuitNow-NH (quitnownh.org and 1-800-QUIT-NOW) for adults, and MYLIFEMYQUIT (nh.mylifemyquit.org and Text 36072) for children 13-17 years old.

4.9.5.3.1 [Amendment #1:] The MCO shall collaborate with the New Hampshire Tobacco Cessation Program (TPCP) within the Department's Division of Public Health

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Services to update and maintain a website presence for QuitNow-NH and resources for nicotine cessation.

4.9.5.3.2 [Amendment #1:] Quarterly, the MCO shall use claims data to identify Members receiving nicotine cessation counseling and mail promotional materials, as indicated by TPCP.

4.9.5.3.3 [Amendment #1:] The MCO shall participate in quitline data sharing with the TPCP by reporting on tobacco cessation activities in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.9.5.4. [Amendment #1:] The MCO shall report on tobacco cessation activities in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10. Primary Care and Prevention Focused Care Model

4.10.1 General Requirements

4.10.1.1. Under the Primary Care and Prevention Focused Care Model of Care, Primary Care services shall be furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant, or nurse practitioner, including alternative provider types as designated by the Department.

4.10.1.2. The MCO shall ensure that the Primary Care and Prevention Care Focused Care Model of Care shall be administered in accordance with this Agreement, including:

4.10.1.2.1 Assurance of comprehensive PCP participation in the Model of Care wholly supported by the MCO;

4.10.1.2.2 Guaranteed access to related services for all Members;

4.10.1.2.3 Delivery of services in a manner that are both clinically and developmentally appropriate, patient-focused, and that consider the Member's, parent's, caregiver's and other networks of support the Member may rely upon, in accordance with this Agreement and all applicable State and federal laws and regulations;

4.10.1.2.4 PCP (and other Providers who share responsibility for primary care of the Member) responsibility for Provider-Delivered Care Coordination as described at Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) of this Agreement consistent with Practice Guidelines and Standards required and stipulated in Section 4.8.2, including a plan for integration of these programs;

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4.10.1.2.5 Member's selection or assignment of a PCP within fifteen (15) calendar days of enrollment with the MCO;

4.10.1.2.6 Completion of the Member welcome call as stipulated at Section 4.4.11 (Welcome Call);

4.10.1.2.7 Member receipt of a Wellness Visit with their PCP, as defined in Section 4.10.3 (Wellness Visits), at least once annually. If the Member is assigned a new PCP, the MCO shall ensure the Member receives a Wellness Visit with the new PCP regardless of when the last Wellness Visit occurred with another Provider;

4.10.1.2.8 Initial and regular reporting to PCPs the names of Members attributed to the PCP's panel within thirty (30) calendar days of PCP assignment or selection, including the date of the attributed Member's last Wellness Visit and HRA Screening, as available, and/or the absence of such visit and screenings if there have been none;

4.10.1.2.9 Demonstration of the authentic engagement between the Member and PCP. At a minimum, as demonstrated through claim encounters initially within ninety (90) days of PCP selection/assignment, and routinely thereafter.

4.10.1.2.10 Provider reimbursement for provision of the following Member services:

4.10.1.2.10.1. Wellness Visits in accordance with Section 4.10.3 (Wellness Visits), including assurance there are no barriers to professional claim billing and payment outside of a Wellness Visit for U.S. Preventive Services Task Force (USPSTF) recommended services that utilize a standardized tool in the screening for obesity, anxiety, depression and suicide risk, unhealthy alcohol use, unhealthy drug use, and falls prevention;

4.10.1.2.10.2. HRA Screening as stipulated in Section 4.10.2 (Health Risk Assessment (HRA) Screening) can occur during a visit for any separate acute service and is not

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solely restricted to a Wellness Visit;

4.10.1.2.10.3. Preventive screenings in accordance with the Practice Guidelines and Standards (Section 4.8.2), including but not limited to the recommendations of the U.S. USPSTF for the provision of primary and secondary care for adult, adolescent, and pediatric populations, rated Level A or B and other preventive screening and services as required by the Department; and

4.10.1.2.10.4. Medically Necessary diagnostic and treatment Covered Services based on the findings or risk factors identified in the annual Wellness Visit, completion of a HRA Screening, or during routine, urgent, or emergent health care visits.

4.10.1.2.10.5. [Amendment #1:] Comprehensive Medication Reviews for Required Priority Population Members, and children and adults meeting Polypharmacy criteria as stipulated in Section 4.2.6.

4.10.1.2.11 Provider and Member incentives for completion of the following:

4.10.1.2.11.1. A Wellness Visit;

4.10.1.2.11.2. A HRA Screening; and

4.10.1.2.11.3. Preventive screenings.

4.10.1.3. Support the PCP to engage Members to complete the HRA Screening in accordance with Section 4.10.2.

4.10.1.4. [Amendment #1:] Intentionally left blankComprehensive Medication Reviews for children and adults meeting Polypharmacy criteria as stipulated in Section 4.2.6.

4.10.1.5. Provider-Delivered Care Coordination utilization of closed-loop referral processes in accordance with Section 4.11.7 (Provider-Delivered Care

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Coordination and Integration with Social Services and Community Care), including:

4.10.1.5.1 PCP initiation and coordination of closed-loop referrals for clinical and non-clinical services the Member needs, including but not limited to Behavioral Health Services and health-related social needs, with the Provider remaining engaged with clinical and non-clinical Provider(s) throughout the course of treatment for the referred service(s);

4.10.1.5.2 PCP adoption and utilization of closed-loop referral processes, and the Department's closed-loop referral system, as it becomes available, to promote efficiency and optimal communication among and between Providers; and

4.10.1.5.3 PCP education and training to ensure that the PCP knows when and how to utilize a closed-loop referral system.

4.10.1.6. The MCO shall ensure the Primary Care and Prevention Focused Model satisfies care and coordination of services as follows: [42.CFR 438.208]

4.10.1.6.1 The MCO shall ensure that each Member has a designated PCP who shall serve as an ongoing source of case appropriate to his or her needs and the Member shall be provided information on how to contact their designated PCP;

4.10.1.6.2 The MCO shall provide Care Management services for times at which a Member does not have an established and designated PCP (e.g., corrections populations, DCYF children and youth);

4.10.1.6.3 The MCO shall also cover Transitions of Care Management (TCM) codes for Participating Providers to perform care transition assistance including coordinating appropriate services between settings of care;

4.10.1.6.4 [Amendment #1:] The MCO shall make best effort to connect each Member to a PCP and to pay network PCPs to review the Member's HRA Screening results with the Member at least once annually or when the Member's circumstances or needs change significantly ~~pay network PCPs to conduct an initial screening of each Member's needs within ninety (90) calendar days of the effective date of enrollment for new Members~~;

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4.10.1.6.5 [Amendment #1:] The MCO shall request documentation from the Participating Provider regarding HRA Screenings ~~and initial screenings~~ of Member needs should the MCO determine that additional entities such as the State, PIHPs and PAHPs are serving the enrollee to prevent duplication of those activities;

4.10.1.6.6 The MCO shall ensure Participating Providers that furnish services to Members maintains and shares, as appropriate, Member health records in accordance with professional standards; and

4.10.1.6.7 The MCO shall ensure that in the process of coordinating care, each Member's privacy is protected in accordance with state and federal privacy requirements in to the extent that they are applicable. [45 CFR parts 160 and 164 subparts A and E]

4.10.1.7. The MCO shall collaborate with the other contracted Medicaid MCOs to offer training for Providers on the Primary Care and Prevention Focused Care Model in an efficient and effective manner that reduces the administrative burden of Providers.

4.10.2 **Health Risk Assessment (HRA) Screening**

4.10.2.1. The HRA Screening process shall identify the need for the Member's Care Coordination and Care Management services and the need for clinical and non-clinical services, including closed-loop referrals to specialists, not limited to Behavioral Health services Providers, and community resources.

4.10.2.2. The MCO shall implement a process to allow professional services billing and payment for Participating Providers who complete and review a Member's HRA Screening, and shall create incentive programs to facilitate the Participating Provider's completion and review of the HRA Screening.

4.10.2.3. [Amendment #1:] The MCO shall support and empower Providers to conduct and review a HRA Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of MCO enrollment and at least annually thereafter for all Members, and when the Member's circumstances or needs change significantly to identify Members who may have unmet health care needs. [42 CFR 438.208(c)(1)]

4.10.2.4. [Amendment #1:] The HRA Screening tool and methodology shall be the same for each MCO~~. The HRA Screening tool~~ and approved ~~shall be developed by the Department and made available for Provider use~~.

4.10.2.4.1 [Amendment #1:] The Provider may utilize an alternate HRA Screening tool that includes the minimum HRA Screening criteria specified by the Department in separate guidance.

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4.10.2.5. [Amendment #2] [Amendment #1:] The MCO shall ~~empower and~~ support and incentivize the PCP to engage Members to complete the HRA screening in an agency office/clinic setting, during a scheduled home visit or medical appointment. The HRA Screening may be conducted in-person or through a HIPAA compliant electronic means, telephonic means, or through completion of the written form by the Member. ~~The MCO shall make best efforts to verify the PCP has made at least three (3) reasonable attempts to contact a Member at the phone number and address most recently reported by the Member.~~ [42 CFR 438.208(b)(3)]

4.10.2.5.1 For Members determined eligible for Community Mental Health services pursuant to He-M 401, the MCO shall encourage the Member's PCP to coordinate completion of the HRA Screening (Section 4.10.2) with the Member's applicable Community Mental Health program (a Community Mental Health Center) or other Community Mental Health Provider, if the Member consents, to enable the Community Mental Health Provider to provide support for effective completion of the Health Risk Assessment Screening by the PCP and the Member.

4.10.2.6. The MCO shall report the number of Members who received a HRA Screening, using claims data, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.10.2.7. [Amendment #1:] Intentionally left blankThe MCO shall share with the Department the results of any identification and assessment of Member's needs to prevent duplication of activities as described in separate guidance. [42 CFR 438.208(b)(4)]

4.10.2.7.1 [Amendment #1:] The PCP shall review HRA Screening data and make appropriate referrals to social service agencies or other entities whether the data is collected in-person, digitally or electronically, telephonically, ~~in-person, digitally or electronically, telephonically,~~ or through completion of the written form by the Member.

4.10.2.7.2 The Provider conducting the HRA Screening shall share Member HRA results with the MCO upon request.

4.10.2.8. The MCO shall ensure, through incentives or professional provider reimbursement, that the Participating Provider reviews the HRA Screening results and make appropriate referrals to social service agencies or other entities whether the HRA is collected in person, electronically, telephonically, or through completion of the written form by the Member.

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4.10.2.9. [Amendment #1:] Intentionally left blank.~~The Participating Provider conducting the HRA Screening shall share Member HRA Screening results with the MCO upon request.~~

4.10.2.10. The MCO shall ensure Participating Providers complete and review Member HRA Screenings at least annually as follows:

4.10.2.10.1 By the end of Year 1 (SFY 2025 (June 30, 2025)), the HRA minimum completion rate requirement is twenty percent (20%) of the plan's total membership;

4.10.2.10.2 By the end of Year 2 (SFY 2026 (June 30, 2026)), the HRA minimum completion rate requirement is forty percent (40%) of the plan's total membership;

4.10.2.10.3 By the end of Year 3 (SFY 2027 (June 30, 2027)), the HRA minimum completion rate completion rate requirement is sixty percent (60%) of the plan's total membership; and

4.10.2.10.4 By the end of Year 4 (SFY 2028 (June 30, 2028) and through the end of the contract term, the HRA minimum completion rate requirement is seventy-five percent (75%) of the plan's total membership.

4.10.2.11. [Amendment #1:] The evidence-based HRA Screening tool are described in separate guidance ~~shall identify, at minimum, the following information about Members~~:

4.10.2.11.1 [Amendment #1:] Intentionally left blank ~~Demographics~~;

4.10.2.11.2 [Amendment #1:] Intentionally left blank ~~Chronic and/or acute conditions;~~

4.10.2.11.3 [Amendment #1:] Intentionally left blank ~~Chronic pain;~~

4.10.2.11.4 [Amendment #1:] Intentionally left blank ~~The unique needs of children with developmental delays, Special Health Care Ne eds or involved with the juvenile justice system and child protection agencies (i.e., DCYF);~~

4.10.2.11.5 [Amendment #1:] Intentionally left blank ~~Behavioral Health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.12.10 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.12.20.4 (Comprehensive Assessment and Care Plans), and Section 4.12.26 (Provision of Substance Use Disorder Services);~~

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4.10.2.11.6 [Amendment #1:] Intentionally left blank ~~The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;~~

4.10.2.11.7 [Amendment #1:] Intentionally left blank Nicotine~~Tobacco C~~cessation needs;

4.10.2.11.8 [Amendment #1:] Intentionally left blank ~~Health-related social needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and~~

4.10.3 **[Amendment #1:] Intentionally left blank ~~Other factors or conditions about which the MCO shall need to be aware to arrange available interventions for the Member~~.**

4.10.4 **Wellness Visits**

4.10.4.1. For all Members the MCO shall support the Member to arrange a Wellness Visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs. If the Member changes their PCP, the MCO shall authorize a new Wellness Visit with the new PCP, even if within a calendar year of the last Wellness Visit with the previous PCP.

4.10.4.2. The Wellness Visit conducted by the PCP or other qualified Provider shall include health risk and social determinant of health screening assessments for the purpose of determining a Member's health wellness and development of a plan of care, including evaluations of:

4.10.4.2.1 Both physical and behavioral health, including screening for depression;

4.10.4.2.2 Mood, suicidality; and

4.10.4.2.3 Substance Use Disorder.

4.10.5 **Prior Authorization for Primary Care and Preventive Services**

4.10.5.1. Notwithstanding other provisions of Section 4.8.1.6, Prior Authorizations for any preventive services, as defined in Section 4.8.2.3.2 of this Agreement, and as stipulated to in Practice Guidelines and Standards at Section 4.8.2 shall be prohibited. This prohibition shall include medically appropriate follow-up testing related to the initial test results, as well as any claims or encounters associated with the PCP's coordination and collaboration with Behavioral Health Services to support the Member's participation in preventive services activities.

4.10.6 **Primary Care and Prevention Focused Care Model Implementation Plan**

4.10.6.1. The MCO shall submit a plan for implementing the Primary Care and Prevention Focused Care Model in accordance with Exhibit O: Quality and Oversight Reporting.

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4.11. Care Coordination and Care Management

4.11.1. General Requirements

4.11.1.1. The MCO shall be responsible for ensuring effective management, coordination, and Continuity of Care for all Members, including oversight of Provider-Delivered Care Coordination for the PCPs' attributed Members, and shall develop and maintain policies and procedures to address these responsibilities.

4.11.1.2. The MCO shall submit a plan at time of Readiness Review and implement procedures to facilitate integrated Provider-Delivered Care Coordination and MCO-Delivered Care Management to ensure each Member has an ongoing source of care appropriate to their needs, and includes procedures for confidentiality, consent, or informed consent. [42 CFR 438.208(b)]

4.11.1.3. The MCO shall ensure the services described in this section are provided for all Members who need Care Coordination regardless of their acuity level.

4.11.1.4. The MCO shall implement and monitor Provider-Delivered Care Coordination and MCO-Delivered Care Management, as appropriate, in order to achieve the following goals:

4.11.1.4.1 Improve care of Members;

4.11.1.4.2 Improve health outcomes;

4.11.1.4.3 Increase collaboration among the Member's Providers, including but not limited to Behavioral Health Services Providers;

4.11.1.4.4 Reduce inpatient hospitalizations including readmissions;

4.11.1.4.5 Improve Continuity of Care;

4.11.1.4.6 Improve transition planning;

4.11.1.4.7 Improve medication management;

4.11.1.4.8 Improve U.S. Preventive Services Task Force (USPSTF) recommended Level A and B preventive screenings; as well as State specified screenings

4.11.1.4.9 Reduce utilization of unnecessary Emergency Services;

4.11.1.4.10 Reduce unmet resource needs related to health-related social needs;

4.11.1.4.11 Decrease total costs of care; and

4.11.1.4.12 Increase Member satisfaction with their health care experience.

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4.11.1.5. The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, Behavioral Health Service Providers, and social service resources, and include related documentation in the Member Care Plan.

4.11.1.5.1 The MCO and its Participating Providers shall utilize, leverage and partner with the Department's closed-loop referral system, if available, or 2-1-1 NH if it is not, which is a New Hampshire statewide information and referral service, using closed-loop referral processes to ensure warm transfers are completed and outcomes are reported for all closed-loop referrals.

4.11.1.6. The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from another MCO. [42 CFR 438.208(b)(2)(ii)]

4.11.1.7. The MCO shall also implement procedures to coordinate services the MCO furnishes to the Required Priority Population Member with the services the Member receives in FFS Medicaid, including Medicaid dental services, as applicable. For other Members not included in the Required Priority Population, the PCP shall coordinate these services. [42 CFR 438.208(b)(2)(iii)].

4.11.1.8. The MCO shall provide Care Management support for Required Priority Population Members who utilize services not covered by this Agreement (e.g., Medicaid, commercial, or government health insurance programs). In such cases, the MCO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii-iv). The MCO shall use the Department's closed-loop referral solution, if available, to initiate and support the Required Priority Population Member's access to other services to which the MCO, or its applicable PCP or other Participating Provider is referring the Member.

4.11.2. **MCO-Delivered Care Management for Required Priority Populations**

4.11.2.1. Required Priority Populations are most likely to have Care Management needs that shall be met with the MCO-Delivered Care Management processes described in this Agreement.

4.11.2.2. The following high-risk groups are identified as Required Priority Populations in need of Care Management focus by the MCO:

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Contract Provision	Minimum Care Management Timeframe
[Amendment #1:] 4.11.2.2.1 Individuals who have required an inpatient admission for a behavioral health diagnosis and were discharged within the previous twelve (12) months;	[Amendment #1:] Beginning immediately upon MCO Notice of Discharge, then an additional twelve (12) calendar months after the month of discharge
[Amendment #4:] [Amendment #1:] 4.11.2.2.2 Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care ~~and/or those who have elected voluntary supportive services~~;	[Amendment #1:] Beginning immediately upon DCYF agency engagement, then an additional twelve (12) calendar months after the month of discharge
[Amendment #1:] 4.11.2.2.3 Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS);	[Amendment #1:] Beginning immediately upon MCO identification of low birth weight and/or neonatal abstinence syndrome (NAS) diagnoses, then an additional twelve (12) calendar months after the month of discharge
[Amendment #1:] 4.11.2.2.4 Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval[20]	[Amendment #1:] Beginning immediately upon MCO enrollment for 45 days prior to the scheduled release date, then an additional twelve (12) calendar months after the month of incarceration release
[Amendment #1:] 4.11.2.2.5 Other Required Priority Populations identified by the Department with advance notification to the MCO with an effective date for Care Management services within ninety (90) calendar days of written notice from the Department.	[Amendment #1:] As appropriate for new populations identified by the Department
[Amendment #2:] 4.11.2.2.6 Eligible incarcerated youth as defined by CAA section 5121	[Amendment #2:] Beginning 30-days prior to the scheduled release date, then an additional twelve (12) calendar months after the month of incarceration release

4.11.2.2.1 [Amendment #1:] ~~Individuals who have required an inpatient admission for a behavioral health diagnosis~~

[20] Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver available on July 18, 2023 at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request.pdf.

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and were discharged within the previous twelve (12) months;

4.11.2.2.2 [Amendment #1:] Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services;

4.11.2.2.3 [Amendment #1:] Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS);

4.11.2.2.4 [Amendment #1:] Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval; and

4.11.2.2.5 [Amendment #1:] Other Required Priority Populations identified by the Department with advance notification to the MCO with an effective date for Care Management services within ninety (90) calendar days of written notice from the Department.

4.11.2.3. [Amendment #1:] The MCO may identify other Members who may benefit from the plan's Care Management services as needed for Members in accordance with the clinical care needs of the Member; however, MCO-Delivered Care Management requirements specified in this Agreement apply only to the Required Priority Populations identified by the Department, which may be expanded from time to time with advance notification to the MCO.

4.11.2.4. [Amendment #2:] The MCO shall support reporting for Required Priority Populations as specified by Exhibit O: Quality and Oversight Reporting Requirements of this Agreement.

4.11.3. **Comprehensive Assessment**

4.11.3.1. [Amendment #1:] The MCO shall implement mechanisms to minimally conduct a Comprehensive Assessment for Required Priority Populations to identify whether a Member has Special Health Care Needs and any ongoing special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.208(c)(2)]

4.11.3.1.1 [Amendment #1:] The MCO shall, conduct an initial Comprehensive Assessment screening during a welcome call to assess care needs and to coordinate services for all existing and newly enrolled Members within ninety (90) calendar days of the Member's effective date of MCO enrollment for all new Members,

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including subsequent attempts if the initial attempt to contact the Member is unsuccessful. [42 CFR 438.208(b)(3) and (c)]

4.11.3.2. The Comprehensive Assessment shall identify a Member's health condition that requires a course of treatment that isok either episodic, which is limited in duration or significance to a particular medical episode, or requires ongoing Provider-Delivered Care Coordination or MCO-Delivered Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder).

4.11.3.3. [Amendment #1:] The Comprehensive Assessment shall be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that shall inform whether the Priority Population Member or other Member should receive Care Management, and shall inform the Member's ~~ongoing Care Plan and~~ treatment plan, as well as the Required Priority Population Member's Care Plan managed by the MCO. The MCO shall incorporate into the Comprehensive Assessment information obtained from Providers ~~as a result of Provider referral, or the Wellness Visit~~.

4.11.3.4. [Amendment #1:] ~~In addition to any initial Comprehensive Assessment cited at Section 4.11.3.1.1, t~~The MCO shall complete a Comprehensive Assessment within thirty (30) calendar days of identifying a Priority Population Member at the time of a welcome call or at any time a Member is identified as being part of a one or more Required Priority Population. ~~as being part of one or more Required Priority Population as identified~~ Methods for identifying Required Priority Population Members may include ~~through~~ Medicaid enrollment records, HRA Screening, risk scoring and stratification or other means at the MCO's discretion, or means as determined by the Department.

4.11.3.5. The MCO shall not withhold any Medically Necessary Covered Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.11.3.6. The MCO shall conduct the Comprehensive Assessment in a location of the Member's, parent's or guardian's choosing, as applicable, and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as family members, paid and natural supports as agreed upon and appropriate to the Member/Member's parent, if a minor, or guardian to the maximum extent practicable.

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4.11.3.7. Additionally, participation in the Comprehensive Assessment shall be extended to the Member's Care Team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs, Special Medical Services, and 1915(i) case managers as practicable, with Member consent to the extent required by State and federal law.

4.11.3.8. The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

4.11.3.8.1 Members' immediate care needs;

4.11.3.8.2 Demographics;

4.11.3.8.3 Education;

4.11.3.8.4 Housing;

4.11.3.8.5 Employment and entitlements;

4.11.3.8.6 Legal involvement;

4.11.3.8.7 Risk assessment, including suicide risk;

4.11.3.8.8 Other State or local community and family support services currently used;

4.11.3.8.9 Medical and other health conditions;

4.11.3.8.10 Physical, I/DDs;

4.11.3.8.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living (IADL)) including cognitive functioning;

4.11.3.8.12 Medications;

4.11.3.8.13 Available informal, caregiver, or social supports, including peer supports;

4.11.3.8.14 Current and past mental health and substance use status and/or disorders;

4.11.3.8.15 Health-related social needs; and

4.11.3.8.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).

4.11.3.9. The MCO shall provide to the Department a copy of the Comprehensive Assessment tool and all policies and procedures related to conducting the Comprehensive Assessment for the Department's review as part of Readiness Review and annually thereafter.

4.11.3.10. The MCO shall conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing Care Management:

4.11.3.10.1 At least annually;

4.11.3.10.2 When the Member's circumstances or needs change significantly;

4.11.3.10.3 At the Member's request; and/or

4.11.3.10.4 Upon the Department's request.

4.11.3.11. The MCO shall share the results of the Comprehensive Assessment in writing with the Member's Care Team within 14 calendar days of completion of the assessment to inform care and treatment planning, with Member consent to the extent required by State and federal law.

4.11.3.12. The MCO shall report to the Department the following in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

4.11.3.12.1 Assessments conducted as a percentage (%) of total Members and by Required Priority Population category;

4.11.3.12.2 Assessments completed by a Subcontractor entity, such as but not limited to CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.11.3.12.3 Timeliness of assessments;

4.11.3.12.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other members of the local community based care team; and

4.11.3.12.5 Quarterly report of unmet resource needs, aggregated by county, based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.11.4. **Member Care Management Engagement**

4.11.4.1. [Amendment #2:] The MCO shall conduct Care Management in accordance with this Agreement and as specified in separate guidance which shall include assignment a designated Care Manager for every Required Priority Population Member.

4.11.4.2. [Amendment #4:] Intentionally left blank. ~~For any Member identified as part of a Required Priority Population relative to behavioral health, as described in this Agreement, and subsequently identified by the MCO as not needing Care Management, the MCO shall provide documentation to the Member's PCP and behavioral health provider(s), if applicable, of this decision, and to the Department. If, based on Member utilization data or consultation with the behavioral health provider, the Department notifies the MCO that the Member's~~

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~~utilization history is of continuing concern to the Department, such that Care Management is still warranted, the Department will notify the MCO and the MCO shall provide Care Management and designate a Care Manager for the Member.~~

4.11.4.3. Members selected for MCO-Delivered Care Management shall be informed of:

4.11.4.3.1 The nature of the Care Management engagement relationship;

4.11.4.3.2 Circumstances under which information shall be disclosed to third parties, consistent with State and federal law;

4.11.4.3.3 The availability of a grievance and appeals process;

4.11.4.3.4 The rationale for implementing Care Management services; and

4.11.4.3.5 The processes for opting out of and terminating Care Management services.

4.11.4.4. The MCO's Care Management responsibilities shall include, at a minimum:

4.11.4.4.1 Coordination of physical, mental health, Substance Use Disorder and social services using Provider engagement approaches not inconsistent with those described in this Agreement for certain Department identified Required Priority Populations and Behavioral Health Providers, including but not limited to Community Mental Health Programs and Certified Community Behavioral Health Centers, and other Providers providing Behavioral Health Services;

4.11.4.4.2 [Amendment #1:] Comprehensive medication review results and q~~Q~~uarterly medication reconciliation;

4.11.4.4.3 Monthly telephonic contact with the Member;

4.11.4.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the Care Plan for dissemination to care team participants;

4.11.4.4.5 Referral follow-up monthly;

4.11.4.4.6 Peer support;

4.11.4.4.7 Support for unmet resource needs;

4.11.4.4.8 Training on disease self-management, as relevant; and

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4.11.4.4.9 Transitional Care Management as defined in Section 4.11.6 (Transitional Care Management).

4.11.4.5. [Amendment #1:] The MCO shall convene an initial Care Team for each Required Priority Population Member receiving MCO-Delivered Care Management where necessary to improve health outcomes for the Member, dependent on a Member's needs ~~including~~, including but not limited to, the Member, caretaker(s) and guardian(s), PCP, behavioral health Provider(s), specialist(s), targeted case managers, children's behavioral health system coordinators, Critical Time Intervention coaches, Supportive Housing case~~ing~~ managers, transitional case managers, school personnel, nutritionist(s), and/or pharmacist(s) based on applicable need to participate to effectively support achievement of improved health outcomes for the Member.

4.11.4.6. The ongoing Care Team shall be chosen or approved by the Member, or their parent(s) or guardian(s) if a minor, or their guardian(s) if an adult and applicable, whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.11.4.7. The MCO shall identify the information necessary to support improved health outcomes for the Member to be shared among all Care Team participants concerned with a Member's care to achieve safer, more effective health care delivery and improved health outcomes for the Member, including how the Provider-Delivered Care Coordination and MCO-Delivered Care Management programs interface with the Member's PCP, behavioral health providers for mental illness, SMI, SPMI, SED, I/DD, and Substance Use Disorder, and other applicable specialist Providers and existing community resources and supports. The MCO shall communicate this information, with the Member or their parent(s)' or guardian(s)' consent in compliance with state and federal laws and regulations.

4.11.4.8. [Amendment #1:] The MCO shall maintain a Care Plan for the Required Priority Population Members and shall work in collaboration with the Member's Care Team ~~to identify responsibilities for the Member's Care Plan which is optimally maintained by the PCP, in collaboration with the Care Team participants~~ within thirty (30) calendar days of the completed Comprehensive Assessment to develop a Care Plan in accordance with [42 CFR 438.208].~~, for each Priority Population Member identified through a Comprehensive Assessment or other means as in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)]~~

4.11.4.8.1 The MCO shall ensure that each Provider furnishing services to Members maintains and shares Member health records in accordance with professional standards. [42 CFR 438.208(b)(5)]

4.11.4.8.2 The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with

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confidentiality requirements in 45 CFR 160 and 164, this Agreement, and all other applicable laws and regulations. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164]

4.11.4.8.3 The MCO shall develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.

4.11.4.8.4 The MCO shall contribute to the Member's Care Plan as follows:

4.11.4.8.4.1. At least quarterly;

4.11.4.8.4.2. When a Member's circumstances or needs change significantly;

4.11.4.8.4.3. At the Member's request;

4.11.4.8.4.4. When a re-assessment occurs; and

4.11.4.8.4.5. Upon the Department's request.

4.11.4.8.5 The MCO shall submit coordinating Care Plan processes to the Department for review as part of the Readiness Review process and annually thereafter.

4.11.4.9. The MCO shall track the Member's progress through routine Care Team conferences, the frequency to be determined by the MCO based on the Member's level of need.

4.11.4.10. The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the Care Team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring. Policies and procedures for discharge shall include a Member notification process.

4.11.4.11. For Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.11.5. **MCO Care Managers**

4.11.5.1. The MCO shall formally designate a Care Manager that is primarily responsible for MCO-Delivered Care Management for each Required Priority Population Member, including regular contact with the Member's PCP who is

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responsible for Provider-Delivered Care Coordination as defined in this Agreement.

4.11.5.2. The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.11.5.3. Care Managers shall have qualifications and competency in the following areas:

4.11.5.3.1 All aspects of person-centered needs assessments and Care Planning;

4.11.5.3.2 Motivational interviewing and self-management;

4.11.5.3.3 Trauma-informed care;

4.11.5.3.4 Cultural and linguistic competency;

4.11.5.3.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and

4.11.5.3.6 Adverse childhood experiences and trauma.

4.11.5.4. Care Managers shall be trained in the following:

4.11.5.4.1 Disease self-management;

4.11.5.4.2 Person-centered needs assessment and Care Planning including coordination of care needs;

4.11.5.4.3 Integrated and coordinated physical and behavioral health, including as they intersect with and are served within the State's Community Mental Health system, Substance Use Disorder system, and Children's Behavioral Health system;

4.11.5.4.4 The State's Behavioral Health Crisis Response system and available resources (for Care Managers with assigned Members with behavioral health needs);

4.11.5.4.5 Cultural and linguistic competency;

4.11.5.4.6 Family support; and

4.11.5.4.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.

4.11.5.5. 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.

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4.11.5.6. The MCO shall provide real-time, high-touch, Care Management for Required Priority Populations and consistent follow up with Providers and Members to assure that Members are making progress with their Care Plans.

4.11.5.7. The MCO shall design an effective Care Management structure for the Required Priority Population Members.

4.11.5.7.1 At a minimum by the measurement period ending June 30, 2026 (SFY 2026), the MCO shall have no less than fifty percent (50%) of each Required Priority Population in MCO-Delivered Care Management.

4.11.5.8. The MCO shall, as described in Section 4.11.6 (Transitional Care Management), demonstrate that it has active access to an Admission, Discharge, Transfer (ADT) data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital or DRF in real-time or near real-time.

4.11.5.8.1 The MCO shall ensure that ADT data from applicable hospitals be made available to the Member's PCP, behavioral health Providers, Care Team, and applicable community-based agencies within twelve (12) hours of the admission, discharge, or transfer.

4.11.6. **Transitional Care Management**

4.11.6.1. For all Members, the MCO shall be responsible, in collaboration with the Member's Care Team, as applicable, which may include the Member's PCP, behavioral health provider(s), specialist(s), targeted case managers, children's behavioral health system service coordinators, Critical Time Intervention coaches, Supportive Housing case managers, and transitional case managers, school personnel as needed, pharmacists, and others as appropriate, for managing transitions of care for all Members moving from one (1) clinical setting to another, including step-up or step-down treatment programs for Members in need of continued mental health and Substance Use Disorder services, to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

4.11.6.2. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management for all Members, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

4.11.6.3. The MCO shall develop policies and procedures for the Department's review, as part of Readiness Review and annually thereafter, which describe how transitions of care between settings shall be effectively managed including data systems that trigger notification that a Member is in transition.

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4.11.6.4. The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(12)]

4.11.6.5. The MCO shall have a documented process to, at a minimum:

4.11.6.5.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.11.6.5.2 Support continuity of care for Members when they move from home to foster care placement; foster care to independent living; return from foster care placement to community; change in legal status from foster care to adoption; or when the Member moves from one level of care to another within the State's behavioral health system for Community Mental Health, Substance Use Disorders, or children's behavioral health;

4.11.6.5.3 [Amendment #1:] Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's Care Plan when a Member of the Required Priority Population is hospitalized;

4.11.6.5.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.12.21 (Agreements for New Hampshire State-Owned Hospital Agreement(s) and Other State Determined IMDs for Mental Illness), and upon discharge from an ED due to a mental illness or substance use disorder; and

4.11.6.5.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.11.6.6. The MCO shall have an established process, inclusive of but not limited to use of the Department's event notification system and closed-loop referral solution, if available, to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs.

4.11.6.6.1 [Amendment #1:] The MCO shall interface with the Department's closed loop referral solution to support Members. The integration shall transfer information and data as necessary to facilitate Member referrals to participating closed loop referral providers.

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4.11.6.7. The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.11.6.8. The MCO shall demonstrate, at a minimum, it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real-time or near real-time.

4.11.6.9. The MCO shall ensure that ADT data from applicable hospitals be made available to PCPs, and behavioral health Providers within twelve (12) hours of the admission, discharge, or transfer.

4.11.6.10. The MCO shall ensure that Transitional Care Management includes, at a minimum:

4.11.6.10.1 Care Management or other services to ensure the Member's Care Plan continues;

4.11.6.10.2 Facilitating clinical hand-offs;

4.11.6.10.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

4.11.6.10.4 Communicating with the Member's PCP about discharge plans and any changes to the Care Plan;

4.11.6.10.5 Conducting medication reconciliation within forty-eight (48) business hours of discharge;

4.11.6.10.6 Ensuring that a Care Manager is assigned to manage the transition, and that the Care Manager collaborates with the Member's applicable Community Mental Health system, Substance Use Disorder system, or Children's Behavioral Health system providers to support the Member's effective transition and continuous access to needed services throughout the transitional period;

4.11.6.10.7 Follow-up by the assigned Care Manager, or otherwise designated member of the Member's care management team, within forty-eight (48) business hours of discharge of the Member;

4.11.6.10.8 Determining when a follow up visit should be conducted in a Member's home;

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4.11.6.10.9 Supporting Members to keep outpatient appointments; and

4.11.6.10.10 [Amendment #1:] A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care within 24 hours of enrollment with the MCO~~who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered~~.

4.11.6.11. The MCO shall assist with coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information.

4.11.6.12. The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.11.6.12.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.11.6.12.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge);

4.11.6.12.3 The hospital's evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.11.6.12.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented.

4.11.7. **Provider-Delivered Care Coordination and Integration with Social Services and Community Care**

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4.11.7.1. The MCO shall implement and provide administrative support of a Provider-Delivered Care Coordination Program that includes reimbursement and other incentives to enable Participating Providers to coordinate health-related and community support services for Members.

4.11.7.2. The MCO shall provide program administrative support that includes, at a minimum:

4.11.7.2.1 Secure transmission of data and other information to Providers about their attributed Members' service utilization and care coordination needs;

4.11.7.2.2 Provider assistance with securing:

4.11.7.2.2.1. Health-related services and community support services, including but not limited to housing, that can improve health and family well-being, including assistance filling out and submitting applications; and

4.11.7.2.2.2. Access to medical-legal partnership for legal issues adversely affecting health, subject to the availability and capacity of a medical-legal assistance Provider.

4.11.7.3. Provider education and training, including:

4.11.7.3.1.1. How to access information about community support services, and housing for Members; and

4.11.7.3.1.2. How to facilitate Member closed-loop referrals utilizing the Department's event notification system and closed-loop referral solution, if available, or another closed-loop referral solution.

4.11.7.3.2 [Amendment #1:] Incentivizing the Provider's use of closed-loop referrals for effective care coordination and reporting on related incentives in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.11.7.4. The MCO shall assist Providers to actively link Members with other State, local, and community programs that may provide or assist Members with health and social services including, but not limited to [42 CFR 438.208(b)(2)(iv)]:

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4.11.7.4.1 Juvenile Justice and Adult Community Corrections;

4.11.7.4.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

4.11.7.4.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.11.7.4.4 Public Health Agencies;

4.11.7.4.5 Schools;

4.11.7.4.6 The court system;

4.11.7.4.7 ServiceLink Resource Network;

4.11.7.4.8 2-1-1 NH;

4.11.7.4.9 Housing; and

4.11.7.4.10 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.11.7.5. The MCO shall report on the number of referrals for social services and community care provided to Required Priority Population Members by Member type, consistent with the format and content requirements in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12. Behavioral Health

4.12.1 General Coordination Requirements

4.12.1.1. This section describes the delivery and coordination of Behavioral Health Services and supports for mental health, Serious Mental Illness, Substance Use Disorders, and Serious Emotional Disturbances, delivered to children, youth and transition-aged youth/young adults, and adults.

4.12.1.2. The MCO shall ensure Behavioral Health Services are delivered in a manner that is both clinically and developmentally appropriate, and that considers the Member, parents, caregivers, and other networks of support the Member may rely upon.

4.12.1.3. The delivery of service shall be Member-centered and align with the principles of system of care, recovery, and resiliency.

4.12.1.4. The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal laws and regulations.

4.12.1.5. The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services, as authorized under the State's Medicaid State Plans and in accordance with the applicable NH Administrative

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Rules identified in this Agreement specific to Behavioral Health Services; ensuring continuity and coordination of care between covered physical health and Behavioral Health Services Providers; and requiring collaboration between physical health and Behavioral Health Providers.

4.12.1.6. The continuum of Behavioral Health Services shall include the following categories of Providers approved by the Department for providing one or more types of services under the State Medicaid Plan, certain Administrative Rules, and under contracts with the Department when necessary to ensure Member access to higher levels of care for Serious Mental Illness, Substance Use Disorder, Serious Emotional Disturbance, and I/DD:

4.12.1.6.1 **Mental Health Services**, including but not limited to psychotherapy, psychological evaluation and testing, authorized in the Medicaid State Plan under Attachment 3.1-A for Medical, Remedial Care and Services. These services shall be provided by appropriately licensed and certified Providers who are not providing the service on behalf of or under agreement with a Community Mental Health Program (also known as Community Mental Health Center) or a Community Mental Health Provider. The MCO shall not authorize payment of these services under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members who are currently eligible for that level of care under He-M 401 and which are only a covered service if provided by Community Mental Health Programs or Community Mental Health Providers.

4.12.1.6.2 **Community Mental Health Services** (CMH Services), authorized in the Medicaid State Plan under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members with current He-M 401 eligibility and which are provided by:

4.12.1.6.2.1. **Community Mental Health Programs** (CMH Programs), also known as Community Mental Health Centers (CMHC) that are currently approved by the Department pursuant to He-M 403; there are ten such programs in NH; or by

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4.12.1.6.2.2. **Community Mental Health Providers** (CMH Providers) that have been previously approved by the Commissioner of the Department of Health and Human Services to provide Community Mental Health Services identified in He-M 426.07-He-M 426.17 for which they have received approval to provide pursuant to He-M 426.04 and remain in compliance with the requirements specified in He-M 426.04.

4.12.1.6.3 **Substance Use Disorder Services** authorized in accordance with the Medicaid State Plan, He-W 513, and where applicable, He-W 300 for Opioid Treatment Programs (OTP).

4.12.2 **Behavioral Health Subcontracts**

4.12.2.1. If the MCO enters into a Subcontractor relationship with a behavioral health (Mental Health, Community Mental Health or Substance Use Disorder Provider) Subcontractor to provide or manage Behavioral Health Services, the MCO shall provide a copy of the agreement between the MCO and the Subcontractor to the Department for review and approval, including but not limited to any agreements with CMH Providers as required in Section 4.12.20 (Community Mental Health Services).

4.12.2.2. Such subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

4.12.2.3. The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to all requirements and guidelines, as outlined in Section 3.10 (Subcontractors).

4.12.3 **Promotion of Integrated Care**

4.12.3.1. The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

4.12.3.2. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall include in its Behavioral Health Strategy Plan

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and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.12.4 **Approach to Behavioral Health Services**

4.12.4.1. The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA[21] and reflect a focus on Recovery and resiliency.[22]

4.12.4.2. The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s).

4.12.4.3. The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

4.12.4.4. In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.12.5 **Behavioral Health Strategy Plan and Report**

4.12.5.1. The MCO shall submit to the Department an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the initial Plan shall address but not be limited to how the MCO shall:

4.12.5.1.1 Assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare;

4.12.5.1.2 Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.12.5.1.3 Assure the promotion of Integrated Care;

4.12.5.1.4 Reduce Psychiatric Boarding described in Section 4.12.20.16 (Psychiatric Boarding);

4.12.5.1.5 Reduce Behavioral Health Readmissions described in Section 4.12.11 (Reduction in Behavioral Health Readmissions and Emergency Department Utilization);

[21] Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at https://www.samhsa.gov/nctic/trauma-interventions.
[22] Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at https://www.samhsa.gov/recovery.

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4.12.5.1.6 Reduce Behavioral Health related emergency department utilization as described in Section 4.12.11 (Reduction in Behavioral Health Readmissions and Emergency Department Utilization);

4.12.5.1.7 Support the NH 10-Year Mental Health Plan23;

4.12.5.1.8 Assure the appropriateness of psychopharmacological medication;

4.12.5.1.9 Assure access to appropriate services;

4.12.5.1.10 Implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and

4.12.5.1.11 Other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.5.2. On an annual basis and in accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which shall include an effectiveness analysis of the initial Plan's program, policies and procedures.

4.12.5.2.1 The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination (i.e., enhanced Care Coordination and Care Management to minimize inpatient readmissions, emergency department utilization, and psychiatric boarding), and collaboration for physical health and Behavioral Health Services.

4.12.6 **Collaboration with the Department**

4.12.6.1. At the discretion of the Department, the MCO shall provide mental health and Substance Use Disorder updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.6.2. To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and the Department at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

[23] New Hampshire Department of Health and Human Services, New Hampshire 10-Year Mental Health Plan (January 2019), available on July 20, 2023 at https://www.dhhs.nh.gov/programs-services/health-care/behavioral-health/10-year-mental-health-plan#:~:text=The%2010-Year%20Mental%20Health%20Plan%20is%20the%20result,health%20needs%20of%20people%20across%20their%20life%20span

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4.12.6.3. Quarterly meetings shall also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O: Quality and Oversight Reporting Requirements. Progress and data reports shall be produced and exchanged between the MCO and the Department two (2) weeks prior to each quarterly meeting.

4.12.6.3.1 At each meeting, the MCO shall update the Department on the following topics:

4.12.6.3.1.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.12.6.3.1.2. Utilization of ACT services and any waitlists for ACT services;

4.12.6.3.1.3. Current EBSE rates;

4.12.6.3.1.4. Current compliance with New Hampshire Hospital discharge performance standards;

4.12.6.3.1.5. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.12.6.3.1.6. Updates regarding services identified in Section 4.12 (Behavioral Health);

4.12.6.3.1.7. Updates on Mental Health and Substance Use Disorder PIPs; and

4.12.6.3.1.8. Other topics requested by the Department.

4.12.6.4. For all Members, the MCO shall work in collaboration with the Department and the NH Suicide Prevention Council to promote suicide prevention awareness programs, including the Zero Suicide program.

4.12.6.5. The MCO shall submit to the Department, as specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements, its implementation plan for incorporating the "Zero Suicide" program into its operations; the plan shall include, in addition to any other requirements specified in Exhibit O: Quality and Oversight Reporting Requirements related to the plan, how the MCO shall:

4.12.6.5.1 Incorporate efforts to implement standardized provider screenings and other preventative measures; and

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4.12.6.5.2 Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines and Standards).

4.12.7 **Primary Care Provider Screening for Behavioral Health Needs**

4.12.7.1. The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

4.12.7.2. At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary.

4.12.7.3. The MCO shall encourage PCPs and other Providers to use a screening tool approved by the Department, as well as other mechanisms to facilitate early identification of behavioral health needs.

4.12.7.4. The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

4.12.7.4.1 Demographic,

4.12.7.4.2 Medical,

4.12.7.4.3 Substance Use Disorder,

4.12.7.4.4 Housing,

4.12.7.4.5 Family & support services,

4.12.7.4.6 Education,

4.12.7.4.7 Employment and entitlement,

4.12.7.4.8 Legal, and

4.12.7.4.9 Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.12.7.5. The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

4.12.7.5.1 Depression screening (e.g., PHQ 2 & 9); and

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4.12.7.5.2 Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.12.8 **Referrals**

4.12.8.1. [Amendment #2:] The MCO shall ensure through its initial screening of new Members, Comprehensive Screening for Priority Population Members, ~~HRA Screening (Section 4.10.2) and~~ risk scoring and stratification, or other means at the MCO's discretion that Members with a potential need for Behavioral Health Services, particularly Required Priority Population Members as described in Section 4.11.2 (MCO-Delivered Care Management for Required Priority Populations) are identified by the MCO and appropriately and timely referred to a regionally available CCBHC or other behavioral health Providers if co-located care is not available.

4.12.8.2. [Amendment #2:] This shall include education about Behavioral Health Services, including the availability of CCBHCs, the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s).

4.12.8.3. [Amendment #2:] The MCO shall develop a referral process to be used by Participating Providers, including what information shall be exchanged and when to share this information, as well as notification to the Member's Care Manager. The referral process shall include information about regionally available CCBHCs, including warm hand-off referrals, at the time of a discharge from inpatient, institutional, or substance use disorder residential treatment.

4.12.8.4. The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know when and how to refer Members who need specialty Behavioral Health Services.

4.12.8.5. The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health needs when Integrated Care is not available.

4.12.8.6. The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider.

4.12.8.7. The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.12.9 **Prior Authorization for Behavioral Health Services**

4.12.9.1. As of September 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 517 for behavioral health drugs, including use of the universal online Prior Authorization form provided by the Department for drugs used to treat mental illness.

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4.12.9.2. The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.12.10 **Comprehensive Assessment and Care Plans for Behavioral Health Needs**

4.12.10.1. The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a Care Plan.

4.12.10.2. [Amendment #1:] For Required Priority Population Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by a~~n~~ Care Team~~integrated Provider team~~, the MCO shall maintain a Care Plan and ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and Care Plan development process as well as the ongoing provision of services.

4.12.11 **Reduction in Behavioral Health Readmissions and Emergency Department Utilization**

4.12.11.1. Within the MCO's annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O: Quality and Oversight Reporting Requirements, subject to approval by the Department, the MCO shall develop and detail its plan to reduce readmissions and emergency department utilization attributed to a Member's behavioral health. The plan shall include but is not limited to:

4.12.11.1.1 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs, and other CMH Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day, ninety (90)-day and one hundred and eighty (180)-day readmission.

4.12.11.1.2 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day readmission rates to acute care hospitals attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies

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within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.3 The MCO's approach to monitoring the thirty (30)-day, ninety (90)-day, and one hundred and eighty (180)-day repeated ED utilization rates attributed to mental illness, to review Member specific data with each of the CMH Programs, and other CMH Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.4 The MCO's approach to monitoring Members' repeated ED utilization rates within thirty (30)-days and ninety (90)-days attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce these rates.

4.12.11.1.5 The MCO's approach to ensuring Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Behavioral Health Services after discharge from inpatient or ED care due to a Behavioral Health reason, with sufficient frequency and amounts, to support the Member's progress on achieving their Behavioral Health goals.

4.12.11.1.6 For Members with readmissions to any inpatient psychiatric setting within thirty (30) days and one hundred and eighty (180) days, the MCO shall report on the CMH and related service utilization that directly proceeded readmission in accordance with Exhibit O: Quality and Oversight Reporting Requirements. This data shall be shared with the Member's CMH Program/CMH Provider, if applicable, and the Department in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.12.12 **Written Consent for Release of Behavioral Health Information**

4.12.12.1. Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider

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request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both, and primary care.

4.12.12.2. The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file.

4.12.12.3. The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.13 **Coordination Among Behavioral Health Providers**

4.12.13.1. The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.12.13.1.1 Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.12.13.1.2 Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.12.13.1.3 Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.12.13.1.4 Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

4.12.13.1.5 Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.12.14 **Member Service Line**

4.12.14.1. As further outlined in Section 4.4.10 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

4.12.14.2. The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a “warm transfer”).

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4.12.14.3. If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.12.15 **Provision of Services Required by Courts**

4.12.15.1. The MCO shall pay for all NH Medicaid State Plan services that are within the Managed Care Program including, but not limited to, assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care only when consistent with Medical Necessity for the service.

4.12.16 **Behavioral Health Member Experience of Care Survey**

4.12.16.1. The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

4.12.16.2. The survey shall be designed by the Department and the MCO's results shall be reported in accordance with Exhibit O: Quality and Oversight Reporting Requirements. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.12.17 **Behavioral Health Emergency Services**

4.12.17.1. The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services.

4.12.17.2. Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program.

4.12.17.2.1 [Amendment #1:] Intentionally left blank. ~~Mobile crisis services may be provided by CMH Programs outside of their designated CMH Region to ensure accessibility to Members in crisis 24 hours a day / 7 days a week and within the Geographic Access Standard requirement. Mobile crisis services provided outside of the applicable CMH region are also included.~~

4.12.17.2.2 CMH Program-delivered emergency services that are not delivered by mobile crisis teams, such as for use in determining whether involuntary emergency admission is required, and applying an existing client's crisis safety plan in an office setting, are also included in the meaning of emergency services, and shall be provided within the CMH Program's applicable CMH region only.

4.12.17.2.3 Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention and who have access to

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a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

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4.12.18 **Behavioral Health Training Plan**

4.12.18.1. [Amendment #2:] In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health service and accessibility capacity for Members within the state and to support the efforts of its Behavioral Health provider network to hire, retain and train qualified staff including, but not limited to, CCBHCs, CMH Programs, other Community Mental Health Providers of services covered under He-M 426, Substance Use Disorder harm reduction, treatment and recovery providers, and other providers of behavioral health services in the MCO's network that provide services under the Medicaid State Plan. The MCO shall ensure that any training provided to employees or Subcontractors of a CCBHC do not violate any specific training restrictions within the SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria, updated March 2023 and any subsequent revisions.[24]

4.12.18.2. The MCO shall coordinate its behavioral health training plan's training offerings with the Department to reduce duplication of training efforts, and shall submit the behavioral health training plan to the Department prior to program start, and annually thereafter, inclusive of the training schedule and target Provider audiences.

4.12.18.3. As part of the behavioral health training plan, the MCO shall also incorporate strategies to engage Providers in accessing the training opportunities, including explaining the benefits of participating in the training, how it may increase or improve provider competence, and how the knowledge gained will lead to improved quality of care. The MCO's approach shall include opportunities for skill-enhancement through its training opportunities and consultation, through either the MCO or other consultants with expertise in the subject of the training.

4.12.18.4. The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.12.18.4.1 Trauma Focused Cognitive Behavioral Therapy;

4.12.18.4.2 Trauma Informed Care;

4.12.18.4.3 Motivational Interviewing;

4.12.18.4.4 Interventions for Nicotine Education and Treatment;

4.12.18.4.5 Dialectical Behavioral Therapy (DBT);

4.12.18.4.6 Cognitive Behavioral Therapy;

4.12.18.4.7 Client Centered Treatment Planning;

4.12.18.4.8 Family Psychoeducation;

[24] [Amendment #2:] SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria available on November 21, 2024 at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

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4.12.18.4.9 Crisis Intervention;

4.12.18.4.10 SBIRT for PCPs;

4.12.18.4.11 Depression Screening for PCPs;

4.12.18.4.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.12.18.4.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

4.12.18.5. The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.12.18.5.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

4.12.18.5.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.12.18.5.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.12.18.5.4 Cross training to ensure that Mental Health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive Mental Health training;

4.12.18.5.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.12.18.5.6 Clinical care integration models to Participating Providers; and

4.12.18.5.7 Community-based resources to address health-related social needs.

4.12.18.6. The MCO shall offer a minimum of two (2) hours of training each Agreement year to all contracted CMH Program staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the Department's objective of reducing the number of suicides in NH.

4.12.18.7. The MCO shall provide, on at least an annual basis, training on appropriate billing practices to Participating Providers. The Department reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

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4.12.18.8. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.12.19 **Parity**

4.12.19.1. The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.12.19.2. Semi-Annual Report on Parity

4.12.19.2.1 The MCO shall complete the Department's Parity Compliance Report which shall include, at a minimum:

4.12.19.2.1.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCO pursuant to the Department's criteria;

4.12.19.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.12.19.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.12.19.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.12.19.2.1.5. Any other requirements identified in Exhibit O: Quality

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and Oversight Reporting Requirements. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.12.19.2.2 The MCO shall review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities.

4.12.19.2.3 The MCO shall annually submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

4.12.19.2.4 If the MCO determines that any administrative, clinical, or utilization practices were not in compliance with relevant requirements of the federal Mental Health Parity Law or guidance issued by State and federal entities during the calendar year, the certification shall state that not all practices were in compliance with federal Mental Health Parity Law or any guidance issued by state or federal entities and shall include a list of the practices not in compliance and the steps the MCO has taken to bring these practices into compliance.

4.12.19.2.5 A Member enrolled in any MCO may file a complaint with the Department at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance.

4.12.19.2.6 As described in Section 4.4 (Member Services), the MCO shall describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.12.19.3. Prohibition on Lifetime or Annual Dollar Limits

4.12.19.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

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4.12.19.4. Restrictions on Treatment Limitations

4.12.19.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.12.19.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.12.19.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO shall provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.12.19.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for Community Mental Health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.12.20 **Community Mental Health Services**

4.12.20.1. General Requirements

4.12.20.1.1 The MCO shall be required to enter into a Department approved capitation model of contracting with every CMH Program that is currently approved by the Department pursuant to NH Code of Administrative Rules, Chapter He-M 403, which is essential to

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supporting Member access to the full continuum of Community Mental Health Services under NH Code of Administrative Rules, Chapter He-M 426 in the MCM program. The MCOs shall utilize a Department provided standard contract for this purpose to ensure continuity of services and care across the Community Mental Health Services systems for Members.

4.12.20.1.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by the Department no later than ninety (90) calendar days after the MCM program's Agreement execution.

4.12.20.1.3 For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in September 2024.

4.12.20.1.4 The MCO shall be subject to payment requirements described in Section 4.16 (Provider Payments).

4.12.20.1.5 The MCO shall comply with key administrative functions and processes for CMH Services delivered by CMH Programs (CMHCs), which may include, but are not limited to:

4.12.20.1.5.1. Timely processing of CMH Services Member eligibility lists, which shall be provided to the MCO by the CMH Programs and shall indicate the Member's eligibility for CMH Services pursuant to the eligibility categories under NH Code of Administrative Rules, Chapter He-M 401. The MCO shall validate the eligibility lists through a process developed in collaboration with the CMH Programs and approved by the Department;

4.12.20.1.5.2. Determining whether Members are eligible for the DHHS-required CMH Services Capitation Payments to CMH Programs, or whether the CMH Program should be paid on a

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FFS basis for the service the Member received;

4.12.20.1.5.3. Providing detailed MCO data submissions to DHHS and the CMH Program for purposes of reconciling payments and performance pursuant to the MCO-CMH Program Contract, and for CMH Services provided by a CMH Provider not under subcontract with a CMH Program for the applicable service for purposes of reconciling payments and performance (e.g., 835 file);

4.12.20.1.5.4. Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs by CMH Region, as defined in NH Code of Administrative Rules, Chapter He-M 425, and with CMH Providers not under subcontract with a CMH Program, to ensure Members have access to Substance Use Disorder treatment services they may need from other providers, if not provided by the CMH Program or the CMH Provider under NH Code of Administrative Rules, Chapter He-M 426; and

4.12.20.1.5.5. Monitoring of CMH Program performance through quality metrics and oversight procedures

4.12.20.1.5.6. Ensuring compliance with this Agreement, where applicable, and all applicable State and federal laws, rules and regulations.

4.12.20.1.5.7. Overseeing, enforcing, and remedying contract disputes

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between the MCO and CMH Program.

4.12.20.1.5.8. All additional capabilities set forth by DHHS during the Readiness Review process.

4.12.20.1.6 [Amendment #2:] In the event a CMH Program is designated by the Department as a Certified Community Behavioral Health Clinic, the MCO shall enter into a different contractual relationship and payment model for the payment and delivery of the full continuum of Community Mental Health Services delivered by the agency, Mental Health Services available at lower levels of care, and applicable Substance Use Disorder services as described in Section 4.16 (Provider Payments).

4.12.20.2. MCO Agreements and Payment for Community Mental Health Services – CMH Providers

4.12.20.2.1 Consistent with 4.14, Network Requirements, the MCO shall maintain and monitor a network of CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who are eligible for such services in accordance with He-M 401.

4.12.20.2.2 The MCO shall provide for monitoring of CMH Provider performance through quality metrics and oversight procedures detailed in the MCO's provider or network agreement with each CMH Provider.

4.12.20.2.3 The MCO shall ensure that its agreements with CMH Providers meet the following requirements:

4.12.20.2.3.1. Comply with the requirements of this Agreement and all applicable State and federal laws, rules and regulations;

4.12.20.2.3.2. Define the role of the MCO versus the CMH Provider;

4.12.20.2.3.3. Include procedures for communication and coordination between the MCO and the CMH Provider, other Providers serving the same Member, CMH Programs as may be required by

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He-M 426 for CMH Provider provided services and the need to collaborate with the applicable CMH Program, and the Department;

4.12.20.2.3.4. Include provisions for data sharing on Members;

4.12.20.2.3.5. Include data reporting between the CMH Provider and the MCO and the Department; and

4.12.20.2.3.6. Include provisions for oversight, enforcement, and remedies for contract disputes.

4.12.20.2.4 The MCO shall ensure that Community Mental Health Services provided by CMH Providers are provided in accordance with the Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426.

4.12.20.2.5 This includes, but is not limited to, ensuring that Community Mental Health Services for which the CMH Provider is currently approved by the Department to provide, are appropriately provided to eligible Members.

4.12.20.2.5.1. [Amendment #2:] [Amendment #1:] Upon the termination of a Member's eligibility with the MCO, the MCO shall end date the Member's ~~CMH Program~~ behavioral health certification eligibility span in the next Behavioral Health Certification Data transmission provided to the Department.

4.12.20.2.6 For all Community Mental Health Services provided by a CMH Provider, the CMH Provider shall comply with He-M 426.04, including but not limited to, ensuring that all Members receiving CMH Services from the CMH Provider have been identified as currently eligible Members to receive CMH Services by a CMH Program, pursuant to He-M 401, and that the CMH Provider has a method for collaborative service planning and service delivery with the regional CMH Program, including joint development and approval of an Individual Service Plan for each Member.

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4.12.20.2.7 [Amendment #3:] Beginning January 1, 2026, the MCO shall provide each CMH Program with a monthly electronic 835 file for reconciling CMH program payments and services.

4.12.20.3. Community Mental Health Services Continuum

4.12.20.3.1 Eligible Members shall be offered the provisions of supports for illness self-management and recovery;

4.12.20.3.2 Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.

4.12.20.3.3 The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.12.20.3.4 As described in He-M 400, only Members who are currently eligible for Community Mental Health Services are eligible to receive Community Mental Health Services. Eligibility shall be determined by a CMH Program pursuant to He-M 401, due to a:

4.12.20.3.4.1. Severe or persistent mental illness (SPMI) for an adult;

4.12.20.3.4.2. SMI for an adult;

4.12.20.3.4.3. SPMI or SMI with low service utilization for an adult;

4.12.20.3.4.4. SED for a child; or

4.12.20.3.4.5. SED and interagency involvement for a child.

4.12.20.3.5 Any MCO quality monitoring or audits of the performance of the CMH Programs or of CMH Providers shall be available to the Department upon request.

4.12.20.3.6 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO shall meet with CMH Programs, CMH Providers, and the Department at least quarterly to coordinate data collection and ensure data sharing.

4.12.20.3.7 At a minimum, this shall include sharing of quality assurance activities conducted by the MCO and the Department and a review of quality improvement plans, data reports, Care Coordination activities, and

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outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.12.20.3.8 The MCO shall work in collaboration with the Department, CMH Programs and CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.12.20.4. Comprehensive Assessment and Care Plans

4.12.20.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of the Department administered quality service reviews for adults, that Community Mental Health Services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans.

4.12.20.4.2 [Amendment #1:] The MCO shall ensure that initial and updated Care Plans maintained by CMH Programs are based on a Comprehensive Assessment conducted and completed by a CMH Program using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

4.12.20.4.3 If the MCO, or a CMH Program acting on behalf of the MCO, elects to permit clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO shall notify and receive approval of the specific tool from the Department.

4.12.20.4.4 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by the Department within one hundred and twenty (120) calendar days of implementation by the Department of a web-based training and certification system.

4.12.20.4.5 The MCO shall require that CMH Program's certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by the Department for any newly evaluated Member and for

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an existing Member no later than at the Member's first eligibility renewal determination for CMH Services, following certification.

4.12.20.5. Assertive Community Treatment (ACT)

4.12.20.5.1 The MCO shall work in collaboration with DHHS, CMH Programs, and CMH Providers to ensure that Members identified as needing ACT services are provided ACT services pursuant to He-M 426.16, and in sufficient quantity to ensure applicable Members have appropriate access to these service.

4.12.20.5.2 In collaboration with the Department, the MCO shall support CMH Programs and CMH Providers, if applicable, to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with the Department to achieve full implementation of ACT.

4.12.20.5.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services.

4.12.20.6. Mental Health Performance Improvement Project

4.12.20.6.1 As outlined in Section 4.13.3.8 (Performance Improvement Projects), the MCO shall focus on the Department's objectives outlined in the NH MCM Quality Strategy.

4.12.20.7. Services for the Homeless

4.12.20.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

4.12.20.7.2 In its contract with CMH Programs, the MCO shall describe how it shall provide appropriate oversight of CMH Program responsibilities, including:

4.12.20.7.2.1. Identifying housing options for Members at risk of experiencing homelessness;

4.12.20.7.2.2. Assisting Members in filing applications for housing and

gathering necessary documentation;

4.12.20.7.2.3. Coordinating the provision of supportive housing; and

4.12.20.7.2.4. Coordinating housing-related services amongst CMH Programs, the MCO and NH's Housing Bridge Subsidy Program.

4.12.20.7.3 The contract with CMH Programs shall require quarterly assessments and documentation of housing status and homelessness for all Members.

4.12.20.7.4 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) within twenty-four (24) hours upon release.

4.12.20.8. Supported Employment

4.12.20.8.1 In coordination with CMH Programs and CMH Providers, if applicable, the MCO shall actively promote an Evidence Based Supported Employment (EBSE) or an Individual Placement and Support Model of Supported Employment (IPS-SE) to eligible Members, whichever is the Department approved model pursuant to He-M 426.

4.12.20.8.2 The MCO shall obtain fidelity review reports from the Department to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program and CMH Provider, if providing supported employment services.

4.12.20.8.3 In collaboration with DHHS, the MCO shall support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the applicable model's Quality Improvement Plan on file with DHHS to achieve full implementation of the model.

4.12.20.8.4 Based on data provided by the Department, the MCO shall support DHHS's goals to ensure that at least nineteen percent (19%) of adult CMH eligible Members are engaged in a Department approved supported employment model of supported employment services and that employment status is

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updated by the CMH Program and CMH Provider, if applicable on a quarterly basis.

4.12.20.8.5 The MCO shall report the Supported Employment participation rate to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements and provide updates as requested by DHHS during regular behavioral health meetings between the MCO and the Department.

4.12.20.9. Illness Management and Recovery (IMR)

4.12.20.9.1 In coordination with CMH Programs and CMH Providers, if applicable, the MCO shall actively promote the delivery of, and increased penetration rates of, Illness Management and Recovery to Members with SMI and SPMI.

4.12.20.9.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and the Department.

4.12.20.10. Dialectical Behavioral Therapy (DBT)

4.12.20.10.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder.

4.12.20.10.2 The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by the Department during regular behavioral health meetings between the MCO and DHHS.

4.12.20.11. Peer Support Services (PSS)

4.12.20.11.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of PSS provided by Peer Support Specialists who are employees of CMH Programs.

4.12.20.11.2 The MCOs, in coordination with CMH Programs, the Department and Peer Support Agencies authorized by the Department under He-M 402, shall actively promote in a variety of settings, such as New Hampshire Hospital, primary care clinics, EDs, CMH Programs, and CMH Provider sites, the delivery of peer support services provided by Peer Support Agencies under He-M 402.

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4.12.20.11.3 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and DHHS on its efforts to promote Peer Support Services delivered in CMH Program and those provided by Peer Support Agencies under He-M 402.

4.12.20.12. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

4.12.20.12.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems25 for children and youth Members experiencing anxiety, depression, trauma and conduct issues.

4.12.20.12.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.13. First Episode Psychosis

4.12.20.13.1 In coordination with CMH Programs, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis.

4.12.20.13.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.14. Child Parent Psychotherapy

4.12.20.14.1 In coordination with CMH Programs, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children.

4.12.20.14.2 The MCO shall provide updates as requested by the Department during regular behavioral health meetings between the MCO and the Department.

4.12.20.15. Changes in Healthy Behavior

4.12.20.15.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities.

4.12.20.15.2 [Amendment #1:] Efforts can encompass interventions (e.g., ~~tobacco~~nicotine cessation, "InShape") or other efforts designed to improve health.

[25] Available at: http://www.practicewise.com/portals/0/match_public/index.html.

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4.12.20.15.3 The MCO shall gather smoking status data on all Members and report to the Department in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.20.15.4 The MCO shall support CMH Programs to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.12.20.16. Psychiatric Boarding

4.12.20.16.1 The MCO shall provide assistance and support to Members, directly or through the Member's care team, to reduce the frequency and duration of the Member's wait for psychiatric services needed on an acute or crisis basis, regardless of the facility type best-suited to meet the Member's immediate care and treatment needs. The MCO's assistance shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or other State determined facility or IMDs for mental illness or Substance Use Disorder services.

4.12.20.16.2 At the request of the Department, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.12.20.16.3 The MCO shall pay no less than the rate paid by NH Medicaid FFS program for all inpatient and outpatient service categories for billable services related to psychiatric boarding.

4.12.20.16.4 The MCO's capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital or other State determined IMDs for mental illness or Substance Use Disorder services.

4.12.20.16.5 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.20.16.6 At minimum, the Plan shall address how:

4.12.20.16.6.1. The MCO identifies when its Members are in the ED awaiting psychiatric placement or in a

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hospital setting awaiting an inpatient psychiatric bed;

4.12.20.16.6.2. Policies for ensuring a prompt crisis team consultation and face-to-face evaluation;

4.12.20.16.6.3. Strategies for identifying placement options or alternatives to hospitalization; and

4.12.20.16.6.4. Coordination with the CMH Programs and CMH Providers, as applicable, serving Members.

4.12.20.16.7 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.12.20.17. Services [Amendment #2:] Certified Community Behavioral Health (CCBHC)

4.12.20.17.1 [Amendment #2:] Effective for dates of services on or after January 1, 2025, New Hampshire has been awarded a SAMHSA demonstration for CCBHCs. CCBHCs are comprehensive centers for behavioral health needs for all populations, and CCBHCs are required to serve anyone who requests care for mental health or substance use. Under the CCBHC model, CCBHCs are reimbursed through a cost based prospective payment methodology for CCBHC services.

4.12.20.17.2 [Amendment #2:] The MCO shall implement the CCBHC model in accordance with SAMHSA demonstration certification criteria and guidance specified by the Department, and shall support the CCBHCs in implementing the CCBHC model of care for Members.

4.12.20.17.3 [Amendment #2:] The MCO shall work with CCBHCs on quality improvement of required and optional CCBHC measures included in New Hampshire's demonstration. The MCO shall submit narrative

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reports describing their plan and activities supporting CCBHC quality improvement in accordance with Exhibit O: Quality and Oversight Reporting Requirements of this Agreement.

4.12.21 **Agreements for New Hampshire State-Owned Hospital Agreement(s) and Other State Determined IMDs for Mental Illness**

4.12.21.1. [Amendment #3:] The MCO shall utilize the Department's model contract for State-owned New Hampshire Hospital and ~~Hampstead Hospital~~ Covered Services.

4.12.21.2. This collaborative agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program and CMH Provider, as applicable, to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and State-Owned Hospitals and other State determined IMDs for mental illness.

4.12.21.3. The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to State-Owned Hospitals and other State determined IMDs for mental illness.

4.12.21.4. Prior to admission to State-Owned Hospitals or other State determined IMDs for mental illness, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist.

4.12.21.5. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to State-Owned Hospitals and determine whether all available less restrictive alternative services and supports are unsuitable.

4.12.22 **Discharge Planning**

4.12.22.1. The MCO shall ensure that upon discharge from a State-Owned Hospital, inpatient psychiatric facility, or other State determined IMDs for mental illness, the Member has immediate access to an appropriate living situation rather than a homeless shelter.

4.12.22.2. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

4.12.22.3. At the Department's option, the MCO shall designate an off-site liaison with privileges to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to State-Owned Hospitals or other State determined IMDs for mental illness.

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4.12.22.4. In the event the Member is attributed to a CMH Program upon their admission or discharge, the MCO's liaison shall assist and collaborate with the applicable CMH Program to expedite discharge and engagement in ongoing CMH Services provided by the CMH Program or CMH Provider, as may be applicable, which may include the Member's participation in Critical Time Intervention, Supportive Housing Services, or other Department approved evidence based practices covered as an In Lieu of Service, a 1915(i) service, or under a Department approved contract for Transitional Housing Services.

4.12.22.5. In the event the Member is not attributed to a CMH Program upon admission or discharge, the MCO's shall actively participate in State-Owned Hospital and other State determined IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

4.12.22.6. The MCO shall actively participate, and assist State-Owned Hospitals and other State determined IMDs for mental illness staff in the development of a written discharge plan within twenty-four (24) hours of admission.

4.12.22.7. [Amendment #2] The MCO shall ensure that the final ~~State-Owned Hospitals or other State determined IMDs for mental illness~~ discharge instruction sheet ~~shall~~ be provided to the Member and the Member's authorized representative prior to discharge, or the next business day after the discharge, for at least ninety-eight percent (98%) of Members discharged from State-Owned Hospitals or other State determined IMDs for mental illness.

4.12.22.8. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.12.22.9. For ACT team service recipients, the MCO shall ensure that the discharge progress note is provided to the CMH Program or CMH Provider, if applicable, within twenty-four (24) hours of Member discharge.

4.12.22.10. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.12.22.11. The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from State-Owned Hospitals and other State determined IMDs for mental illness in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.12.22.12. The performance metric shall be that one hundred percent (100%) of Members discharged shall have been attempted to be contacted within three (3) business days.

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4.12.22.12.1 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member within twenty-four (24) hours.

4.12.22.12.2 The MCO shall ensure an appointment with a CMH Program or CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member.

4.12.22.13. Such appointment shall occur within seven (7) calendar days after discharge.

4.12.22.14. Members receiving ACT team services shall be seen within twenty-four (24) hours of discharge by the applicable CMH Program or CMH Provider.

4.12.22.15. For Members discharged from psychiatric hospitalization who are not currently attributable to a CMH Program, the Member shall have an intake appointment that is scheduled to occur with the CMH Program assigned to the CMH Region in which the Member resides within seven (7) calendar days after discharge.

4.12.22.16. The MCO shall work with DHHS and the applicable CMH Program and CMH Provider to review cases of Members that New Hampshire Hospital and other State determined IMDs for mental illness have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

4.12.23 **Administrative Days and Post Stabilization Care Services**

4.12.23.1. The MCO shall perform Member in-reach activities within State-Owned Hospitals and other State determined IMDs for mental illness and other State determined IMDs for mental illness designed to accomplish transitions to the community in collaboration with the CMH Program applicable to the CMH Region to which the Member's town of residence is attributed. These activities shall include, but not be limited to:

4.12.23.1.1 The MCO's use of the Department's event notification system and closed-loop referral solution, if available, to facilitate sharing of clinical, care, transition to other levels of care, discharge planning, CMH eligibility assessment, and final discharge information;

4.12.23.1.2 The MCO's and CMH Program's meaningful and effective collaboration with applicable members of the IMD's care team assigned to the Member to ensure that the MCO and CMH Program are appropriately informed of the Member's ongoing care needs post-discharge.

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4.12.23.1.3 In the event the Member declines to consent to the CMH Program's involvement in discharge planning and the CMH Program becoming their post-discharge ongoing provider of CMH Services, the MCO shall follow this same approach to in-reach activities utilizing the Member's CMH Provider, if applicable, or other Mental Health Services provider of covered services at levels lower than CMH Services. In such cases, the MCO shall directly, or through the other CMH Provider or Mental Health services, connect, in sufficient frequency and effective duration, with the Member post-discharge to ensure the Member's access to the post-discharge services is sufficient to support the Member's continued progress toward achieving the behavioral health related goals.

4.12.24 **Substance Use Disorder**

4.12.24.1. The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including but not limited to, Chapter 420-J, Section J:15 through Section J:19 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.12.24.2. In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.12.24.3. The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.12.25 **Contracting for Substance Use Disorder**

4.12.25.1. The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.[26]

4.12.25.2. The contract between the MCO and the Substance Use Disorder programs and Participating Providers shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.10.2 (Contracts with Subcontractors).

4.12.25.3. The contract shall, at minimum, address the following:

4.12.25.3.1 The scope of services to be covered;

[26] Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html.

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4.12.25.3.2 Compliance with the requirements of this Agreement and applicable State and federal law;

4.12.25.3.3 The role of the MCO versus the Substance Use Disorder program and/or Provider;

4.12.25.3.4 Procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider;

4.12.25.3.5 Other Providers serving the same Member, and DHHS as applicable;

4.12.25.3.6 The approach to payment, including payment for MAT services;

4.12.25.3.7 Data sharing on Members;

4.12.25.3.8 Data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and

4.12.25.3.9 Oversight, enforcement, and remedies for contract disputes.

4.12.25.4. The contract shall provide for monitoring of Substance Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.12.25.5. When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the State through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract.

4.12.25.6. Intentionally left blank.

4.12.25.7. When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.12.26 **Provision of Substance Use Disorder Services**

4.12.26.1. The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513, this includes but is not limited to all of the MCO's Substance Use Disorder service providers' compliance with the Covered Services provisions in He-W 513.0 applicable to their provider type, to Opioid Treatment Programs, other Substance Use Disorder Treatment, and Recovery Services providers. This includes, but is not limited to:

4.12.26.1.1 Ensuring that the full continuum of care is appropriately provided to eligible Members including, but not limited to the provision of treatment and services that meet the Member's assessed ASAM level of care needs, and subject to the following

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additional conditions associated with certain providers of Substance Use Disorder services:

4.12.26.1.1.1. For those providers for whom the MCO is contracted with under a Department-approved directed payment model, such as Community Mental Health Programs, or a prospective payment system model, such as Certified Community Behavioral Health Clinics, the MCO's obligation to ensure the provision of the continuum of care shall be achieved through the MCO's review of services provided to Members, audits of clinical records no less than annually, and through its collaboration between those providers and the balance of the Member's care team, as appropriate;

4.12.26.1.1.2. Ensuring that eligible Members are provided with recovery support services; and

4.12.26.1.1.3. Ensuring that eligible Members are provided with coordinated care by the current treatment program provider and the provider(s) to whom the Member is being referred for ongoing treatment and services when entering or leaving a treatment program.

4.12.26.1.2 For those providers for whom the MCO is contracted with under a Department-approved directed payment model, such as Community Mental Health Programs, or a prospective payment system model, such as Certified Community Behavioral Health Clinics, the MCO's obligation to ensure the provision of coordinated care shall be achieved through the MCO's direct involvement that facilitates connection between the providers, or at minimum confirms that the connection has been made between the providers.

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4.12.26.1.3 In the event the MCO cannot ensure or otherwise confirm that the Member has been connected to subsequent treatment or other services identified as necessary for the Member, within a time period that is sufficient to support effective continuity of care, including authorization of pharmacotherapy, the MCO shall contact the Member directly to facilitate connection to such services.

4.12.26.2. The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513, through mechanisms including but not limited to claims utilization review, record audits, reauthorizations when applicable, and provider enrollment qualifications and certification audits.

4.12.26.2.1 The MCO shall conduct reviews and audits of clinical records and claims for Members receiving Substance Use Disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP), as described in separate guidance.

4.12.26.2.2 For Providers of Substance Use Disorder services that are delivered through CMH Programs under a Department approved APM, and Certified Community Behavioral Health Clinic under a Department approved PPS, this shall be limited to analysis of utilization patterns, provider and Department released quality reviews, and MCO conducted audits as required by the Department in this Agreement.

4.12.26.3. The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes, including, but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.12.26.4. The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.12.26.5. This includes, but is not limited to:

4.12.26.5.1 Ensuring that Members at-risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and

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4.12.26.5.2 Providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether a Peer Recovery Support Service (PRSS) is an aspect of an additional service provided to the Member.

4.12.26.6. The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.

4.12.26.7. The provision of services to recipients enrolled in an MCO shall not be subject to more stringent service coverage limits than specified under this Agreement or State Medicaid policies.

4.12.27 **Substance Use Disorder Clinical Evaluations and Treatment Plans**

4.12.27.1. The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

4.12.27.2. A clinical evaluation is a biopsychosocial evaluation completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.

4.12.27.3. The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013 or as revised by ASAM.

4.12.27.4. The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission.

4.12.27.5. For a Member being transferred from or otherwise referred by another Provider, the Provider shall use the clinical evaluation completed by a licensed behavioral health professional from the referring agency, which may be amended by the receiving Provider.

4.12.27.6. [Amendment #2:] The Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation (or three (3) sessions, if the Member is meeting with an outpatient treatment provider no more than once per week), that addresses problems in all ASAM ~~2013~~ domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).

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4.12.27.7. The treatment plan shall include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.12.27.8. [Amendment #2:] Treatment plans shall be updated based on any changes in any ASAM domain and at minimal intervals as described by ASAM ~~(2013)~~ for each level of care.

4.12.27.9. Treatment plan updates shall include:

4.12.27.9.1 Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.12.27.9.2 Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives, as appropriate;

4.12.27.9.3 The Provider's assessment of whether or not the Member needs to move to a different level of care based on ASAM continuing care, transfer and discharge criteria; and

4.12.27.9.4 The signature of the Member and the Provider agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.12.28 **Substance Use Disorder Performance Improvement Project**

4.12.28.1. In compliance with the requirements outlined in Section 4.13.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum, conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.12.29 **Reporting**

4.12.29.1. The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O: Quality and Oversight Reporting Requirements including, but not limited to, measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment retention, safety monitoring, and service utilization.

4.12.29.2. The MCO shall provide, in accordance with Exhibit O: Quality and Oversight Reporting Requirements, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns.

4.12.29.3. The MCO shall conduct reviews and audits of clinical records and claims for Members receiving Substance Use Disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).

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4.12.29.4. The MCO shall utilize audit tool(s) provided by or approved by DHHS, collected via one or more mediums made available or approved by DHHS, to assess the activities of Substance Use Disorder Providers and Opioid Treatment Programs (OTPs), to ensure compliance with the He-W 513 rules, He-A 304 rules, and the MCO Contract, and this Agreement. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.12.29.4.1 The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorders conducted by the MCO or on behalf of the MCO.

4.12.29.4.2 The MCO shall report on SUD Provider compliance with service provisions outlined in the SUD audit tool in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.12.29.5. [Amendment #2:] On a ~~monthly~~quarterly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members.

4.12.29.6. The MCO shall also provide annual training to Participating Providers.

4.12.30 **Services for Members Who are Homeless or At-Risk of Homelessness**

4.12.30.1. In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.12.20.7 (Services for the Homeless).

4.12.31 **Peer Recovery Support Services**

4.12.31.1. In coordination with Peer Recovery Programs and Peer Recovery Coaches, as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.12.32 **Naloxone Availability**

4.12.32.1. The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.12.33 **Prescription Drug Monitoring Program**

4.12.33.1. The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

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4.12.33.2. The Provider agreements shall require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

4.12.33.3. The MCO 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.

4.12.34 **Response After Overdose**

4.12.34.1. Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital.

4.12.34.2. Whenever a Member discharges themselves against medical advice, the MCO shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.12.34.3. Limitations on Prior Authorization Requirements

4.12.34.3.1 To the extent permitted under State and federal law, the MCO shall cover MAT.

4.12.34.3.2 Methadone received at a methadone clinic shall not require Prior Authorization.

4.12.34.3.3 Methadone used to treat pain shall require Prior Authorization.

4.12.34.3.3.1. Any Prior Authorization for office based MAT shall comply with RSA 420-J:17 and RSA 420-J:18.

4.12.34.3.4 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per treated Member.

4.12.34.3.5 In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.12.34.3.6 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.12.34.3.7 The MCO may require prior authorization for SUD treatments, excluding MAT services.

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4.12.34.3.8 The MCO shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

4.12.34.3.9 Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

4.12.34.3.10 [Amendment #2:] The MCO may require prior authorization for covered services only if the MCO has a medical clinician or licensed alcohol and drug counselor available on a 24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care, and the MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than 6 hours of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria, as ~~defined in~~ specified in Section 2.1.9.1 of this Agreement~~RSA 420-J:15, I~~.

4.12.34.3.11 The Department may grant exceptions to this provision in instances where it is necessary to prevent Fraud, Waste or Abuse.

4.12.34.3.12 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.4 (Pharmacy Clinical Policies and Prior Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.12.34.4. Opioid Prescribing Requirements

4.12.34.4.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members.

4.12.34.4.2 As required under the NH Board Administrative Rule MED 502 Opioid Prescribing, the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.12.34.4.2.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

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4.12.34.4.2.2. Random and periodic UDS; and

4.12.34.4.2.3. Utilizing written, informed consent.

4.12.34.4.3 The MCO shall ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED or more per day for longer than ninety (90) calendar days.

4.12.34.4.3.1. If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.12.34.5. Neonatal Abstinence Syndrome

4.12.34.5.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2.

4.12.34.5.2 Substance Use Disorder Care Management features shall include, but not be limited to:

4.12.34.5.2.1. Conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose).

4.12.34.5.2.2. Ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services.

4.12.34.5.2.3. Scheduling Substance Use Disorder treatment appointments and following up to

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ensure appointments are attended.

4.12.34.5.2.4. Coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies.

4.12.34.5.2.5. The MCO shall make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.12.34.5.3 The MCO shall work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed.

4.12.34.5.4 The MCO shall work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care.

4.12.34.5.4.1. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.12.34.5.5 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment protocol for infants at risk of NAS.

4.12.34.5.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.12.34.5.6.1. Opportunities for the primary care giver(s) to room-in;

4.12.34.5.6.2. Transportation and childcare for the primary care giver(s);

4.12.34.5.6.3. Priority given to non-pharmaceutical approaches

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(e.g., quiet environment, swaddling);

4.12.34.5.6.4. Education for primary care giver(s) on caring for newborns;

4.12.34.5.6.5. Coordination with social service agencies proving supports, including coordinated case meetings and appropriate developmental services for the infant;

4.12.34.5.6.6. Information on family planning options; and

4.12.34.5.6.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.12.34.5.7 The MCO shall work with the Department and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network's (NNEPQIN) standards.

4.12.34.6. Discharge Planning After Substance Use Disorder Event

4.12.34.6.1 In all cases where the MCO is notified or otherwise learns that a Member has had an ED visit or is hospitalized for an overdose or Substance Use Disorder, the MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan.

4.12.34.6.2 The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged.

4.12.34.6.3 The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.12.34.6.3.1. If a Member lacks a reasonable means of communicating with a

plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.12.34.6.4 The MCO shall ensure that any referrals necessary to connect the Member to post-discharge treatment Provider(s) are made as closed-loop referrals prior to the Member's discharge, including those that may be necessary for an ASAM evaluation.

4.12.34.6.5 The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

4.12.34.6.6 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.12.34.6.7 At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.12.34.6.8 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member within twenty-four (24) hours.

4.12.34.6.9 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.12.34.6.10 [Amendment #1:] In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been treated in an ED~~seen~~ for more than three (3) overdose events within a thirty (30) calendar day period or ~~those~~ when the ED discharged Member with a behavioral health diagnosis has~~that have had a~~

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difficulty engaging in treatment services following referral and Care Management~~Coordination~~ provided by the MCO.

4.12.34.6.11 The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.13 Quality Management

4.13.1 General Provisions

4.13.1.1. The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.13.1.2. The MCO shall work in collaboration with the Department, Members and Providers to actively improve the quality of care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement.

4.13.1.3. The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.13.1.4. The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.13.1.5. The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.13.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.13.1.5.2 Foster data-driven decision-making;

4.13.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.13.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.13.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

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4.13.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.13.2 **Health Plan Accreditation**

4.13.2.1. The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module.

4.13.2.2. If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.13.2.3. If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date.

4.13.2.4. To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.13.2.4.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify the Department of the initiation of the process to obtain NCQA Health Plan Accreditation; and

4.13.2.4.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, the MCO shall notify the Department of the date of the scheduled on-site review.

4.13.2.5. The MCO shall inform the Department of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation.

4.13.2.6. The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to the Department, including [42 CFR 438.332(a)]:

4.13.2.6.1 Accreditation status, survey type, and level (as applicable);

4.13.2.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.13.2.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1-3)]

4.13.2.7. 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

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protocols and that the Department shall consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.13.2.8. An MCO going through an NCQA renewal survey shall complete the full Accreditation review of all NCQA Accreditation Standards.

4.13.2.9. During the renewal survey, the MCO shall:

4.13.2.9.1 Request from NCQA the full review of all NCQA Accreditation Standards and cannot participate in the NCQA renewal survey option that allows attestation for certain requirements; and

4.13.2.9.2 Submit to the Department a written confirmation from NCQA stating that the renewal survey for the MCO will be for all NCQA Accreditation Standards without attestation.

4.13.3 **Quality Assessment and Performance Improvement Program**

4.13.3.1. The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.13.3.2. The MCO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to the Department for its review annually.

4.13.3.3. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the QAPI Plan shall contain at a minimum, the following elements:

4.13.3.3.1 A description of the MCO's organization-wide QAPI program structure;

4.13.3.3.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.13.3.3.2.1. Department-required PIPs;

4.13.3.3.2.2. Department-required quality performance data;

4.13.3.3.2.3. Department-required quality reports; and

4.13.3.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.13.3.3.2.5. Mechanisms to detect both underutilization and

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overutilization of services; [42 CFR 438.330(b)(3)]

4.13.3.3.2.6. 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

4.13.3.3.2.7. 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)]

4.13.3.4. The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.13.3.5. The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.13.3.5.1 Is organization-wide, with clear lines of accountability within the organization;

4.13.3.5.2 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;

4.13.3.5.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.13.3.5.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

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4.13.3.6. If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by 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 MCO's QAPI Plan submitted to the Department annually.

4.13.3.7. 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.

4.13.3.8. Performance Improvement Projects

4.13.3.8.1 The MCO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.13.3.8.2 Throughout the contract period, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

4.13.3.8.2.1. At least one (1) clinical PIP shall have a focus on the Department's objectives outlined in the NH MCM Quality Strategy;

4.13.3.8.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.12.24 (Substance Use Disorder);

4.13.3.8.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by the Department;

4.13.3.8.2.4. If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the

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seventy-fifth (75th) percentile; and

4.13.3.8.2.5. Should no quality measure have a lower than seventy-fifth (75th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.13.3.8.3 Throughout the five-year contract term, the MCO shall conduct at least one (1) non-clinical PIP, which shall be related to one (1) of the following topic areas and approved by the Department:

4.13.3.8.3.1. Addressing health-related social needs; and

4.13.3.8.3.2. Integrating physical and behavioral health.

4.13.3.8.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

4.13.3.8.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.13.3.8.5.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.13.3.8.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.13.3.8.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.13.3.8.5.4. Planning and initiation of activities for increasing or

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sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.13.3.8.6 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.

4.13.3.8.7 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO 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 MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.13.3.8.8 At the sole discretion of the Department, the PIPs may be delayed in the event of a public health emergency.

4.13.4 **Member Experience of Care Survey**

4.13.4.1. The MCO shall be responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.13.4.1.1 CAHPS Health Plan Survey 5.1H, Adult Version or later version as specified by the Department;

4.13.4.1.2 CAHPS Health Plan Survey 5.1H, Child Version with Children with Chronic Conditions Supplement or later version as specified by the Department.

4.13.4.2. Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by the Department and indicated in Exhibit O: Quality and Oversight Reporting Requirements. Supplemental questions, including the number, are subject to NCQA approval each October preceding the survey fielding timeframe.

4.13.4.3. The MCO shall obtain the Department approval of instruments prior to fielding the CAHPS surveys.

4.13.5 **Quality and Administrative Reporting Deliverables**

4.13.5.1. Required quality and administrative reporting deliverables appear in this Agreement and/or in Exhibit O: Quality and Oversight Reporting Requirements. For ease of reference, the Department shall list quality deliverables in Exhibit O: Quality and Oversight Reporting Requirements where possible. When a reporting requirement is included in the Agreement, but not Exhibit O, or vice versa, the MCO shall still fulfill the requirement. These deliverables include:

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4.13.5.1.1 Quality measures;

4.13.5.1.2 Narrative Reports;

4.13.5.1.3 Plans; and

4.13.5.1.4 Templates.

4.13.5.2. The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with the submission frequency established in 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)]:

4.13.5.2.1 Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)] to include;

4.13.5.2.1.1. CMS Child Core Set of Health Care Quality deliverables for Medicaid and CHIP, as specified by the Department;

4.13.5.2.1.2. Deliverables included in any future CMS Universal Foundation Measure list;

4.13.5.2.1.3. CMS Adult Core Set of Health Care Quality Measures deliverables for Medicaid, as specified by the Department;

4.13.5.2.1.4. Deliverables indicated by the Department as a requirement for fulfilling CMS waiver requirements; and

4.13.5.2.1.5. Deliverables indicated by the Department as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.13.5.2.2 NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA.

4.13.5.2.2.1. The MCO shall include supplemental Confidential Data in HEDIS measures identified in Exhibit O: Quality and Oversight Reporting Requirements for NCQA Accreditation and

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reporting through the Interactive Confidential Data Submission System.

4.13.5.2.2.2. The MCO shall report Member level Confidential Data for audited HEDIS measures as identified in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.2.3 All available CAHPS measures and sections and additional supplemental questions defined by the Department;

4.13.5.2.4 Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts; and

4.13.5.2.5 Select measures specified by the Department as priority measures for use in assessing and addressing local challenges to high-quality care and access;

4.13.5.3. Where the Department, NCQA, CMS or other key stakeholders require the use of electronic clinical data in deliverable calculation, the MCO shall obtain this data as stipulated in measure specifications and by the measure stewards.

4.13.5.4. If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to the Department.

4.13.5.5. 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 MCO quality measure reporting requirements shall be communicated to MCOs and documented within a format similar to Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.6. The MCO shall report all quality deliverables in accordance with Exhibit O: Quality and Oversight Reporting Requirements, regardless of whether the MCO has achieved accreditation from NCQA.

4.13.5.7. The MCO shall submit all quality deliverables in the formats and schedule in Exhibit O: Quality and Oversight Reporting Requirements or otherwise identified by the Department.

4.13.5.8. The MCO shall work with the Department to ensure their understanding of Department deliverable specifications, deliverable submission processes, and deliverable review processes. This includes, as determined by the Department:

4.13.5.8.1 The MCO shall gain access to and utilize the NH Medicaid Quality Information System, to include participation in any Department-required training deemed necessary;

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4.13.5.8.2 The MCO shall gain access to and utilize the Department SharePoint site utilized for deliverables other than measures, to include any deliverables which contain confidential data;

4.13.5.8.3 The MCO shall attend all meetings with relevant MCO subject matter experts to discuss specifications for deliverables indicated in Exhibit O: Quality and Oversight Reporting Requirements; and

4.13.5.8.4 The MCO shall communicate and distribute all specifications and templates provided by the Department for deliverables in Exhibit O: Quality and Oversight Reporting Requirements, to all MCO subject matter experts involved in the production of deliverables in Exhibit O: Quality and Oversight Reporting Requirements.

4.13.5.9. The Department shall provide the MCO, with a ninety (90) calendar day notice, any additions or modifications to the deliverables and quality deliverable specifications.

4.13.5.10. At such time as the Department provides access to Medicare Confidential Data sets to the MCO, the MCO 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 MCO shall:

4.13.5.10.1 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;

4.13.5.10.2 Include Medicare Confidential Data in the Department quality reporting; and

4.13.5.10.3 Sign Confidential Data use Agreements and submit Confidential Data management plans, as required by the Department and CMS.

4.13.5.10.4 For failure to submit required reports and quality Confidential Data to the Department, NCQA, the EQRO, and/or other Department-identified entities, the MCO shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

4.13.6 **Evaluation**

4.13.6.1. The Department shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O:

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Quality and Oversight Reporting Requirements, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.13.6.1.1 Performance on required quality measures; and

4.13.6.1.2 The MCO's QAPI Plan.

4.13.6.2. Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.13.6.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.13.6.2.2 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;

4.13.6.2.3 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;

4.13.6.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.13.6.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.13.6.3. The annual evaluation report, developed in accordance with Exhibit O: Quality and Oversight Reporting Requirements, shall be reviewed and approved by the MCO's governing body and submitted to the Department for review [42 CFR 438.330(e)(2)].

4.13.6.4. The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as for posting on the web.

4.13.6.5. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of Quality Management activity are documented and reported on a semi-annual basis to the Department and reviewed by the appropriate individuals within the organization.

4.13.7 **Accountability for Quality Improvement**

4.13.7.1. External Quality Review

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4.13.7.1.1 The MCO shall collaborate and cooperate fully with the Department's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.13.7.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

4.13.7.1.3 To facilitate this process, the MCO shall supply information, including but not limited to:

4.13.7.1.3.1. Claims data,

4.13.7.1.3.2. Medical records,

4.13.7.1.3.3. Operational process details, and

4.13.7.1.3.4. Source code used to calculate performance measures to the EQRO as specified by the Department.

4.13.7.2. Auto-Assignment Algorithm

4.13.7.2.1 As indicated in Section 4.3.4 (Auto-Assignment), the auto-assignment algorithm shall, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members.

4.13.7.2.2 The measures used to determine auto-assignment shall not be limited to alignment with the priority measures assigned to the program MCM Withhold and Incentive Program, as determined by the Department.

4.13.7.3. Quality Performance Withhold

4.13.7.3.1 As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by the Department and indicated to the MCO in periodic guidance.

4.14 Network Management

4.14.1 Network Requirements

4.14.1.1. The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.14.1.1.1 Supported by written agreements; and

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4.14.1.1.2 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)]

4.14.1.2. In developing its Participating Provider network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.14.1.3. The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1); 42 CFR 455.101; Section 1932(d)(5) of the Act].

4.14.1.4. The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.14.1.5. The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.14.1.6. 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.

4.14.1.7. The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions. [42 CFR 438.3(q)(1)]

4.14.1.8. The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(3)]

4.14.1.9. The MCO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.14.1.10. The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.14.1.11. When contracting with DME Providers, the MCO shall contract with and have in its network all qualified Willing Providers in the State.

4.14.2 **Provider Enrollment**

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4.14.2.1. The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.14.2.2. The MCO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by the Department for determination of the MCO's network adequacy.

4.14.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.14.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the MCO.

4.14.2.2.3 The MCO 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.

4.14.2.3. The MCO 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.

4.14.2.4. If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.14.2.5. The requirements in 42 CFR 438.12(a) shall not be construed to:

4.14.2.5.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.14.2.5.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.14.2.5.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1-3)]

4.14.2.6. The MCO shall ensure that Participating Providers are enrolled with the Department 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]

4.14.3 Provider Screening, Credentialing and Re-Credentialing

4.14.3.1. The Department shall screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

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4.14.3.2. The MCO 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)]

4.14.3.3. The MCO 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.

4.14.3.4. The MCO 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)]

4.14.3.5. The MCO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)]

4.14.3.6. The MCO 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.

4.14.3.7. For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.14.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with the Department;

4.14.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.14.3.7.3 Concurrently work through MCO and the Department contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.14.3.7.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.14.3.7.4.1. Authorization of out-of-network services;

4.14.3.7.4.2. Single case agreements for an individual Member; and

4.14.3.7.4.3. If agreed upon by the prospective Participating

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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.

4.14.3.8. The MCO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.14.3.8.1 [Amendment #4:] For PCPs (and mental health providers effective January 1, 2026) , within thirty (30) calendar days of receipt of clean and complete credentialing applications; RSA 420-J:4, I(h)

4.14.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications; and

4.14.3.8.3 For any Provider submitting new or missing information for its credentialing application, the MCO shall act upon the new or updated information within ten (10) business days.

4.14.3.9. The start time for the approval process begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.14.3.10. A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.14.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.14.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.14.3.11. In the event the MCO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in this section.

4.14.3.12. For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by the Department or its designee, the MCO shall be fined in accordance with Exhibit N(Liquidated Damages Matrix).

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4.14.3.13. Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.14.4 **Provider Engagement**

4.14.4.1. Provider Support Services

4.14.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

4.14.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.14.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday, and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision, except Department-approved holidays.

4.14.4.1.1.3. Ability for Providers to contact the MCO regarding contracting, billing, and service provisions;

4.14.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, health-related social needs, and quality, privacy and confidentiality of certain conditions;

4.14.4.1.1.5. Training curriculum, to be developed, in coordination with the Department that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for

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EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.14.4.1.1.6. Training on billing and required documentation;

4.14.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.14.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as described this Agreement; and

4.14.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

4.14.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.14.4.1.3 As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of Department-approved holidays. The Provider call center shall meet the following minimum standards, which may be modified by the Department as necessary:

4.14.4.1.3.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

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4.14.4.1.3.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds; and

4.14.4.1.3.3. 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).

4.14.4.1.4 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.14.4.1.5 The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.14.4.1.6 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs.

4.14.4.1.7 The Department may provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

4.14.4.1.8 The MCO 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.

4.14.5 Provider Advisory Board

4.14.5.1. The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback

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on the MCM program, and shall include representation from at least one (1) FQHC, and at least one (1) CMH Program.

4.14.5.2. The Provider Advisory Board should meet face-to-face and/or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.14.6 **Provider Contract Requirements**

4.14.6.1. General Provisions

4.14.6.1.1 The MCO's agreement with health care Providers shall:

4.14.6.1.1.1. Be in writing;

4.14.6.1.1.2. Be in compliance with applicable State and federal laws and regulations; and

4.14.6.1.1.3. Include the requirements in this Agreement.

4.14.6.1.2 The MCO shall submit all model Provider contracts to the Department for review before execution of the Provider contracts with NH Medicaid Providers.

4.14.6.1.3 The MCO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.14.6.1.4 The Department retains the right to reject or require changes to any Provider contract.

4.14.6.1.5 In all contracts with Participating Providers, the MCO 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.

4.14.6.1.6 In all contracts with Participating Providers, the MCO 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)]

4.14.6.1.7 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act

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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.

4.14.6.1.8 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.14.6.1.9 The MCO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.14.6.1.10 Within 90 days upon availability or in accordance with applicable law, the MCO shall include in Provider contracts or MCO provider office reference manual a requirement securing cooperation with the QAPI program and shall align the QAPI program to other Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.15 (Alternative Payment Models).

4.14.6.1.11 The MCO shall keep Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.13.3 (Quality Assessment and Performance Improvement Program).

4.14.6.1.12 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.15 (Alternative Payment Models).

4.14.6.1.13 The MCO may execute Participating Provider agreements and begin credentialing, 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 the Department that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120)

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day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.14.6.1.14 [Amendment #2:] The MCO shall notify the Department on a Department developed form no later than fourteen (14) calendar days in advance of the one hundred twenty (120) calendar day termination period to request the Department's assistance with NH Medicaid provider enrollment ~~which may be available for~~ pending ~~enrollment~~ applications.

4.14.6.1.15 The MCO shall notify impacted Members upon the MCO's Provider termination at the end of the one hundred twenty (120) day period.

4.14.6.1.16 The MCO shall maintain a Provider relations presence in NH, as approved by the Department.

4.14.6.1.17 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.14.6.1.17.1. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.14.6.1.17.2. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by the Department.

4.14.6.1.17.3. Provider materials shall comply with State and federal laws and the Department and NHID requirements.

4.14.6.1.17.4. The MCO 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.

4.14.6.1.17.5. Any revisions to the Provider Manual(s) and Provider training materials required by the Department shall be provided to

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the MCO within thirty (30) calendar days.

4.14.6.1.18 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and all Participating Providers, including any necessary specialty manuals (e.g., behavioral health).

4.14.6.1.18.1. The Provider Manual shall be available and easily accessible on the web and updated no less than annually.

4.14.6.1.18.2. The Provider Manual shall consist of, at a minimum:

4.14.6.1.18.2.1 A description of the MCO's enrollment and credentialing process;

4.14.6.1.18.2.2 How to access MCO Provider relations assistance;

4.14.6.1.18.2.3 A description of the MCO's medical management and Case Management programs;

4.14.6.1.18.2.4 Detail on the MCO's Prior Authorization processes;

4.14.6.1.18.2.5 A description of the Covered Services and Benefits for Members,

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including EPSDT and pharmacy;

4.14.6.1.18.2.6 A description of Emergency Services coverage;

4.14.6.1.18.2.7 Member parity;

4.14.6.1.18.2.8 The MCO Payment policies and processes; and

4.14.6.1.18.2.9 The MCO Member and Provider Grievance System.

4.14.6.1.19 The MCO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1-2)]

4.14.6.1.19.1. The MCO shall require the Provider 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)]

4.14.6.1.20 In all contracts with Participating Providers, the MCO shall require Participating Providers to remain neutral when assisting potential Members and Members with enrollment decisions.

4.14.6.1.21 The MCO shall not include any provision in a contract with a Provider that incentivizes a Provider not to

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contract, or prohibits or discourages the Provider from contracting, with any other Managed Care Organization to provide services to such other Managed Care Organization's members. [NH RSA 420-I et al]

4.14.6.2. Compliance with MCO Policies and Procedures

The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.14.6.2.1.1. The MCO's DRA policy;

4.14.6.2.1.2. The Provider Manual;

4.14.6.2.1.3. The MCO's Compliance Program;

4.14.6.2.1.4. The MCO's Grievance and Appeal Processes and Provider Appeal Processes;

4.14.6.2.1.5. Clean Claims and Prompt Payment requirements;

4.14.6.2.1.6. ADA requirements;

4.14.6.2.1.7. Clinical Practice Guidelines; and

4.14.6.2.1.8. Prior Authorization requirements.

4.14.6.2.2 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO and periodically thereafter, about the following requirements:

4.14.6.2.2.1. Member grievance and appeal processes as described in Section 4.5 (Member Grievances and Appeals), including:

4.14.6.2.2.1.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.14.6.2.2.1.2 The Member's

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right to file grievances and appeals and the requirements and timeframe for filing;

4.14.6.2.2.1.3 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)];

4.14.6.2.2.1.4 The Member's right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]; and

4.14.6.2.2.1.5 The Member's right to request continuation of benefits

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that the MCO 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)]

4.14.6.3. Requirement to Return Overpayment

4.14.6.3.1 Requirements for the Provider to comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.14.6.3.1.1. 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.

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4.14.6.4. Background Screening

4.14.6.4.1 The MCO shall require the Provider to conduct background screening of its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists.

4.14.6.4.1.1. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the MCO.

4.14.6.5. Books and Records Access

4.14.6.5.1 The selected MCO must maintain the following records during the resulting contract term where appropriate and as prescribed by the Department:

4.14.6.5.1.1. 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).

4.14.6.5.1.2. 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

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time cards, payrolls, and other records requested or required by the Department.

4.14.6.5.1.3. 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.

4.14.6.5.2 Medical records on each patient/recipient of services.

4.14.6.5.3 During the term of the resulting contract(s) and the 10-year period for retention, 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).

4.14.6.5.4 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth in this Agreement and in the MCO's Member Handbook.

4.14.6.6. Continuity of Care

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4.14.6.6.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by the Department and included in the Department's Model Member Handbook.

4.14.6.7. Anti-Gag Clause

4.14.6.7.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient:

4.14.6.7.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.14.6.7.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.14.6.7.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.14.6.7.1.4. 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. [Section 1932(b) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.14.6.7.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Member Appeal). [42 CFR 438.410(b)]

4.14.6.8. Anti-Discrimination

4.14.6.8.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or

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certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment.

4.14.6.8.2 This paragraph shall not be construed to prohibit an organization from:

4.14.6.8.2.1. Including Providers only to the extent necessary to meet the needs of the organization's Members;

4.14.6.8.2.2. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization; or

4.14.6.8.2.3. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.14.6.8.3 If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

4.14.6.8.4 In all contracts with Participating Providers, the MCO'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)]

4.14.6.9. Access and Availability

4.14.6.9.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.5 (Timely Access to Service Delivery).

4.14.6.10. Payment Models

4.14.6.10.1 The MCO shall negotiate rates with Providers in accordance with Section 4.15 (Alternative Payment Models) and Section 4.16 (Provider Payments) of this Agreement, unless otherwise specified by the Department (e.g., minimum Medicaid fee schedule rates, directed payments).

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4.14.6.10.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the PBM.

4.14.6.10.3 The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.14.6.11. Non-Exclusivity

4.14.6.11.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.14.6.12. Proof of Membership

4.14.6.12.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.14.6.13. Other Provisions

4.14.6.13.1 The MCO's Provider contract shall also contain:

4.14.6.13.1.1. All required activities and obligations of the Provider and related reporting responsibilities;

4.14.6.13.1.2. Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement; and

4.14.6.13.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.14.7 **Reporting**

4.14.7.1. The MCO 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.

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4.14.7.2. The MCO 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 MCO. [42 CFR 438.608(a)(4)]

4.14.7.3. The MCO shall notify the Department within seven (7) calendar days of any significant changes to the Participating Provider network.

4.14.7.4. As part of the notice, the MCO shall submit a Transition Plan to the Department to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.

4.14.7.5. A significant change is defined as:

4.14.7.5.1 A decrease in the total number of PCPs by more than five percent (5%);

4.14.7.5.2 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

4.14.7.5.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.14.7.5.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

4.14.7.6. The MCO shall provide to the Department and/or the Department's Subcontractors (e.g., the EQRO) 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, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.15 Alternative Payment Models

4.15.1 General

4.15.1.1. The Department is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization. The Department will define a Medicaid APM Strategy that may include supporting

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guidance, worksheets, and templates that will build upon the parameters set forth in this Agreement.

4.15.1.2. The Department will implement 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, with a focus on engaged primary and preventive care model and in a manner that is transparent to the Department, Providers, and the stakeholder community.

4.15.1.3. 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:

4.15.1.3.1 Clearly and effectively communicate the Department requirements through use of the defined categories established by HCP-LAN;

4.15.1.3.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.15.1.3.3 Provide an established framework for monitoring MCO performance on APMs.

4.15.2 Prior to and/or over the course of the Term of this Agreement, the Department shall develop the Department's Medicaid APM Strategy, which shall result in additional guidance, templates, worksheets, required provider contractual provisions and other material that elucidate the requirements to which the MCO is subject under this Agreement.

4.15.3 The MCOs shall develop APMs consistent with guidance in the Department's Medicaid APM Strategy including, but not limited to:

4.15.3.1. Incentivize primary care clinicians to engage attributed Members in Primary and Prevention Focused Model and Provider Delivered Care Coordination.

4.15.4 According to models that incentivize consistent quality outcomes as prescribed by the Department.

4.15.5 Within the guidance parameters established and issued by the Department and subject to Department approval, the MCO shall design Qualifying APMs as defined in Section 4.15.9 (Qualifying Alternative Payment Models) consistent with the Department Medicaid APM strategy and in conformance with CMS guidance.

4.15.6 The MCO shall support the Department in developing the Department's Medicaid APM Strategy through participation in regular stakeholder meetings and planning efforts, implementing required provider contractual provisions, providing all required and otherwise requested information related to APMs, sharing Confidential Data and analysis, and other activities as specified by the Department.

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4.15.7 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and the Department shall ensure that it:

4.15.7.1. 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;

4.15.7.2. Uses a common set of quality performance measures across all similarly situated Providers as directed in the Department's Medicaid APM Strategy;

4.15.7.3. Does not set the amount or frequency of the expenditures; and

4.15.7.4. Does not permit the Department to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.15.8 Required Use of Alternative Payment Models

4.15.8.1. The MCO shall ensure through its APM Implementation Plan as described in Section 4.15.10 (MCO Alternative Payment Model Implementation Plan), and confirmed through Exhibit O: Quality and Oversight Reporting Requirements, reporting that fifty percent (50%) of all Covered Services medical expenditures are in Qualifying APMs, as defined by the Department, subject to the following:

4.15.8.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have twelve (12) months to meet this requirement; and

4.15.8.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.15.8.2. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 12-month period.

4.15.8.3. The MCO shall implement the Qualifying APM models as directed by the Department in the Department's Medicaid APM Strategy including, but not limited to, directed payments with quality incentives for achieving statewide outcomes for Community Mental Health Centers and providers, total cost of care models with large providers including quality metrics incentivizing Provider-Delivered Care Coordination and Primary Care and Prevention Focused care.

4.15.8.4. For failure to meet Section 4.15.8 (Required Use of Alternative Payment Models), the Department reserves the right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N (Liquidated Damages Matrix).

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4.15.8.5. Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined Department, MCO, and Providers to achieve the purpose of the incentives.

4.15.8.6. The MCO shall be subject to incentives, at the Department's sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new Members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.15.9 **Qualifying Alternative Payment Models**

4.15.9.1. A Qualifying APM is a payment approach required and approved by the Department as consistent with the standards specified in this Section 4.15.9 (Qualifying Alternative Payment Models) and the Department's Medicaid APM Strategy.

4.15.9.2. 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.

4.15.9.3. HCP-LAN Categories 3A, 3B, 4A, 4B and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the Department's Medicaid APM Strategy.

4.15.9.4. The Department shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.15.12.3 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to the Department, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.15.9.5. Under no circumstances shall the Department consider as a Qualifying APM a payment methodology that takes cost of care into account without also paying providers for achieving quality outcomes consistent with those set forth in the Department's Medicaid APM Strategy. Providers participating in Qualifying APMs shall have the opportunity to share in cost savings through a formula that is no less than 50/50 split in favor of the participating providers and shall incorporate a opportunity to share up to an additional #% of total payments paid through the APM as provider incentive payments for achieving quality outcomes as part of the Qualifying APM.

4.15.9.6. At the sole discretion of the Department, additional APMs specifically required by and defined as an APM by the Department shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.15.9.7. Standards for Large Providers and Provider Systems

4.15.9.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the Department's Medicaid APM Strategy, including incentives for the Primary Care and

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Prevention Focused Model inclusive of Provider Delivered Care Coordination.

4.15.9.8. Treatment of Payments to Community Mental Health Programs

4.15.9.8.1 The CMH Program payment model prescribed by DHHS in Section 4.12.20 (Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.15.9.9. Alternative Payment Models for Substance Use Disorder Treatment

4.15.9.9.1 The MCO shall include in its APM Implementation Plan:

4.15.9.9.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to birthing parents and infants born affected by exposure to substance use; and

4.15.9.9.1.2. At least one (1) APM that promotes greater use of Medication for treatment of substance use disorders through a bundled payment as set forth in the Department's Medicaid APM Strategy.

4.15.9.10. Accommodations for Other Providers

4.15.9.10.1 The MCO may develop Qualifying APM models appropriate for other primary care Providers, and Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy to incentivize engaged primary and preventive care.

4.15.9.10.2 For example, the MCO 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.

4.15.9.11. Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.15.9.11.1 The MCO shall incentivize Providers participating in the Qualifying APMs by paying incentives for achieving quality outcomes established by the Department in the Department's Medicaid APM Strategy.

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4.15.9.11.2 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden, incentivize primary and preventive care and promote the integration of Behavioral Health.

4.15.9.11.3 The MCO may incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Advanced APM."

4.15.10 **MCO Alternative Payment Model Implementation Plan**

4.15.10.1. The MCO shall submit to the Department for review and approval an APM Implementation Plan in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

4.15.10.2. 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.

4.15.10.3. Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by the Department in Exhibit O: Quality and Oversight Reporting Requirements and/or through additional guidance.

4.15.10.4. Alternative Payment Model Transparency

4.15.10.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and evaluating Participating Provider performance in the APM, as described in Section 4.15.11 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how the MCO intends to achieve Provider to Member engagement in Primary Care and Prevention model and Provider-Delivered Care Coordination including health and wellness assessments and integrated behavioral health care through the APM.

4.15.10.5. Intentionally Left Blank

4.15.10.6. Provider Engagement and Support

4.15.10.6.1 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

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strategies the MCO shall use to assess and advance such readiness over time.

4.15.10.6.2 The APM Implementation Plan shall outline in detail what strategies the MCO 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. The MCO shall ensure regular and consistent engagement with Providers around APMs on at least a quarterly basis through direct or virtual visits by the MCOs key staff responsible for the MCOs provider relations and APM Implementation Plan.

4.15.10.6.3 The MCO 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.

4.15.10.6.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.15.10.7. Implementation Approach

4.15.10.7.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.15.10.7.1.1. In advance of the Program Start Date;

4.15.10.7.1.2. During the first year of this Agreement; and

4.15.10.7.1.3. Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

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4.15.10.7.2 The APM Implementation Plan shall include the MCO'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 MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.15.10.7.3 The MCO 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.

4.15.10.7.4 For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM and notifies the Providers with clarity throughout the APM period of their progress against incentive payment formulas at least quarterly.

4.15.10.7.5 In addition, the MCO shall provide Member and Provider level Confidential Data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.15.10.7.6 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 MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.15.10.7.7 The information provided shall be consistent with the requirements outlined under Section 4.15.11 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.15.11 Alternative Payment Model Transparency and Reporting Requirements

4.15.12 Transparency

4.15.12.1. In the MCO APM Implementation Plan, the MCO shall provide to the Department for each APM, as applicable, the following information at a minimum:

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4.15.12.1.1 The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.15.12.1.2 The methodology for incentivizing Providers engage Members in Provider-Delivered Care Coordination and Primary Care and Prevention, including, but not limited to, health and wellness screenings;

4.15.12.1.3 The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, and the attachment points for cost targets, and risk adjustment methodology;

4.15.12.1.4 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

4.15.12.1.5 The frequency at which the MCO shall regularly report Confidential Data related to APM performance to Providers on cost, quality, evaluation of progress towards incentive payments and the information that shall be included in each report.

4.15.12.2. 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 MCO requests and receives the Department approval for specified information not to be made available.

4.15.12.3. Standardized Assessment of Alternative Payment Model Usage

4.15.12.3.1 Additional information may be required by the Department's Medicaid APM Strategy and 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 MCO requests and receives the Department approval for specified information not to be made available.

4.15.12.4. Standardized Assessment of Alternative Payment Model Usage

4.15.12.4.1 The MCO 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.

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4.15.12.4.2 Thereafter, the MCO 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.

4.15.12.4.3 If the MCO reaches an agreement with the Department that its implementation of the required APM model(s) may be delayed, the MCO shall comply with all terms set forth by the Department for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.15.12.5. Additional Reporting on Alternative Payment Model Outcomes

4.15.12.5.1 The MCO 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.

4.15.13 Development Period for MCO Implementation

4.15.13.1. Consistent with the requirements for new MCOs, outlined in Section 4.15.9 (Qualifying Alternative Payment Models) above, the Department acknowledges that MCOs may require time to advance their MCO Implementation Plan. The Department shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.15.14 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.15.14.1. The MCO's APM Implementation Plan shall adopt the quantitative, measurable clinical outcomes required by the Department in the Department's Medicaid APM Strategy and additional outcomes the MCO seeks to improve through its APM and QAPI initiative(s).

4.15.14.2. At a minimum, the MCO shall address the priorities identified in this Section 4.15.4 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by the Department in the Department's Medicaid APM Strategy.

4.15.14.3. State Priorities in RSA 126-AA

4.15.14.3.1 The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:

4.15.14.3.1.1. [Amendment #4:] Appropriate use of emergency departments relative to low acuity non-emergent visits Opportunities to

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decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

4.15.14.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.15.14.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of births of infants born affected by exposure to substance use;

4.15.14.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission;

4.15.14.3.1.5. Opportunities to incentivize, through payments to Providers and Member incentives, Provider engagement with attributed Members in primary and preventive care, health needs assessments, Provider-Directed Care Coordination at a frequency and in a manner set forth in the Department's Medicaid APM Strategy;

4.15.14.3.1.6. [Amendment #4:] Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing preferred drug ~~generic~~ prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing Polypharmacy, as described in

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Section 4.2.6 (Medication Management);

4.15.14.3.1.7. Opportunities to enhance access to and the effectiveness of medication to treat Substance Use Disorder treatment; and

4.15.14.3.1.8. Opportunities to address health-related social needs (further addressed in Section 4.11.7 (Provider-Delivered Care Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.15.14.4. Emerging State Medicaid and Public Health Priorities

4.15.14.4.1 The MCO shall address priorities identified by the Department in the Medicaid APM Strategy or related guidance.

4.15.14.4.2 If the Department adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of it APM Implementation Plan.

4.15.15 **Physician Incentive Plans**

4.15.15.1. The MCO shall submit all Physician Incentive Plans to the Department for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.15.15.2. The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by the Department.

4.15.15.3. [Amendment #2:] Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," "the Department," and "Members," respectively and 42 CFR 438.3(i). These include that:

4.15.15.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or

indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.15.15.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.15.15.3.3 [Amendment #4:] [Amendment #2:] Effective July 1, 2026, all of MCO's Physician Incentive Plans to a Provider must adhere to the following requirements: (i) have a defined performance period that can be tied to the applicable MLR reporting periods ~~the performance period of the physician incentive contract with the Provider must align with the MLR reporting period;~~ (ii) the Provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCO; (iii) the physician incentive contract with the Provider must include a specific dollar amount or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including an ~~and~~ expected date of payment for meeting the required metrics; and (iv) the physician incentive contracts with the Provider must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e. defined and linked to an applicable MLR reporting period or periods). [42 438.608(e); 42 CFR 438.3(i)(3) and (4)]

4.15.15.3.4 [Amendment #2:] Effective July 1, 2026, for each of MCO's Physician Incentive Plans with a Provider, MCO must (i) maintain documentation of (a) the methodology used by MCO to determine Member attribution, and sharing information on Member attribution with Provider; (b) the mechanism(s) used to determine cost benchmarks, and Provider's performance against those cost benchmarks, including cost targets and calculations, the attachment point of cost targets, and risk adjustment calculations;

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and (c) MCO's evaluation and assessment of Provider's performance against quality benchmarks; (ii) not rely on Provider attestations as the basis for Provider's meeting performance and quality metrics for incentive amounts included in the MLR calculation; and (iii) provide copies of each Physician Incentive Plan with Providers and supporting documentation upon request of the Department and at a frequency determined by the Department.

4.15.15.4. The MCO 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) Physician Incentive Plans, as described in Exhibit O: Quality and Oversight Reporting Requirements.

4.15.15.5. Annual Physician Incentive Plan reports shall provide assurance satisfactory to the Department that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any Department request to understand the terms of Provider payment arrangements.

4.15.15.6. The MCO shall provide to Members upon request the following information:

4.15.15.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.15.15.6.2 The type of incentive arrangement; and

4.15.15.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.16 Provider Payments

4.16.1 General Requirements

4.16.1.1. The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.16.1.2. The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) under the following circumstances: [Section 1903 of the Social Security Act]:

4.16.1.2.1 When furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

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4.16.1.2.2 When furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX 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);

4.16.1.2.3 When 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 or if the individual or entity has not completed their federally required enrollment revalidation with the Department;

4.16.1.2.4 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; and [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]

4.16.1.2.5 When furnished by a Participating Provider or entity that is not enrolled with NH Medicaid or whose Medicaid participation has been terminated by the Department.

4.16.1.3. No payment shall be made to a Participating Provider other than by the MCO for services covered under the Agreement between the Department and the MCO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR 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]

4.16.1.4. The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by the Department, the MCO shall contact the Department and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.16.1.4.1 [Amendment #1:] For Providers and Covered Services eligible for minimum fee schedule reimbursement as described in Section 4.16.2 (Provider Payment Requirements) of this Agreement or under terms of a Provider's contractual terms with the MCO, u~~U~~pon a

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change to the State's Medicaid FFS fee schedule, the MCO shall implement a code or rate change in the MCO's claims adjudication system to effectuate the updated State's Medicaid FFS fee schedule in the MCO's referenced system. The MCO shall complete implementation of the updated State's Medicaid fee schedule as soon as possible and no later than the latter of:

4.16.1.4.1.1. The effective date of the State's Medicaid FFS fee schedule change; or

4.16.1.4.1.2. Sixty (60) calendar days from the date the Department notifies the MCO of such State Medicaid FFS fee schedule change.

4.16.1.4.2 To the extent the MCO's effective date of implementing a change in the State's Medicaid FFS fee schedule is later than the effective date of the State's Medicaid FFS fee schedule change, the MCO shall retroactively reimburse Provider claims based on the State's effective date of the then current State Medicaid FFS fee schedule.

4.16.1.5. The MCO shall permit Providers up to one hundred and twenty (120) calendar days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.

4.16.1.6. Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.16.1.6.1 A Member providing the wrong Medicaid identification number;

4.16.1.6.2 Natural disasters; or

4.16.1.6.3 Failed information technology systems.

4.16.1.7. The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.16.1.8. Within the first one hundred and eighty (180) calendar days of the Program Start Date, the Department has discretion to direct MCOs to extend the one hundred and twenty (120) calendar days on case by case basis.

4.16.1.9. The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

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4.16.1.10. The MCO 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)]

4.16.1.11. [Amendment #4:] The MCO shall implement and maintain arrangements or procedures for prompt reporting within 30 calendar days of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste or Abuse, to the Department. [42 CFR 438.608(a)(2)]

4.16.1.12. The MCO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider Preventable Conditions.

4.16.1.12.1 The MCO shall not make payments to a Provider for a Provider Preventable Condition that meets the following criteria:

4.16.1.12.1.1. Is identified in the Medicaid State Plan;

4.16.1.12.1.2. 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;

4.16.1.12.1.3. Has a negative consequence for the Member;

4.16.1.12.1.4. Is auditable; and

4.16.1.12.1.5. 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)]

4.16.1.12.2 The MCO 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

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CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.16.1.12.3 Any directed payments proposed to CMS shall be described in the program's actuarial certification for the rating period.

4.16.1.12.3.1. [Amendment #3:] State directed payments payable at minimum fee schedules are excluded for Covered Services in which the Member has active Medicare or other insurance at the time the service was rendered.

4.16.1.12.4 The MCO shall not impose an administrative fee, cost or any other charge upon any form of payment (e.g., electronic or paper checks) to Providers rendering Covered Services to Members.

4.16.1.12.5 The term "minimum fee schedule" in this Section 4.16 (Provider Payments), shall infer the minimum Provider reimbursement amount(s) permissible under the terms of this Agreement.

4.16.2 **Provider Payment Requirements**

4.16.2.1. Ambulance, Stretcher, and Wheelchair Van Providers

4.16.2.1.1 [Amendment #1:] The MCO shall reimburse directed payments to ambulance, stretcher, and wheelchair van Providers for Covered Services, as follows:

4.16.2.1.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), the MCO shall reimburse Participating Providers for all ambulance, stretcher, and wheelchair van Covered Services at no less than NH Medicaid fee schedule rates.

4.16.2.2. Birthing Centers

4.16.2.2.1 [Amendment #1:] The MCO shall reimburse eligible Participating Provider hospital-based and free-

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standing birthing centers directed payments for Covered Services, as follows:~~For the rating period ending August 31, 2024 (subject to future rating period extension(s)), the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.~~

4.16.2.2.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services in accordance with rates that are no less than NH Medicaid FFS rates.

4.16.2.3. [Amendment #1:] Community Mental Health Programs (CMH Programs)~~Centers (CMHCs)~~

4.16.2.3.1 [Amendment #1:] The MCO shall enter into an agreement, defined and approved by the Department, with CMH Programs~~CMHCs Community Mental Health Centers~~ effective September 1, 2024.

4.16.2.3.1.1. [Amendment #3:] [Amendment #2:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s) and reporting required by the Department), the MCO shall reimburse each CMH Program, including CCBHCs that are a CMH Program provider, in accordance with the ~~directed~~ payment minimum monthly directed payment capitated amounts for identified Covered Services provided by a CMH Program~~The agreement shall be defined by the Department and~~

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~~requires a monthly per member rate payment to the Community Mental Health Centers consistent with the directed payment and incentives (subject to CMS approval, as appropriate)~~ for the treatment of Members with Severe/Persistent Mental Illness, Severe Mental Illness, Low Utilizers, Serious Emotionally Disturbed Children (SED and SED-I) in accordance with guidance issued by the Department, and as described in the program's actuarial certification for the rating period. ~~as directed by the Department and detailed in the Department's Medicaid APM Strategy.~~

4.16.2.3.1.1.1 [Amendment #1:] The monthly capitated amount for each CMH Program shall be based on a per Member per month amount, and such per Member per month rate shall be equal to the per Member per month rate determined by the Department for each CMH Program, for each of the following categories (i)

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Severe/Persistent Mental Illness, (ii) Severe Mental Illness, (iii) Low Utilizers, and (iv) Serious Emotionally Disturbed Children (SED and SED-I).

4.16.2.3.1.1.2 [Amendment #1:] The MCO shall determine the aggregate monthly capitated amount to be paid to each CMH Program based on the CMH Program's monthly Member eligibility count in accordance with Department guidance.

4.16.2.3.1.1.3 [Amendment #1:] In the event the MCO is unable to make the monthly capitated payments to

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any CMH Program in accordance with Section 4.16.2.3.2, and in the amount as directed by the Department, the MCO shall make monthly interim payments to the CMH Program in an amount determined by the Department. When such interim payment is invoked, the MCO shall be subject to liquidated damages as specified in Exhibit N (Liquidated Damages Matrix).

4.16.2.3.1.1.4 [Amendment #1:] All such monthly interim payments to a CMH Program shall be reconciled by the MCO against the amount the

MCO would have reimbursed each CMH Program receiving an interim payment if the MCO reimbursed the CMH Program in accordance with Sections 4.16.2.3.1.1 through 4.16.2.3.1.1.2.

4.16.2.3.1.2. [Amendment #1:] A separate and distinct ~~This~~ directed payment shall include an incentive pool to pay CMHCs for achieving quality outcomes established by the Department consistent with the statewide mental health improvement goals and objectives.

4.16.2.3.1.2.1 [Amendment #3:] [Amendment #1:] For the period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the

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Department), directed payment amounts determined by the Department shall comprise a fee schedule adjustment or uniform dollar increase for ~~assertive community treatment~~, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, timely access to services following application for CMH Program services, and step down community residence beds for individuals dually diagnosed with serious mental illness

and developmental disabilities, within the CMH Program class of network providers, as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.3.1.3. The MCO shall not amend, modify, or change the MCO-CMHC agreement effective September 1, 2024 unless MCO obtains prior written approval from the Department.

4.16.2.3.2 [Amendment #1:] The MCO shall reimburse eligible Community Mental Health Programs (CMHPs) directed payments for covered Community Residential Services ~~for Covered Services~~, as follows:

4.16.2.3.2.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30 ~~20~~, 2026 ~~2025~~ ~~ending August 31, 2024~~ (subject to future rating period extension(s) and other changes, and reporting required by the Department), directed payment remittance shall comprise a minimum fee schedule at least at the Medicaid FFS rates established by the Department ~~for Community Residential Services~~.

4.16.2.3.3 [Amendment #3:] [Amendment #2:] ~~Effective January 1, 2025~~ For the rating period July 1, 2025 ~~September~~

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~~1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s) and other changes) for the CCBHC's CMH Program eligible population, the MCO shall reimburse each qualifying CCBHC a directed payment at a NH Medicaid center-specific monthly sub-capitation amount, and at least at NH Medicaid fee schedule rates for all other Members who receive CCBHC services in accordance with separate guidance.

4.16.2.3.3.1. [Amendment #3:] [Amendment #2:] ~~Beginning with the January 2025 payment~~, The MCO shall reimburse each CCBHC ~~its January 2025 CCBHC~~ their center specific monthly subcapitation amount as set forth in the program's actuarial certification based on the effective date of each CCBHC's designation. Failure to do so will be grounds for liquidated damages in accordance with Exhibit N (Liquidated Damages Matrix).

4.16.2.4. [Amendment #1:] Qualifying New Hampshire Hospitals ~~Critical Access Hospitals (CAHs)~~

4.16.2.4.1 [Amendment #1:] Critical Access Hospitals (CAHs): The MCO shall remit directed payment(s) to CAHs in accordance with separate guidance, as follows:

4.16.2.4.1.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of MCO's Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services

utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State directed payment preprint approved by CMS. [~~Amendment #1:] For the rating period September 1, 2024 through June 30, 2025current rating period ending August 31, 2024 (subject to future rating period extension(s), and other changes, and reporting required by the Department), directed payment amounts determined by the Department shall comprise a uniform rate increase for all inpatient discharges and outpatient qualified encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.~~

4.16.2.4.1.2. [Amendment #3:] [Amendment #1:] Intentionally left blank ~~For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse qualifying facilities for inpatient services at no less than NH Medicaid fee schedule rates.~~

4.16.2.4.2 [Amendment #3:] [Amendment #1:] Prospective Payment System (PPS) Hospitals: The MCO shall remit directed payment(s) to in-state general acute care PPS hospitals ~~CAHs~~ in accordance with separate guidance, as follows:

4.16.2.4.2.1. [Amendment #3:] [Amendment #2:] [Amendment #1:] For the rating period July 1, 2025

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through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State directed payment preprint approved by CMS. ~~For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse in-state critical access hospitals and prospective payment systems hospitals specified by the Departmentqualifying facilities at uniform price increase directed payment amounts for inpatient discharges and outpatient encounters as determined by the Department, andshall comprise a uniform rate increase for encounters as approved by CMS., including any alternate CMS-approved directed payment methodology. Qualified Such uniform price increase directed payments are tied to actual inpatient and outpatient hospital services reported by in-state critical access hospitals and prospective payment~~

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~~system hospitalsqualifying Providers~~.

4.16.2.4.2.2. [Amendment #3:] [Amendment #2:] [Amendment #1:] Intentionally left blank For the rating period September 1, 2024 through June 30, 2025 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse qualifying facilities in-state and out-of-state hospitals for inpatient services (except for out-of-state hospital services secured with a single case agreement) at no less than NH Medicaid fee schedule rates.

4.16.2.4.3 [Amendment #3:] Non-Profit Academic Medical Centers with Level I Adult Trauma Center and Level II Pediatric Trauma Center Designations: The MCO shall remit uniform price increase directed payments to in-state non-profit academic medical centers with a Level I adult trauma center and a level II pediatric trauma center in accordance with separate guidance, as follows:

4.16.2.4.3.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), and other changes, and reporting required by the Department), the MCO shall reimburse qualifying hospitals a uniform price increase directed payment for all inpatient discharges and qualifying outpatient encounters of MCO's Members as approved by CMS. Such uniform price increase directed payments are based on actual hospital inpatient and outpatient services utilization during the applicable rating period in accordance with 42 CFR 438.6 and the State

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directed payment preprint approved by CMS.

4.16.2.4.4 [Amendment #3:] Inpatient Hospital Minimum Fee Schedule:

4.16.2.4.4.1. [Amendment #3:] For the rating period July 1, 2025 through June 30, 2026 (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse in-state and out-of-state hospital Providers for inpatient services (except for out-of-state hospital services secured with a single case agreement) at no less than NH Medicaid fee schedule rates.

4.16.2.5. DME Providers

4.16.2.5.1 [Amendment #1:] The MCO shall reimburse DME Providers directed payments for DME and DME related supplies and services, as follows:

4.16.2.5.1.1. [Amendment #3:] [Amendment #1:] For the current rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.6. Hospice Payment Rates

4.16.2.6.1 The Medicaid hospice payment rates shall be calculated based on the annual hospice rates established under Medicare. These rates are authorized by 1814(i)(1)(ii) of the Social Security Act

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which also provides for an annual increase in payment rates for hospice care services.

4.16.2.7. Indian Health Care Providers

4.16.2.7.1 The MCO 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 MCO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i-ii)]

4.16.2.7.2 For contracts involving IHCPs, the MCO 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)]

4.16.2.7.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the MCO shall be paid an amount equal to the amount the MCO 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 MCO pays and what the IIHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.16.2.7.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.16.2.7.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the Department shall make a supplemental payment to

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the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.16.2.8. Private Duty Nursing Services

4.16.2.8.1 [Amendment #1:] The MCO shall remit directed payments for private duty nursing Covered Services, as follows: ~~reimburse private duty nursing agencies for private duty nursing services at least at the FFS rates established by the Department.~~

4.16.2.8.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO shall reimburse covered private duty nursing services in accordance with rates that are no less than NH Medicaid FFS rates.

4.16.2.9. Substance Use Disorder Providers

4.16.2.9.1 [Amendment #1:] The MCO shall reimburse eligible Substance Use Disorder Providers, including Peer Recovery Programs, directed payments for Covered Services, as follows: ~~in accordance with rates that are no less than the equivalent DHHS FFS rates on the applicable Substance Use Disorder Provider fee schedule.~~

4.16.2.9.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s)), other changes, and reporting required by the Department), the MCO shall reimburse Substance Use Disorder Providers, including Peer Recovery Programs, in accordance with rates that are no less than NH Medicaid FFS rates.

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4.16.2.10. Transition Housing Program

4.16.2.10.1 [Amendment #1:] The MCO shall reimburse eligible Transition Housing Programs directed payments for Covered Sservices, as follows: ~~at least at the FFS rates established by the Department~~.

4.16.2.10.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), directed payment remittance shall comprise a minimum fee schedule at least at the Medicaid FFS rates established by the Department.

4.16.2.11. Designated Receiving Facility (DRF)

4.16.2.11.1 [Amendment #1:] The MCO shall reimburse eligible Medicaid enrolled DRFs as designated by the Commissioner directed payments, as follows:

4.16.2.11.1.1. [Amendment #3:] [Amendment #1:] For the current rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025 ending August 31, 2024~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 NH Medicaid State Plan DRG fee schedule payment amounts.

4.16.2.11.2 For administrative days and post stabilization care services delivered under the inpatient and outpatient service categories, the MCO shall pay State-Owned Hospitals and other State determined IMDs for mental illness at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate

community-based care and services. Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in State-Owned Hospitals and other State determined IMDs for mental illness.

4.16.2.12. Neuropsychological Testing Services

4.16.2.12.1 [Amendment #1:] The MCO shall reimburse eligible Medicaid-enrolled Providers directed payments for covered neuropsychological testing services, as follows:

4.16.2.12.1.1. [Amendment #3:] [Amendment #1:] For the ~~current~~ rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025 ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes, and reporting required by the Department), directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.16.2.13. [Amendment #1:] State-Owned Inpatient Psychiatric Hospitals

4.16.2.13.1 [Amendment #3:] [Amendment #1:] The MCO shall reimburse state-owned New Hampshire Hospital ~~and Hampstead Hospital~~ directed payments as described below:

4.16.2.13.1.1. [Amendment #3:] [Amendment #1:] For inpatient psychiatric services, the MCO shall reimburse state-owned New Hampshire Hospital ~~and Hampstead Hospital~~, as follows:

4.16.2.13.1.1.1 [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025

~~September 1, 2024~~ through June 30, 2026 ~~2025 current rating period ending August 31, 2024~~ (subject to future rating period extension(s) other changes, and reporting required by the Department), the state-owned facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.16.2.13.2 [Amendment #3:] [Amendment #1:] ~~For psychiatric professional services, t~~The MCO shall reimburse psychiatric—professional services delivered at the state-owned New Hampshire Hospital ~~and Hampstead Hospital~~ directed payments, as follows:

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4.16.2.13.2.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~,~~current rating period ending August 31, 2024~~ (subject to future rating period extension(s), ~~and~~ other changes~~)~~, and reporting required by the Department), directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for eligible psychiatric professional services delivered in the state-owned facilities established and periodically adjusted by CMS.

4.16.2.14. [Amendment #1:] ~~4.16.3.3~~ Qualifying Children's Hospitals

4.16.2.14.1 The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:

4.16.2.14.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s), other changes, and reporting required by the Department), the directed payment amounts determined by the Department shall comprise a uniform rate increase for each eligible inpatient and outpatient hospital service encounter.

4.16.2.15. [Amendment #1:] Certain Primary Care Services

4.16.2.15.1 [Amendment #1:] The MCO shall reimburse eligible primary care Providers directed payments for certain primary care services identified by the Department and specified in separate guidance.

4.16.2.15.1.1. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to

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future rating period extension(s) and reporting required by the Department), the MCO shall reimburse eligible Providers, including Federally Qualified Health Centers (FQHC), FQHC Look-Alike clinics, Rural Health Clinics/Hospital-Based/Non-Hospital Based and other eligible providers, for certain services at rates that are no less than NH Medicaid FFS rates.

4.16.2.16. [Amendment #1:] Federally Qualified Health Centers and Rural Health Clinics

4.16.2.16.1 [Amendment #1:] FQHCs and RHCs shall be paid at minimum the encounter rate paid by Department at the time of service and shall also be paid for Department -specified CPT codes outside of the encounter rates.

4.16.2.16.2 [Amendment #1:] The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.16.2.16.3 [Amendment #1:] The MCO shall reimburse Providers for only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

4.16.2.16.3.1. [Amendment #1:] Subsequent to the first encounter, the Member suffers an illness or injury with a different diagnosis; or

4.16.2.16.3.2. [Amendment #1:] Subsequent to the first encounter, the Member received a different treatment at a different time of the same day.

4.16.3 [Amendment #1:] Intentionally left blank~~The MCO shall reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent New Hampshire Medicaid FFS rates~~.

4.17 Readiness Requirements Prior to Operations

4.17.1 General Requirements

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4.17.1.1. Prior to the Program Start Date, the MCO 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).

4.17.1.2. The Readiness Review requirements shall apply to all MCOs regardless of whether they have previously contracted with the Department. [42 CFR 438.66(d)(1)(ii)]

4.17.1.3. The MCO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by the Department.

4.17.1.4. The Readiness Review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.17.1.5. In order to demonstrate its readiness, the MCO shall cooperate in the Readiness Review conducted by the Department.

4.17.1.6. If the MCO 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).

4.17.1.7. The MCO shall participate in all the Department trainings in preparation for implementation of the Agreement.

4.17.2 **Emergency Response Plan/Disaster Recovery Plan**

4.17.2.1. The MCO 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.

4.17.2.2. The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.17.2.2.1 Staff and Provider training;

4.17.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.17.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.17.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.17.2.2.5 Plans to ensure continuity of services to Providers and Members;

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4.17.2.2.6 How the MCO shall coordinate with and support the Department and the other MCOs; and

4.17.2.2.7 How the plan shall be tested, updated and maintained.

4.17.2.3. On an annual basis, or as otherwise specified in Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.18 Managed Care Information System

4.18.1 System Functionality

4.18.1.1. The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.18.1.1.1 Complies with the Exhibit Q: IT Requirements Workbook;

4.18.1.1.2 Collects, analyzes, integrates, and reports Confidential Data; [42 CFR 438.242(a)];

4.18.1.1.3 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.18.1.1.4 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)];

4.18.1.1.5 Is capable of meeting the requirements listed throughout this Agreement; and

4.18.1.1.6 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.

4.18.1.1.7 Demonstrates to the Department's satisfaction prior to Program Start its readiness and ability to meet all State IT and information security standards as further set forth in Exhibit K: DHHS Information Security Requirements.

4.18.1.2. The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

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4.18.1.2.1 Collection and maintenance of sufficient Member Encounter Confidential Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.18.1.2.2 Submission of Member Encounter Confidential Data to the Department at the frequency and level of detail specified by CMS and by the Department;

4.18.1.2.3 Submission of all Member Encounter Confidential Data that NH is required to report to CMS; and

4.18.1.2.4 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]

4.18.1.3. All Subcontractors shall meet the same standards, as described in this Section 4.18 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.18.1.4. The MCO MCIS shall include, but not be limited to:

4.18.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.18.1.4.2 Management of Provider Enrollment and Credentialing;

4.18.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.18.1.4.4 Eligibility Verification;

4.18.1.4.5 Encounter Data;

4.18.1.4.6 Reference File Updates;

4.18.1.4.7 Service Authorization Tracking, Support and Management;

4.18.1.4.8 Third Party Coverage and Cost Avoidance Management;

4.18.1.4.9 Financial Transactions Management and Reporting;

4.18.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);

4.18.1.4.11 Reporting (Ah hoc and Pre-Defined/Scheduled and On-Demand);

4.18.1.4.12 Call Center Management;

4.18.1.4.13 Claims Adjudication;

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4.18.1.4.14 Claims Payments; and

4.18.1.4.15 QOS metrics.

4.18.1.5. Specific functionality related to the above shall include, but is not limited to, the following:

4.18.1.5.1 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;

4.18.1.5.2 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;

4.18.1.5.3 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;

4.18.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;

4.18.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

4.18.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all Department reporting and encounter requirements;

4.18.1.5.7 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;

4.18.1.5.8 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

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4.18.1.5.9 The Encounter Confidential Data system shall have a mechanism in place to receive, process, and store the required data.

4.18.1.6. The MCO 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.

4.18.1.7. The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect 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)]

4.18.1.8. MCIS capability shall include, but not be limited to the following:

4.18.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.18.1.8.2 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;

4.18.1.8.3 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 MCO system(s) and to perform appropriate reporting and operational activities;

4.18.1.8.4 The Department access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals; and

4.18.1.8.5 Documented instructions and user manuals for each component.

4.18.1.9. Managed Care Information System Up-Time

4.18.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by the Department. The maintenance period shall not exceed four (4) consecutive hours without prior the Department approval.

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4.18.1.9.2 MCO 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.

4.18.2 **Information System Confidential Data Transfer**

4.18.2.1. Effective communication between the MCO and the Department requires secure, accurate, complete, and auditable transfer of Confidential Data to/from the MCO and the Department Confidential Data management information systems. Elements of Confidential Data transfer requirements between the MCO and the Department management information systems shall include, but not be limited to:

4.18.2.1.1 Department read access to all MCM 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;

4.18.2.1.2 Exchanges of Confidential Data between the MCO and the Department in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the Confidential Data source and target;

4.18.2.1.3 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;

4.18.2.1.4 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;

4.18.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.18.2.1.6 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,

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automate the ETL processes, and provide for source to target or source to specification mappings;

4.18.2.1.7 Mechanisms to support the electronic reconciliation of all Confidential Data extracts to source tables to validate the integrity of Confidential Data extracts; and

4.18.2.1.8 A given day's Confidential Data transmissions, as specified in this Section 4.19.2 (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.

4.18.2.2. The MCO shall designate a single point of contact to coordinate Confidential Data transfer issues with the Department.

4.18.2.3. The Department shall provide for a Centralized Electronic Repository, providing for secure access to authorized MCO and the Department staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.18.2.4. Confidential Data transmissions from the Department to the MCO shall include, but not be limited to the following:

4.18.2.4.1 Provider Extract (Daily);

4.18.2.4.2 Recipient Eligibility Extract (Daily);

4.18.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.18.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.18.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.18.2.4.6 Claims History (Bi-Weekly); and

4.18.2.4.7 Capitation Payment Confidential Data (Monthly).

4.18.2.5. Confidential Data transmissions from the MCO to the Department shall include, but not be limited to the following:

4.18.2.5.1 Member Demographic changes (Daily);

4.18.2.5.2 Member Primary Care Physician Selection (Daily);

4.18.2.5.3 MCO Provider Network Confidential Data (Daily);

4.18.2.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.18.2.5.5 Member Encounter Confidential Data including paid, denied, adjustment transactions by pay period (Weekly);

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4.18.2.5.6 Financial Transaction Confidential Data (Weekly); and

4.18.2.5.7 Updates to Third Party Coverage Confidential Data (Weekly).

4.18.2.5.8 Behavioral Health Certification Data (Monthly).

4.18.2.6. The MCO shall provide Department staff with access to timely and complete Confidential Data and shall meet the following requirements:

4.18.2.6.1 All exchanges of Confidential Data between the MCO and the Department shall be in a format, file record layout, and scheduled as prescribed by the Department;

4.18.2.6.2 The MCO 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;

4.18.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide the Department with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between the Department and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.18.2.6.4 The MCO shall provide support to the Department and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data; and

4.18.2.6.5 The MCO shall be responsible for correcting Confidential Data extract errors in a timeline set forth by the Department as outlined within this Agreement.

4.18.3 **Systems Operation and Support**

4.18.3.1. Systems operations and support shall include, but not be limited to:

4.18.3.1.1 On-call procedures and contacts;

4.18.3.1.2 Job scheduling and failure notification documentation;

4.18.3.1.3 Secure (encrypted) Confidential Data transmission and storage methodology;

4.18.3.1.4 Interface acknowledgements and error reporting;

4.18.3.1.5 Technical issue escalation procedures;

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4.18.3.1.6 Business and Member notification;

4.18.3.1.7 Change control management;

4.18.3.1.8 Assistance with UAT and implementation coordination;

4.18.3.1.9 Documented Confidential Data interface specifications – Confidential Data imported and extracts exported including database mapping specifications;

4.18.3.1.10 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.18.3.1.11 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.

4.18.3.2. The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.18.3.2.1 Network diagram that fully defines the topology of the MCO's network;

4.18.3.2.2 DHHS/MCO connectivity;

4.18.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and

4.18.3.2.4 Web access for the Department staff, Providers and recipients.

4.18.3.3. The MCO shall utilize either its own or the State's open model Electronic Visit (EVV) system as prescribed by the Department in separate guidance for all Medicaid personal care services and home health Covered Services that require an in-home visit by a Provider in accordance with Section 12006(a) of the 21st Century Cures Act. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver, as applicable.

4.18.4 **Ownership and Access to Systems and Data**

4.18.4.1. The MCO shall make available to the Department and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.18.4.2. Confidential Data accumulated, as part of the MCM program shall remain the property of the State.

4.18.4.3. The MCO shall provide the Department with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports,

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as well as the ability to respond promptly to ad-hoc requests to support the Department Confidential Data and information needs.

4.18.4.4. The Department acknowledges the MCO'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 MCO's systems.

4.18.5 **Records Retention**

4.18.5.1. The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.18.5.2. 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.

4.18.5.3. 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.

4.18.5.4. 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.

4.18.5.5. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

4.18.6 **Web Access and Use by Providers and Members**

4.18.6.1. The MCIS shall include web access for use by and support to Participating Providers and Members.

4.18.6.2. The services shall be provided at no cost to the Participating Provider or Members.

4.18.6.3. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.18.6.4. The MCO 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:

4.18.6.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.18.6.4.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

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4.18.6.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

4.18.6.4.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.18.6.5. Providers shall have access to drug information;

4.18.6.5.1 The website shall provide an encrypted e-mail link to the MCO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.18.6.5.2 The website shall provide a link to the State's Medicaid website;

4.18.6.5.3 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.18.6.5.4 Access shall be limited to verified users.

4.18.6.6. The MCO 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.

4.18.6.7. System Support Performance Standards shall include:

4.18.6.7.1 Email inquiries–one (1) business day response;

4.18.6.7.2 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;

4.18.6.7.3 Routine maintenance;

4.18.6.7.4 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

4.18.6.7.5 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, MCO shall redirect user to site to install appropriate browser.

4.18.7 Contingency Plans and Quality Assurance

4.18.7.1. Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

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4.18.7.2. The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.18.7.3. 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 MCO and the Department.

4.18.7.4. 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 MCO.

4.18.7.5. [Amendment #1:] Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with Exhibit KG: ~~IT~~ Technical Requirements Workbook and security and access rights granted to users.

4.18.7.6. In accordance with Exhibit O: Quality and Oversight Reporting Requirements, the MCO shall submit the following documents and corresponding checklists for the Departments Information Security review:

4.18.7.6.1 Disaster Recovery Plan;

4.18.7.6.2 Business Continuity Plan;

4.18.7.6.3 Security Plan;

4.18.7.6.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for Department review:

4.18.7.6.4.1. Risk Management Plan;

4.18.7.6.4.2. Systems Quality Assurance Plan; and

4.18.7.6.4.3. Confirmation of 5010 compliance and Companion Guides.

4.18.7.7. 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 MCO's change management process:

4.18.7.7.1 The complete system shall have proper configuration management/change management in place (to be reviewed by the Department).

4.18.7.7.2 The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

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4.18.7.7.3 The MCO 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 MCO and the Department and/or the fiscal agent.

4.18.7.7.4 The Department retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.18.7.7.5 The MCO 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.

4.18.7.7.6 The MCO shall provide the Department with official points of contact for MCIS issues on an ongoing basis.

4.18.7.7.7 The MCO shall ensure appropriate testing is done for all system changes. MCO 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.

4.18.7.7.8 The MCO 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.

4.18.7.8. The Department, or its agent, may conduct a Systems readiness review to validate the MCO's ability to meet the MCIS requirements.

4.18.7.9. 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 MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from the Department.

4.18.7.10. 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.

4.18.7.11. If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by the Department, either correct such deficiency or

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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.

4.18.7.12. QOS metrics shall include:

4.18.7.12.1 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:

4.18.7.12.1.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring;

4.18.7.12.1.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system; and

4.18.7.12.1.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.18.7.12.2 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.

4.18.7.12.3 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.

4.18.8 Interoperability and Patient Access

4.18.8.1. The MCO 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

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Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data.

4.18.8.1.1. The MCO 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:

4.18.8.1.2 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)];

4.18.8.1.2.1. [Amendment #4:] Effective July 1, 2026, implement and maintain a Patient Access Application Programming Interface (API) required in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the MCO, and:

4.18.8.1.2.1.1 [Amendment #4:] Include all encounter data, including encounter data from any network providers compensated by the MCO based on capitation payments and adjudicated claims and encounter data from any Subcontractors

4.18.8.1.2.1.2 [Amendment #4:]

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Exclude covered outpatient drugs as defined in section 1927(k)(2) of the Act.

4.18.8.1.2.1.3 [Amendment #4:] Report metrics specified in 42 CFR 431.60(f) (total members whose data are transferred to an API and total members whose data were transferred more than once). [42 CFR 438.242(b)(5)]

4.18.8.1.3 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

4.18.8.1.4 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)].

4.18.8.2. The MCO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60, and include(s):

4.18.8.2.1 Confidential Data concerning adjudicated claims, including claims Confidential Data for payment decisions that may be appealed, were appealed, or

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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;

4.18.8.2.2 Encounter data, including encounter Confidential Data from any network providers the MCO 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

4.18.8.2.3 Clinical data, including laboratory results, if the MCO maintains any such data, no later than one (1) business day after the Confidential Data is received by the State.

4.18.8.2.4 Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)]

4.18.8.3. [Amendment #2:] The MCO shall implement and maintain a publicly accessible standards-based API 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), as well as Section 5123(c) of the Consolidated Appropriations Act, 2023, amended section 2107(e)(1)(G) of the Act to apply section 1902(a)(83) of the Act to States for CHIP in effect no later than July 1, 2025. [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)~~]~~; SMD 18-007]

4.19 Claims Quality Assurance Standards

4.19.1 Claims Payment Standards

4.19.1.1. For purposes of this Section 4.20 (Claims Quality Assurance Standards), the Department has adopted the claims definitions established by CMS. [42 CFR 447.25(b)]

4.19.1.1.1 “Clean Claim” as defined in Section 2.1 (Definitions); and

4.19.1.1.2 “Incomplete Claim” means a claim that is rejected for the purpose of obtaining additional information from the Provider.

4.19.1.1.3 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is

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received in the MCO's mailroom by its date stamp or the date an electronic claim is submitted.

4.19.1.2. 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]

4.19.1.3. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.19.1.4. The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt, or receipt of additional information.

4.19.1.5. The MCO 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].

4.19.1.6. The MCO 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. Upon request, the MCO shall make available Provider support staff to review Incomplete Claims, and support and educate Providers in the submission of Clean Claims.

4.19.2 **Claims Quality Assurance Program**

4.19.2.1. The MCO shall verify the accuracy and timeliness of Confidential Data reported by Providers, including Confidential Data from Participating Providers the MCO is compensating through a capitated payment arrangement.

4.19.2.2. The MCO shall screen the Confidential Data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

4.19.2.3. The MCO 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.

4.19.2.4. As indicated in Exhibit O: 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.

4.19.2.5. The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to the Department.

4.19.3 **Claims Financial Accuracy**

4.19.3.1. 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.

4.19.3.2. The MCO shall pay ninety-nine percent (99%) of dollars accurately.

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4.19.4 Claims Payment Accuracy

4.19.4.1. 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.

4.19.4.2. The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.19.5 Claims Processing Accuracy

4.19.5.1. 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.

4.19.5.2. The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

5.1.1.1. As indicated throughout this Agreement, the Department shall document ongoing MCO reporting requirements through Exhibit O: Quality and Oversight Reporting Requirements and additional specifications provided by the Department.

5.1.1.2. The MCO shall provide data, reports, and plans in accordance with Exhibit O: Quality and Oversight Reporting Requirements, this Agreement, and any additional specifications provided by the Department.

5.1.1.3. The MCO shall comply with all NHID rules for Confidential Data reporting, including those related to the NH CHIS, NH code of Administrative Rule, Chapter Ins 4000. Failure to submit timely, accurate, and/or complete files to the NH CHIS shall be subject to liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.1.4. For all historical files submitted under NH Code of Administrative Rule, Chapter Ins 4000 after the submission start date, if DHHS or NHID notifies the MCO of not meeting compliance, the MCO shall remediate all related files within forty-five (45) calendar days after such notice.

5.1.1.5. If the MCO fails to comply with either error resolution timeline, DHHS shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.1.6. The MCO shall make all collected Confidential Data available to the Department upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.7. The MCO shall collect Confidential Data on Member and Provider characteristics as specified by the Department and on services furnished to

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Members through a MCIS system or other methods as may be specified by the Department. [42 CFR 438.242(b)(2)]

5.1.1.8. The MCO shall ensure that Confidential Data received from Providers are accurate and complete by:

5.1.1.8.1 Verifying the accuracy and timeliness of reported data;

5.1.1.8.2 Screening the Confidential Data for completeness, logic, and consistency; and

5.1.1.8.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.9. The Department shall at a minimum collect, and the MCO shall provide, 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 MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.9.1 Enrollment and disenrollment data;

5.1.1.9.2 Member grievance and appeal logs;

5.1.1.9.3 Medical management committee reports and minutes;

5.1.1.9.4 Audited financial and encounter data;

5.1.1.9.5 The MLR summary reports;

5.1.1.9.6 Customer service performance data;

5.1.1.9.7 Performance on required quality measures; and

5.1.1.9.8 The MCO's QAPI Plan.

5.1.1.10. The MCO 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:

5.1.1.10.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.10.2 A description of the innovative programs the MCO has developed and the outcomes associated with those programs;

5.1.1.10.3 A description of how the MCO is addressing health-related social needs and the outcomes associated with MCO-implemented interventions;

5.1.1.10.4 A description of how the MCO is improving health outcomes in the State; and

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5.1.1.10.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.11. 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 MCO policies and procedures and/or other administrative documentation.

5.1.1.11.1 The Department shall deem materials as pass or fail following the Department review.

5.1.1.11.2 The MCO shall complete and submit a Department-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.11.3 The Department may require modifications to MCO policies and procedures or other documentation at any time as determined by the Department.

5.1.1.12. The MCO shall submit all required data to meet CMS standards for submission to the Transformed Medicaid Statistical Information System.

5.1.2 **Requirements for Waiver Programs**

5.1.2.1. The MCO 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 MCO. These include but are not limited to:

5.1.2.1.1 Substance Use Disorder and Severe Mental Illness Institute for Mental Disease 1115 waiver;

5.1.2.1.2 Mandatory managed care 1915b waiver; and

5.1.2.1.3 Granite Advantage 1115 waiver.

5.1.3 **Encounter Data**

5.1.3.1. The MCO 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 MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO meets all Department reporting requirements.

5.1.3.3. The MCO shall submit to the Department for review, during the Readiness Review process, its policies and procedures that detail the MCO's encounter

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process. The MCO-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 MCO's encounter process;

5.1.3.3.2 Encounter specific source to target mapping detail that traces the inbound provider claim, in the applicable format, to the MCO's encounter system data storage location. The MCO shall provide the level of detail for each transmission of the source data that is used to create the encounter files that are submitted to DHHS;

5.1.3.3.3 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.4 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4. The MCO shall, as requested by the Department, submit updates to and revise upon request its policies and procedures that detail the MCO'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 MCO shall submit Encounter Confidential Data to the EQRO and the Department or its designated vendor upon the Department's request 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 MCO'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 MCO shall ensure that encounter records are consistent with the Department requirements and all applicable State and federal laws.

5.1.3.9. MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.9.1 The MCO shall submit claim and claim line denial reason codes in the level of detail and format as specified by the Department.

5.1.3.10. The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

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5.1.3.11. The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12. The MCO shall have a computer and 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 MCO 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 MCO 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 MCO'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 Health Care Common Procedure Coding System (HCPCS);

5.1.3.16.2 CPT codes;

5.1.3.16.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.16.4 National Drug Codes which is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.16.5 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);

5.1.3.16.6 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;

5.1.3.16.7 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC

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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

5.1.3.16.8 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 MCO 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 (P – Professional and I - Institutional) or at the discretion of the Department the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NH file format, and other proprietary file layouts as defined by the Department.

5.1.3.18. All MCO encounters shall be submitted with MCO 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. [Amendment #3:] The paid amount (or FFS equivalent) submitted with Encounter Confidential Data shall be the final net amount paid to Providers by the MCO or any Subcontractor and, not limited to the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities.

5.1.3.19.1 [Amendment #3:] For example, the MCO paid amount submitted with pharmacy claim Encounter Confidential Data shall be the amount ultimately paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The submission of only the amount paid to the MCO's PBM is not acceptable

5.1.3.20. [Amendment #3:] Intentionally left blank ~~This requirement means that, for example for pharmacy claims, the MCO paid amount shall include the amount paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The amount paid to the MCO's PBM is not acceptable.~~

5.1.3.21. The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.22. The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.23. The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Confidential Data for all Covered Services.

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5.1.3.24. The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.25. The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.25.1 Batch and Online Transaction Types are as follows:

5.1.3.25.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.25.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.25.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction;

5.1.3.25.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction;

5.1.3.25.1.5. ASC X12N 837P Professional Claim/Encounter Transaction;

5.1.3.25.1.6. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.25.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.25.2 Online transaction types are as follows:

5.1.3.25.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

5.1.3.25.2.2. ASC X12N 276 Claims Status Inquiry;

5.1.3.25.2.3. ASC X12N 277 Claims Status Response;

5.1.3.25.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and

5.1.3.25.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.26. 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.

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5.1.3.27. The MCO shall submit summary reporting in accordance with Exhibit O: Quality and Oversight Reporting Requirements, to be used to validate Encounter submissions.

5.1.3.28. The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by the Department for reporting Encounters and fee- for-service claims.

5.1.3.29. Any exceptions shall be considered on a code-by-code basis after the Department receives written notice from the MCO requesting an exception.

5.1.3.30. The MCO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.31. The MCO 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.

5.1.3.32. The MCO 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).

5.1.3.33. The MCO shall assign staff to participate in encounter technical work group meetings as directed by the Department.

5.1.3.34. The MCO shall provide complete and accurate encounters to the Department.

5.1.3.35. The MCO shall implement review procedures to validate Encounter Confidential Data submitted by Providers. The MCO shall meet the following standards:

5.1.3.35.1 Completeness

5.1.3.35.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.35.2 Accuracy

5.1.3.35.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions of

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each individual batch and online transaction type.

5.1.3.35.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.35.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.35.2.4. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.35.2.5. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.35.2.6. The MCO 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.

5.1.3.35.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Confidential Data quality.

5.1.3.35.2.8. The end to end test shall include a review of the Provider claim to what Confidential Data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.35.2.9. The MCO shall report a pass or fail to the Department. If the

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result is a fail, the MCO shall also submit a root cause analysis that includes plans for remediation.

5.1.3.35.2.10. If the Department or the MCO identifies a Confidential Data defect, the MCO 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.

5.1.3.35.2.11. If two (2) or more Encounter Confidential Data defects are identified within a rolling twelve (12) month period, the Department may require the MCO to contract with an external vendor to independently assess the MCO Encounter Confidential Data process. The external vendor shall produce a report that shall be shared with the Department.

5.1.3.35.3 Timeliness

5.1.3.35.3.1. Encounter Confidential Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.35.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.35.3.3. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.35.4 Error Resolution

5.1.3.35.4.1. For all historical encounters submitted after the submission

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start date, if the Department or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.35.4.2. For all ongoing claim encounters, if the Department or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

5.1.3.35.4.3. If the MCO 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).

5.1.3.35.4.4. The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by the Department.

5.1.3.35.5 Survival

5.1.3.35.5.1. All Encounter Confidential Data accumulated as part of the MCM 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 7.2 (Termination for Other Reasons).

5.1.3.35.6 Reporting

5.1.3.35.6.1. The MCO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to the MCO, including base Confidential Data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

5.1.3.35.6.2. When requested by the Department, the MCO 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.

5.1.3.35.6.3. The MCO'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 MCO shall be certified by one (1) of the following:

5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CFO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

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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 MCO 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 MCO shall submit the MCO 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 MCO shall have a Confidential Data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.14.3 (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 MCO 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 MCO 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 MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1. Section 3.10 (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 MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board

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of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The MCO 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 MCO 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 MCO 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 MCO 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 MCO 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 MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2. Within thirty (30) calendar days from the date of contract signing and annually thereafter, the MCO shall submit all updates and modifications to the Department for approval at least thirty (30) calendar days in advance of the effective date. The MCO 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 MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and re-credentialing processes.

5.3.1.4. The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 Section 1902(a)(68) of the Social Security Act;

5.3.1.4.2 42 CFR Section 438;

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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 MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of Fraud, Waste and Abuse, and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to the Department.

5.3.1.6. The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against Fraud, waste and abuse.

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 MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9. The MCO 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 MCO program integrity meetings with the Department following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O: Quality and Oversight Reporting Requirements:

5.3.1.9.1.1. The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.2 Discussion at these meetings shall include, but not be limited to, case development and monitoring, implementation of Fraud, Waste, and Abuse Annual Plans, plan use of data analytic Fraud detection algorithms required in Section 5.3.2.2.4.4, quality control and review of Encounter Confidential Data submitted to the Department, and corrective actions from the Department Program Integrity audits.

5.3.1.9.3 The MCO shall ensure Subcontractors attend monthly meetings based on relevant agenda items and ensure

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agenda items are removed if essential MCO or Subcontractor staff are unavailable;

5.3.1.9.4 Participation in any MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned; and

5.3.1.9.5 Participation in meetings with MFCU, as determined by MFCU and the Department.

5.3.2 **Fraud, Waste and Abuse**

5.3.2.1. The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste and Abuse. [42 CFR 438.608(a)]

5.3.2.2. The arrangements or procedures 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:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

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5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i-vii)]

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such as inducements;

5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or Fraud, Waste and Abuse to the Department within thirty (30) business days;

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5.3.2.2.4 The MCO shall maintain and report as requested specific controls to detect and prevent potential Fraud, Waste and Abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.4.4. 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 MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change based on outcomes of the algorithms and Department approval;

5.3.2.2.4.5. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.6. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or

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inappropriate use of Medicaid services and a description demonstrating the results of such protocols when requested by the Department;

5.3.2.2.4.7. 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 MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.8. Provider and Member materials identifying the MCO's Fraud and Abuse reporting hotline number;

5.3.2.2.4.9. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.10. The Department reserves the right to require at least ten (10) specific on-site investigations based on the MCO's request to open an investigation;

5.3.2.2.4.11. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency

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of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.12. 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

5.3.2.2.4.13. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and/or abusive, incorrect billing trends with a particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.5 [Amendment #4:] A provision for the prompt reporting within 30 calendar days of all Overpayments identified and recovered, specifying the Overpayments due to potential Fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider Fraud, Waste and Abuse that the MCO or Subcontractor identifies to the Department Program Integrity and any potential Fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO'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

5.3.2.2.8 A provision for notification to the Department when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O: Quality and Oversight Reporting Requirements.

5.3.2.3. The MCO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide

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detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4. The MCO, and if required by the MCO's Subcontractors, shall post and maintain 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.

5.3.2.5. [Amendment #3:] By October, 1, 2025, the MCO shall establish protocols to identify and report any NH Medicaid Member concurrently enrolled in the corporate entity's other state Medicaid plan(s) (as applicable), and also report Members discovered to be enrolled in any other State Medicaid program in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

5.3.3 **Identification and Recoveries of Overpayments**

5.3.3.1. The MCO shall maintain an effective Fraud, Waste and Abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2. The MCO 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.

5.3.3.4. The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to Fraud, Waste and Abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5. The MCO 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. [Amendment #4:] The Department may recover Overpayments that are not recovered by or returned to the MCO within ninety (90) ~~sixty (60)~~ calendar days

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of the end of the appeal timeframe ~~notification by final findings letter to the Provider by the MCO~~ unless the MCO has a recovery agreement with the Provider,or is actively recovering through claims recoupment. The Department will notify MCO if the Department has plans to pursue recovery.

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.

5.3.3.8. Any settlement reached by the MCO 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 MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.10. If the MCO does not meet the required metrics related to expected Fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O: Quality and Oversight Reporting Requirements, the Department shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

5.3.4 **Referrals of Credible Allegations of Fraud, Waste or Abuse and Provider and Payment Suspensions**

5.3.4.1. General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to 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 MCO 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. The Department’s Program Integrity Unit shall have fifteen (15) business days to respond to the MCO’s “Request to Open” form.

5.3.4.1.3 When the MCO or its Subcontractor has concluded that a credible allegation of Fraud or abuse exists, the MCO shall make a referral to the Department’s 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 MCO 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 [Amendment #2:] The MCO shall employ pre-payment review when directed or approved by the Department.

5.3.4.1.6 [Amendment #2:] The MCO may employ pre-payment review with approval from the Department when requirements specified in separate guidance are met.~~In addition, the MCO may employ pre-payment review in the following circumstances without approval:~~

5.3.4.1.6.1. [Amendment #2:] Intentionally left blank~~Upon new Participating Provider enrollment;~~

5.3.4.1.6.2. [Amendment #2:] Intentionally left blank~~For delayed payment during Provider education;~~

5.3.4.1.6.3. [Amendment #2:] Intentionally left blank~~For existing Providers with billing inaccuracies; or~~

5.3.4.1.6.4. [Amendment #2:] Intentionally left blank.~~Fraud 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 MCO's Compliance Officer

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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 an exception to suspension does not apply, as determined by the Department under 42 CFR 455.23.

5.3.4.1.8 The Department shall notify the MCO 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, Waste or Abuse referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this section of the Agreement.

5.3.4.1.10 Upon receipt of notification from the Department, the MCO 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

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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 MCO.

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 MCO is notified by the Department that there is insufficient evidence of Fraud, Waste or Abuse by the Provider; or

5.3.4.1.12.2. The MCO is notified by the Department that the legal proceedings related to the Provider's alleged Fraud, Waste or Abuse are completed.

5.3.4.1.13 The MCO 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 as set forth in 42 CFR 455.23.

5.3.4.1.15 Every thirty (30) calendar days that a payment suspension exists, the Department shall direct the

MCO to continue, reduce, or remove the payment suspension.

5.3.4.1.16 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.1.16.1. Details of payment suspensions that were imposed in whole or in part; and

5.3.4.1.16.2. Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.1.17 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of Fraud, Waste or Abuse without good cause, and the Department directed the MCO to suspend payments, the Department may impose liquidated damages.

5.3.4.1.18 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 MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.1.19 Furthermore, the MCO 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 MCO 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.

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5.3.4.1.20 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 MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate Fraud, Waste and Abuse.

5.3.5.2. The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3. The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, the Department, OIG, and CMS).

5.3.5.4. The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5. The MCO 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 MCO 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 MCO 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 MCO 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.

5.3.5.9. These refunds shall be reported to the Department as Overpayments.

5.3.5.10. The Department shall conduct investigations related to suspected Provider Fraud, Waste or Abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO has not submitted a request to open or for which the MCO has not continued to pursue the case. The State shall notify the MCO of any investigation it intends to open prior to contacting the Provider.

5.3.5.11. Investigations should be concluded within nine (9) months of the approval of the request to open. The MCO must submit a justification for the investigation remaining open if it exceeds nine (9) months with an expected date for the conclusion of the investigation and receive approval from the Department to continue the investigation. The MCO may be penalized if the justification is not approved in accordance with Exhibit N: Liquidated Damages

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Matrix. A case shall be considered completed when a final conclusion letter is sent to the provider or a referral has been made to MFCU.

5.3.5.11.1 The MCO shall submit a final letter to the Department's Program Integrity Unit for each investigation, which explains the outcome of the case and actions taken by the MCO.

5.3.5.12. The MCO shall conduct a follow up investigation twelve (12) months after the final recovery letter date to ensure the same issue is not repeated.

5.3.6 **Reporting**

5.3.6.1. Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

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:

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.

5.3.6.1.3 As part of this report, the MCO shall submit to the Department the Overpayments it recovered, certified by its CFO that this information is accurate to the best

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of their information, knowledge, and belief, as required by Exhibit O: Quality and Oversight Reporting Requirements. [42 CFR 438.606]

5.3.6.2. Reporting Member Fraud

5.3.6.2.1 The MCO shall notify the Department of any cases in which the MCO believes there is a serious likelihood of Member Fraud, Waste and Abuse by sending a secure email to the Department Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member Fraud, Waste and Abuse and referring Member Fraud, Waste or Abuse to the Department. The MCO shall provide initial allegations, investigations and resolutions of Member Fraud, Waste and Abuse to the Department.

5.3.6.3. Termination Report

5.3.6.3.1 The MCO 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 MCO shall submit to the Department demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 [Amendment #4:] The MCO shall report at least annually to the Department, and as otherwise required by this Agreement, on all ~~their recoveries of~~ Overpayments identified and recovered. [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 MCO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the MCO shall provide the Department program integrity staff (or its designee), real time access to all of the MCO electronic encounter and claims Confidential Data (including the

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Department third-party liability) from the MCO's current claims reporting system.

5.3.7.2. The MCO shall provide the Department with the capability to access accurate, timely, and complete Confidential Data as specified in Section 4.20.2 Claims Quality Assurance Program).

5.3.7.3. The MCO and the MCO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.

5.3.7.4. The MCO 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 Medical 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 an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

5.3.7.6. Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate the Department, MFCU or other State or federal agencies.

5.3.7.7. The MCO and the MCO's Providers and Subcontractors shall permit the Department, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours. [42 CFR 438.3(h)]

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5.3.7.8. The MCO 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 MCO or its Subcontractors at the MCO's expense.

5.3.7.10. The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.11. The Department shall conduct, or contract for the conducting of, periodic audits of the MCO 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 MCO. [42 CFR 438.602(e)]

5.3.7.12. This shall include, but not be limited to, any records relevant to the MCO'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 MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 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 MCO resulting from the State's periodic audit; and

5.3.8.1.4 Performance metrics and outcomes.

5.4 **MCM Withhold and Incentive Program**

5.4.1 [Amendment #3:] Beginning September 1, 2024, t~~T~~he Department shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted Capitation Payment will be recouped from the MCO and be available for distribution ~~in future years~~ upon meeting specific criteria set forth in program guidance issued by the Department.

5.4.2 The Department shall issue Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by the Department.

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5.4.3 [Amendment #3:] Beginning September 1, 2024, t~~T~~he Department shall institute a Withhold and Incentive Program which directs an annual actuarially sound two percent (2%) retention of the MCO'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.

5.4.4 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall:

5.4.4.1. 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;

5.4.4.2. Not be renewed automatically;

5.4.4.3. Be made available to both public and private contractors under the same terms of performance;

5.4.4.4. Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements; and

5.4.4.5. Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.5 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.5.1. Pursuant to 42 CFR 438.6(b)(2), this incentive arrangement shall:

5.4.5.1.1 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;

5.4.5.1.2 Not be renewed automatically;

5.4.5.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.5.1.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.5.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.6 Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

5.4.7 [Amendment #1:] Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the

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Withhold and Incentive Program is to maintain withhold funds in the program for actuarial soundness, should there be a remaining amount in withheld funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract closeout period~~term~~ in accordance with separate guidance.

5.4.8 [Amendment #4:] In accordance with RSA 126-A:3, the Department will seek to implement an outpatient procedure incentive program beginning as early as January 1, 2026, subject to review and approval from the fiscal committee of the general court.

5.5 Remedies

5.5.1 Reservation of Rights and Remedies

5.5.1.1. The MCO 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 MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State 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 MCO'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

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non-compliance, and update Exhibit N: Liquidated Damages Matrix as needed via contract amendment.

5.5.2.2. DHHS and the MCO agree that it shall be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event the MCO 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: Liquidated Damages Matrix, 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 MCO 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.

5.5.2.8. At its sole discretion, the Department may temporarily provide the MCO 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 MCO 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 MCO in

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excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 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 MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide 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 $25,000 for each failure to provide medically necessary services, and may also:

5.5.4.2.2.1. Appoint temporary management for the MCO,

5.5.4.2.2.2. In the event of multiple MCOs, 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 MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.2.5. Suspend payments for new enrollments to the MCO 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

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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 $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 MCO;

5.5.4.2.3.2. Grant Members the right to disenroll without cause;

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or 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 one hundred thousand dollars ($100,000) for each determination by the Department of discrimination. The Department may impose a civil monetary penalty of up to fifteen thousand dollars ($15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar ($100,000) maximum. The Department may also:

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5.5.4.2.4.1. Appoint temporary management to the MCO;

5.5.4.2.4.2. Grant Members the right to disenroll without cause;

5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or 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 $25,000 for each instance of misrepresentation. The Department may also:

5.5.4.2.5.1. Appoint temporary management to the MCO;

5.5.4.2.5.2. Grant Members the right to disenroll without case;

5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

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5.5.4.2.5.4. Suspend payments for new enrollments to the MCO 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 one hundred thousand dollars ($100,000) for each instance of misrepresentation. The Department may also:

5.5.4.2.6.1. Appoint temporary management to the MCO;

5.5.4.2.6.2. Grant Members the right to disenroll without cause;

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act; and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or 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);

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1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.7 Fails to comply with the Medicare Physician Incentive Plan requirements, in which case, DHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply. DHHS may also:

5.5.4.2.7.1. Appoint temporary management to the MCO;

5.5.4.2.7.2. Grant Members the right to disenroll without cause;

5.5.4.2.7.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.7.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3. The Department shall have the right to impose civil monetary penalty of up to $25,000 for each distribution if the Department determines that the MCO 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 MCO's Members in other MCOs if the Department determines that the MCO 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

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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 MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b-d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6. The Department shall only have the right to impose the following intermediate sanctions when the Department determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of 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 MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or 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.

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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 MCO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.1.4. The Department shall impose mandatory temporary management when the MCO 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 MCO 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**

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5.5.6.1. If requested by the Department, the MCO 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) business days of receipt.

5.5.6.3. The MCO 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 MCO 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 MCOs 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. MCOs 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 MCO;

5.5.8.1.5 Whether a CAP is being requested; and

5.5.8.1.6 The timeframe and procedure for the MCO to dispute the Department's determination.

5.5.8.2. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.3. 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 MCO'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 to allow for adjustments to start-up operations; thereafter,

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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 The Department, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right to audit the records and/or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.2 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 MCO or its Subcontractors pertaining to:

5.6.2.1. The ability of the MCO to bear the risk of financial losses; and

5.6.2.2. Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.3 In accordance with Exhibit O: Quality and Oversight Reporting Requirements, no later than forty (40) business days after the end of the State Fiscal Year, the MCO shall provide the Department a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.4 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.

5.6.5 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:

5.6.5.1. Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

5.6.5.2. Written assertion by the MCO's management about whether:

5.6.5.2.1 The aforementioned description fairly presents the system in all material respects;

5.6.5.2.2 The controls were suitably designed to achieve the control objectives stated in that description; and

5.6.5.2.3 The controls operated effectively throughout the specified period to achieve those control objectives.

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5.6.5.3. Report of the MCO's auditor, which:

5.6.5.3.1 Expresses an opinion on the matters covered in management's written assertion; and

5.6.5.3.2 Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

5.6.6 The MCO shall notify the Department if there are significant or material changes to the internal controls of the MCO.

5.6.7 If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

5.6.8 The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

5.6.9 The Department may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing CAPs and review MCO compliance with requirements and standards as specified in this Agreement.

5.6.10 The MCO shall use reasonable efforts to respond to the Department oral and written correspondence within one (1) business day of receipt.

5.6.11 The MCO shall file annual and interim financial statements in accordance with the standards set forth below.

5.6.12 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 MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]

5.6.13 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.

5.6.14 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.

5.6.15 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

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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 MCO may protest such action or decision by the delivery of a written notice of protest to the Department and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director").

5.7.1.2. The MCO 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 MCO 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 MCO 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 MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of the Department under RSA chapter 541-A, if applicable, or any applicable

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provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from 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 MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO 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 MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

6.1.6 The MCO shall submit Confidential Data on the basis of which the Department has the ability to determine that the MCO has made adequate provisions against the risk of insolvency.

6.1.7 The MCO 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 MCO to perform under this Agreement.

6.1.8 [Amendment #3:] The MCO shall not participate in and shall prohibit clawback business arrangements, network access fees, transaction fees, and all other similar types of arrangements with its Pharmacy Benefit Managers (PBM) or any other Subcontractor for Covered Services whereby such PBM or Subcontractor reimburses network pharmacies or other Providers an initial reimbursement amount and subsequently the PBM or

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other Subcontractor receives remuneration for a portion of that fee. Such clawback or similar arrangements include, but are not limited to, both rate guarantee agreements between the PBM and MCO and the PBM and the network pharmacy. Rate guarantee agreement solely between the MCO and PBM shall not be considered a prohibited clawback business arrangement under this Agreement, but must be reported in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

6.2 **Capitation Payments**

6.2.1 Capitation payments made by the Department and retained by the MCO 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 MCO 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 Capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.

6.2.3.1. The risk adjustment process shall use the most recent version of the CDPS+Rx model to assign scored individuals to a demographic category and disease categories based on their medical claims and drug utilization during the study period. The methodology shall also incorporate a custom risk weight related to the cost of opioid addiction services, as deemed necessary by the Department and its actuary. Scored individuals are those with at least six months of eligibility and claims experience in the base data. The methodology shall exclude diagnosis codes related to radiology and laboratory services to avoid including false positive diagnostic indicators for tests run on an individual. Additionally, each scored member with less than 12 months of experience in the base data period shall also be assigned a durational adjustment to compensate for missing diagnoses due to shorter enrollment durations, similar to a missing data adjustment.

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6.2.3.2. Each unscored member shall be assigned a demographic-only risk weight instead of receiving the average risk score for each MCO's scored members in the same rate cell. The risk adjustment methodology shall also incorporate a specific adjustment to address cost and acuity differences between the scored and unscored populations, which shall be documented by a thorough review of historical data for those populations based on generally accepted actuarial techniques.

6.2.3.3. Members shall be assigned to MCOs and rate cells using the actual enrollment by MCO in each quarter to calculate risk scores in order to capture actual membership growth for each MCO.

6.2.3.4. The Department and its actuary reserve the right to modify the risk adjustment methodology.

6.2.4 The MCO 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)]

6.2.5 The MCO and the Department agree the Capitation Rates 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.

6.2.6 The MCO shall submit Confidential Data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, including base Confidential Data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.7 When requested by the Department, the MCO shall submit Encounter Data, financial data, and other Confidential Data to the Department to ensure actuarial soundness in development of the capitation rates, or any other actuarial analysis required by the Department or State or federal law.

6.2.8 The MCO'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 capitation rates, is complete and accurate. [42 CFR 438.606]

6.2.9 The MCO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The MCO may retain such recoveries, subject to the parameters in the Agreement, since the capitation rates are calculated net of expected MCO recoveries.

6.2.10 The Department shall make a monthly payment to the MCO for each Member enrolled in the MCO's plan as the Department currently structures its capitation payments.

6.2.10.1. Capitation Payments for all standard Medicaid Members shall be made retrospectively with a one month plus five (5) business day lag.

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6.2.10.2. Capitation Payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.11 The capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.12 [Amendment #1:] The Department may adjust the capitation rate based on Member enrollment span changes (e.g., category of eligibility, enrollment termination, age) that occurred during the month that are not otherwise recognized in capitation adjustments. ~~The 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~~.

6.2.13 Capitation adjustments are processed systematically each month by the Department's MMIS.

6.2.14 The Department shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.15 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.

6.2.16 **Capitation Settlement**

6.2.16.1. The Department has sole discretion over the capitation settlement process.

6.2.16.2. The MCO shall follow policies and procedures for the settlement process as developed by the Department.

6.2.16.3. Based on the provisions herein, the Department shall not make any further retroactive adjustments other than those described herein or elsewhere in this Agreement.

6.2.16.4. The Department and the MCO agree there is a nine (9) month limitation from the date of the Capitation Payment and is applicable only to retroactive Capitation Payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO.

6.2.16.5. 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.

6.2.16.6. For each live birth, the Department shall:

6.2.16.6.1 Make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.16.6.2 This payment is a global fee to cover all delivery care.

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6.2.16.6.3 In the event of a multiple birth DHHS shall make only one (1) maternity kick payment.

6.2.16.6.4 A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.16.7. Make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.16.7.1 This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services.

6.2.16.7.2 Enrolled babies shall be covered under the MCO capitated rates thereafter.

6.2.16.7.3 Different rates of newborn kick payments may be employed by the Department, in its sole discretion, to increase actuarial soundness.

6.2.16.7.4 Two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns.

6.2.16.7.5 Each type of payment is distinct and only one payment is made per newborn.

6.2.16.7.6 The MCO shall submit information on maternity and newborn events to DHHS, and shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.16.8. [Amendment #3:] [Amendment #1:] For the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025 ending August 31, 2024~~ (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.17.3 below.

6.2.16.8.1 The kick payment shall be specific to the corresponding Peer Groups established by DHHS. Separate kick payments exist for Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09.

6.2.16.8.2 Psychiatric admissions for dually eligible Members are not subject to the kick payment and shall be paid out of the capitation rates.

6.2.16.8.3 [Amendment #3:] Psychiatric admissions for Members at New Hampshire Hospital ~~and Hampstead Hospital~~

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are not subject to the kick payment and shall be paid out of the MCO's capitation rates.

6.2.16.9. [Amenment #4:][Amendment #2:] Beginning f~~F~~or services effective January 1, 2025, for the rating period July 1, 2025 ~~September 1, 2024~~ through June 30, 2026~~2025~~ (subject to future rating period extension(s)), DHHS shall make a one-time kick payment to the MCO for each of three (3) new kick payments to cover juveniles and adults who are incarcerated to comply with new service requirements as part of the implementation of the expansion of its Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance Treatment and Recovery Access 1115 Demonstration Waiver~~Intentionally left blank~~.

6.2.16.10. Intentionally left blank.

6.2.16.11. Intentionally left blank.

6.2.16.12. Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to the Department's MMIS by the MCO.

6.2.16.13. [Amendment #1:] Eligibility for a capitation payment from the MCO to the CMH Program is based on a valid behavioral health certification and the Member having had an encounter in the last three (3) months. ~~The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months.~~

6.2.16.14. [Amendment #1:] Changes to a Member's behavioral health certification enrollment span are reflected in Capitation Payments as described in Section 6.2.12 of this Agreement. ~~Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.~~

6.2.17 **Capitation Adjustments**

6.2.17.1. After the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted Capitation Payment net of directed payments to the MCO shall be calculated as having been withheld by the Department. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance.

6.2.17.1.1 Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by the Department as indicated in Section 5.4 (Withhold and Incentive Payment Program).

6.2.17.1.2 The Department shall inform the MCO of any required program revisions or additions in a timely manner.

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6.2.17.1.3 The Department may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.17.2. The Department shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.17.3. In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member.

6.2.17.4. The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.17.5. 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 MCO must do no work on that part after the effective date of the loss of program authority.

6.2.17.6. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.17.7. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work.

6.2.17.8. If the State paid the MCO 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.

6.2.17.9. However, if the MCO 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 MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6.2.18 Other Reimbursement Considerations

6.2.18.1. Unless MCOs 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 MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

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6.3 Medical Loss Ratio (MLR) Reporting and Settlement

6.3.1 Minimum MLR Performance and Rebate Requirements

6.3.1.1. The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2. [Amendment #1:] In the event the MCO's MLR for any single reporting year is below the minimum ~~of the~~eighty-five percent (85%) requirement as reported by the MCO in accordance with Section 6.3.2 of this Agreement, or determined by the State's actuary or the State's contracted MLR examiner required under CMS rule, the MCO 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 MCO from the Department multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR.

6.3.1.3. If the MCO 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 MCO 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 MLR

6.3.2.1. The MCO 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)]

6.3.2.2.1 The calculation of the MLR will be updated to consider new provisions added or amended by CMS through published rules and guidance.

6.3.2.3. Each MCO 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.

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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 MLR report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims, expenditures for activities that improve health care quality or licensing and regulatory fees or federal and state taxes.

6.3.2.5.1 Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue-based assessments.

6.3.2.5.2 Expenses for administrative services may include amounts that exceed a third party's costs (profit margin), but these amounts must be justified and consistent with prudent management and fiscal soundness requirements to be includable when these transactions are between related parties. [42 C.F.R. § 422.516(b)].

6.3.2.6. Health Care Quality Improvement (HCQI) expenses are limited to the portion of salaries and benefits for employees directly performing administrative functions for inclusion in the MLR calculation. Expenses for items such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, equipment, computer and telephone usage, travel and entertainment, company parties and retreats, information technology infrastructure and systems, and software licenses do not qualify as direct HCQI expenses.

6.3.2.7. The MCO may add a credibility adjustment in accordance with 42 CFR 438.8(h) to a calculated MLR if the MLR reporting year experience is partially credible.

6.3.2.7.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.7.2 The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

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6.3.2.7.3 If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 **MLR Reporting**

6.3.3.1. The MCO shall submit MLR summary reports quarterly to the Department in accordance with Exhibit O: 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 MCO 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)]

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6.3.3.5. The MCO 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 MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying Confidential Data associated with MLR reporting to the MCO 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 MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.6.1 [Amendment #2:] Effective July 1, 2026, the MCO shall require its Subcontractors responsible for the delivery or administration of the covered outpatient drug benefit to report separately to the MCO the amounts related to:

6.3.3.6.1.1. [Amendment #2:] The incurred claims described in 42 CFR 438.8(e)(2) such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to Providers or pharmacies for dispensing or administering a covered outpatient drug; and

6.3.3.6.1.2. [Amendment #2:] Administrative costs, fees and expenses of the Subcontractor. [42 CFR 438.3(s)(8)]

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 MCO 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)]

6.3.3.8. The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.4 **Risk Mitigation**

6.3.4.1. Risk Pool Protections

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6.3.4.1.1 [Amendment #3:] [Amendment #1:] High-Cost Pharmacy Risk Pool. The Department will provide an actuarially sound High-Cost Pharmacy Risk Pool (HCPRP) funded though the MCO capitation rates that will allocate HCPRP funding to each MCO based on the qualifying pharmacy claim payments for Members with annual pharmacy claim payments over a specified threshold. The HCPRP will offer the Department and the MCOs protection for Members with total pharmacy spend exceeding a predetermined threshold. Any pharmacy costs above the threshold are included in the HCPRP pool amount (excluding medications typically included as part of the NH Medicaid DRG grouper reimbursement methodology; gene therapies and other high-cost medications should be billed separate from the DRG grouper for inclusion in the HCPRP), and first subject to an at-risk coinsurance amount that is the responsibility of the MCOs. The remaining HCPRP amount will be redistributed across MCOs based on actual experience of the remaining pharmacy expenses (i.e., in excess of the threshold after coinsurance is applied). All associated pharmacy funding, including the HCPRP amounts, will be prospectively included in the capitation rates by rate cell. The HCPRP amount will be subject to a separate HCPRP risk corridor to provide further protection from under or over funding of the HCPRP amount~~provide MCO protection for Members with pharmacy claims in access of the attachment point. Detailed program features and parameters will be established on an annual basis in guidance~~.

6.3.4.1.1.1. [Amendment #1:] During the contract year, the MCO will be required to pay pharmacy claims as normal.

6.3.4.1.1.2. [Amendment #1:] Reconciliation and reallocation of HCPRP amounts will be based on actual HCPRP expenditures as described in separate guidance.

6.3.4.1.1.3. [Amendment #1:] The HCPRP includes threshold, coinsurance, and risk corridor features, as follows:

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6.3.4.1.1.3.1 [Amendment #3:] [Amendment #1:] For the July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ rating period and annually thereafter, the threshold is set at $250,000 total drug spend per Member.

6.3.4.1.1.3.2 [Amendment #3:] [Amendment #1:] For the July 1, 2025 ~~September 1, 2024~~ through June 30, 2026 ~~2025~~ rating period, the MCO is at-risk for coinsurance across all eligible rate cells, as follows:

6.3.4.1.1.3.2.1 [Amendment #1:] 30% coinsurance for members with a total drug spend of $250,000 - $750,000;

6.3.4.1.1.3.2.2 [Amendment #1:] 20% coinsurance for members with a total drug spend of $750,000 - $1,250,000; and

6.3.4.1.1.3.3.2.3 [Amendment #1:] 10% coinsurance for

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members with a total drug spend greater than $1,250,000.

6.3.4.1.1.4. [Amendment #3:] [Amendment #1:] For the ~~September~~July 1, 2025 ~~2024~~ through June 30, 2026 ~~2025~~ rating period, the Department shall implement a risk corridor for pharmacy costs as described in Section 6.3.4.1.1 of this Agreement ~~for all pharmacy costs (excluding inpatient pharmacy services) around the HCPRP to offer additional protection against under/over funding of the HCPRP~~, as follows:

Under/Overfunding	DHHS Share	MCO Share
Less than Pool Fund -10%	100%	0%
Pool Fund -10% to -5%	50%	50%
Pool Fund -5% to +5%	0%	100%
Pool Fund +5% to +10%	50%	50%
Greater than Pool Fund +10%	100%	0%

6.3.4.1.2 The Department shall implement a budget neutral-risk pool for services provided at Boston Children's Hospital in order to better allocate funds based on MCO-specific spending for these services. Inpatient and outpatient facility services provided at Boston Children's Hospital qualify for risk pool calculation.

6.3.4.2. Minimum and Maximum MLR

6.3.4.2.1 The Department reserves the right to modify its risk mitigation strategies in accordance with actuarially sound practices.

6.3.4.2.2 For each year under this Agreement, the Department and its actuary will determine if a minimum and maximum MLR should be implemented due to unforeseen events that could materially impact the level of uncertainty associated with the financial soundness of the MCM program. The MCM program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such

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as enrollment projections, emerging utilization experience, and retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period based on the target MLRs determined by the Department.

6.3.4.2.2.1. [Amendment #2] [Amendment #1] For the September 1, 2024 through June 30~~August 31~~, 2025 rating period, the Department is committed to reviewing more mature emerging experience to evaluate the need for additional modifications to the acuity adjustment factors that could be required due to a potential deterioration of the aggregate program MLR. As part of the Amendment #2 capitation rate development process, the Department will request additional information from the MCO and conduct a review of recent MLR results. If these results show a material deterioration of the program MLR in aggregate, the Department and its actuaries may implement corrective adjustments to address this deterioration in financial performance retroactive to September 1, 2024.

6.3.4.2.3 Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation (i.e., High-Cost Drug Risk Pool, Boston Children's Hospital risk pool, prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.2.4 Minimum MLR settlement operational requirements include:

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6.3.4.2.4.1. 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 not include costs related to quality improvement activities or Fraud, Waste and Abuse prevention.

6.3.4.2.5 The denominator for the actual MLR shall equal the risk adjusted capitation revenue including risk mitigation settlement amounts as described in Section 6.3.4 (Risk Mitigation).

6.3.4.2.6 Payments and revenue related to directed payments and premium taxes shall be excluded from the numerator and denominator for the actual MLR.

6.3.4.2.7 Any incentive payments made to higher-performing MCOs as part of the Withhold Program shall not impact the minimum or maximum MLR provision of the Agreement.

6.3.4.2.8 The timing of the minimum and maximum MLR settlement shall occur after the contract year is closed and substantial paid claims runout is available.

6.3.4.2.9 Payments or recoupments related to the Withhold and Incentive Program shall be excluded from the MLR settlement. The Withhold and Incentive Program settlement shall occur after the MLR settlement is complete.

6.3.4.2.10 [Amendment #4:] The MLR settlement shall occur after the contract year is closed and sufficient paid claims runout is available. At the Department's discretion, a final revised MLR settlement calculation may occur upon completion of an MLR audit for the period, if applicable, to consider any adjustments identified during the MLR audit impacting the final MLR settlement calculation.

6.3.4.2.11 [Amendment #1:] The projected overall MCO MLR for at-risk services excludes the impact of the separate payment term directed payments and the 2.0% premium tax allowance in both the numerator and denominator of the MLR calculation. The following

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overall MCO MLRs are projected under this Agreement:

6.3.4.2.11.1. [Amendment #1:] For the September 1, 2024 through June 30, 2025 rating period, at-risk services are projected as follows:

6.3.4.2.11.1.1 [Amendment #2:][Amendment #1:] For September 1, 2024 through December 31, 2024, at-risk services are projected as 91.2% ~~90.9%~~ for the Standard Medicaid population and 90.3% ~~89.9%~~ for the GAHCP population which includes an overall 7.3%~~7.6%~~ administrative cost allowance for the Standard Medicaid population, and 8.2% ~~8.6%~~ for the GAHCP population; and 1.5% risk margin applied as a percentage of revenue prior to the

directed payments and the premium tax allowance; and

6.3.4.2.11.1.1.1 [Amendment #2:] For January 1, 2025 through June 30, 2025, at-risk services are projected as 91.2% for the Standard Medicaid population and 90.4% for the GAHCP population which includes an overall 7.3% administrative cost allowance for the Standard Medicaid population, and 8.1% for the GAHCP population; and 1.5% risk margin applied as a percentage of revenue prior to the directed payments and the premium tax allowance; and

6.3.4.2.11.1.2 [Amendment #2:] [Amendment #1:] For the September 1, 2024 through June 30, 2025 rating period, the minimum MLR is set on a program-wide basis for each major population,

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such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target, the minimum MLR will be 88.7% for the Standard Medicaid population and 87.9% for the GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above The minimum e target MLR, such that MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR will be 94.7% for the

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Standard Medicaid population and 93.9% for the GAHCP population.

6.3.4.2.11.1.3 [Amendment #4:] [Amendment #3:] For the July 1, 2025 through June 30, 2026 rating period, the capitation rates reflect an average target MLR, which measures the projected medical service costs as a percentage of the total at-risk capitation rates. The minimum MLR will limit MCO gains if the actual MLR is lower than the minimum MLR. The maximum MLR will limit MCO losses if the actual MLR is higher than the maximum MLR. The average

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target MLR for at-risk services is 91.2%~~90.9%~~ for Standard Medicaid and 90.3%~~90.0%~~ for GAHCP based on the SFY 2026 projected enrollment distribution. The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs for the rating period, the minimum MLR will be 88.7%~~88.4%~~ for the Standard Medicaid population and 87.8%~~87.5%~~ for the

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GAHCP population. The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCO will have a maximum loss of 2%. Based on the target MLRs for the rating period, the average maximum MLR will be 94.7%~~94.4%~~ for the Standard Medicaid population and 93.8%~~93.5%~~ for the GAHCP population.

6.3.4.2.12 [Amendment #1:] Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation (i.e., High-Cost Drug Risk Pool, Boston Children's Hospital risk pool, prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.3. [Amendment #3:] [Amendment #2] [Amendment #1:] CMH Programs: For the July 1, 2025 ~~September 1, 2024~~ through June 30~~August 31, 2026~~ ~~2025~~ rating period, the Department shall mitigate the MCO and Department gains and losses due to significant changes under the new CMH Program payment

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model when experience is above or below the actuarial estimate of a 12.0% ~~14.0%~~ adjustment for the three-month lookback. Specifically, the Department shall review whether the CMH Program outreach efforts targeted at serving more members within the three-month lookback period are higher or lower than the estimate included in the rating period's capitation rates. To compensate for higher or lower utilization estimates, a risk corridor around the 12.0% ~~14.0%~~ adjustment for the three-month lookback shall be included in the development of the CMH Program specific capitation rates for the period. The risk corridor shall reduce or increase overall MCO capitation payment funding for the CMH Programs if actual experience is outside a plus or minus 2% range for the three-month lookback adjustment factor of 12.0% ~~14.0%.~~

6.4 **[Amendment #1:] Financial Responsibility for ~~Dual-Eligible~~ Members with Other Insurance**

6.4.1 For Medicare Part A crossover claims and Medicare Part B crossover claims billed on the UB-04, the MCO shall pay the patient responsibility amount (deductible and coinsurance) for Covered Services.

6.4.1.1. [Amendment #4:] For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment.

6.4.2 For Part B crossover claims billed on the CMS-1500, the MCO shall pay the lesser of:

6.4.2.1. The patient responsibility amount (deductible and coinsurance) for Covered Services, or

6.4.2.2. The difference between the amount paid by the primary payer and the Medicaid allowed amount.

6.4.2.3. [Amendment #4:] Intentionally left blank ~~For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment~~.

6.4.3 [Amendment #1:] For all medical and pharmacy claims with other insurance payment (e.g., commercial, Medicare Advantage), excluding Medicare Part A, Part B, and Part D, the MCO shall use the lessor logic described below unless otherwise stipulated in this Agreement:

6.4.3.1. [Amendment #1:] The patient responsibility amount (deductible, Co-payment, or coinsurance), or

6.4.3.2. [Amendment #1:] The difference between the amount paid by the primary payer and the Medicaid allowed amount, if less than the patient responsibility amount, or

6.4.3.3. [Amendment #1:] If the Member responsibility amount is "0" then the MCO shall make no payment.

6.4.4 [Amendment #4:] [Amendment #1:] For all claims (medical and pharmacy) with other insurance or Medicare Advantage plans, the MCO shall follow

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coordination of benefit processes described in entirety of this Section 6.4, ~~the primary insurance claim process in paying as secondary~~ unless otherwise stipulated in this Agreement.

6.4.4.1. [Amendment #2] For CMHCs and State certified CCBHCs, for (1) Covered Services statutorily excluded from Medicare (excluding Medicare Advantage plans), the MCO shall institute a claims edit approving payment for such Covered Service and shall not require the CMHC or CCBHC to first bill Medicare (excluding Medicare Advantage plans); and (2) Members also enrolled in a Medicare Advantage plan or private commercial plan, the MCO shall only require CMHCs and CCBHCs to receive one denial per year, from the Member's Medicare Advantage plan or private commercial plan, for functional support services or targeted case management Covered Services provided by the CMHC or CCBHC, and MCO shall institute a claims edit approving functional support services or targeted case management Covered Services provided by the CMHC or CCBHC when CMHC or CCBHC has received the required one denial per year from the Member's Medicare Advantage plan or private commercial plan.

6.4.4.2. [Amendment #4:] [Amendment #3:] Beginning March 1, 2026, t~~T~~he MCO shall pay ~~claims~~ as primary payer ~~when a provider~~ for Medicare Part A and Part B claims when the provider is not enrolled with Medicare on the date of service ~~as a participating provider~~.

6.4.4.3. [Amendment #4:] Beginning March 1, 2026, the MCO is responsible for Member Cost Sharing, (e.g., Copayment, deductible) (excluding Medicare Part D medications), as applicable, when other insurance, Medicare Part A or Part B, or Medicare Advantage pays as primary for a Covered Service via an automated crosswalk table or other methodology to effectuate payment regardless of whether the primary payer uses a different billing code for the same Covered Service.

6.4.5 [Amendment #4] The MCO shall not pay Member Cost Sharing for Medicare Part D covered medications regardless of whether the Member has one or both Medicare Part A and/or Medicare Part B.

6.5 **Medical Cost Accruals**

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 **Audits**

6.6.1 The MCO shall permit the Department or its designee(s) and/or the NHID to inspect and audit any of the financial records of the MCO 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,

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appropriateness or timeliness of services and reasonableness of their costs. [SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The MCO 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 MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant.

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 MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.7 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 **Member Liability**

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1. The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2. The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3. The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4. Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c); section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly

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[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 MCO 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 MCO 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 MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 **Federal Matching Funds**

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the MCO by the Department.

6.10 **Third Party Liability**

6.10.1 NH Medicaid shall be the payer of last resort for all Covered Services in accordance with federal regulations.

6.10.2 The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.3 The Department and the MCO shall cooperate in implementing cost avoidance and cost recovery activities.

6.10.4 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.10.5 The Department shall conduct, at times solely determined by the Department, policy and procedure audits of the MCO and its Subcontractors.

6.10.5.1. Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

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6.10.6 The MCO shall have one (1) dedicated contact person for the Department for TPL.

6.10.7 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.

6.10.8 [Amendment #2] All cost recovery amounts shall be retained by the MCO, except overpayments by other insurance. For recoveries over the Provider paid amount see Section 6.10.1112.5.3. of this Agreement.

6.10.9 The MCO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.10.9.1. 42 CFR 433.138;

6.10.9.2. 42 CFR 433.139; and

6.10.9.3. RSA 167:14-a.

6.10.10 **Cost Avoidance**

6.10.10.1. The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, Medicare Advantage plans, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 42 U.S.C. 1396a(a)(25) plans and workers compensation.

6.10.10.2. The MCO shall establish claims edits and deny payment of claims when active Medicare, Medicare Advantage Plans, or active private insurance exist at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.10.10.3. The MCO shall deny payment on a claim that has been denied by Medicare Advantage Plan 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.

6.10.10.4. The MCO shall establish claim edits to ensure claims with Medicare, Medicare Advantage plan, or private insurance denials are properly adjudicated based on the denial reason. The MCO is required to determine which specific Medicare, Medicare Advantage plan, and private insurance denials should be processed for payment or denial by the MCO.

6.10.10.5. The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance, Medicare, or Medicare Advantage plans if either:

6.10.10.5.1 The primary payer does not cover the services and the MCO does; or

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6.10.10.5.2 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.

6.10.10.6. If a claim is denied by the MCO based on active Medicare, Medicare Advantage Plan, or private insurance, the MCO shall provide the Medicare, Medicare Advantage Plan, or private insurance information to the Provider.

6.10.10.7. To ensure the MCO is cost avoiding, the MCO shall implement a file transfer protocol between the Department MMIS and the MCO's MCIS to send new, terminated, and changed Medicare or private insurance information and other information as required pursuant to 42 CFR 433.138.

6.10.10.8. The MCO 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.

6.10.10.9. The MCO shall perform monthly electronic confidential data matches with private insurance companies (medical and pharmacy) unless the Department performs these functions.

6.10.10.9.1 Should the Department establish data matching and provide to the MCO individual member private insurance data, then the MCO will not be required to perform direct data matching.

6.10.10.9.2 The date of the Department transmission of the data will be considered the date of discovery for the plan regarding member private insurance. The MCO will be required to meet cost avoidance requirements outlined in this section of this Agreement within two (2) business days of the date of discovery and four (4) business days for any subcontractors.

6.10.10.9.3 The Department shall provide the MCO with the Member name, Medicaid ID, private insurance company name, the Department's private insurance ID, private insurance policy number, type of coverage, policy begin date, policy end date (if open, end date will be 12/31/9999), and policy holder information, if available.

6.10.10.10. If the Department is not performing the data matching with other insurances, then it will be the responsibility of the MCO to establish, and shall ensure the MCO and its Subcontractors utilize, monthly electronic Confidential Data matches with private insurance companies (Medical and pharmacy), and Medicare Advantage plans that sell insurance in the State to obtain current and accurate private insurance information for their Members in accordance with

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this Agreement. This provision may be satisfied by a contract with a third-party vendor to the MCO or its Subcontractors.

6.10.10.11. Upon audit, the MCO 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 MCO. All communication with the insurer relating to and including the Confidential data matching agreements shall be in writing and in accordance with this Agreement.

6.10.10.12. The MCO 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:

6.10.10.12.1 Member's first and last name;

6.10.10.12.2 Member's policy number;

6.10.10.12.3 Member's group number, if available;

6.10.10.12.4 Policyholder's first and last name, if available;

6.10.10.12.5 Policy coverage type to include at a minimum:

6.10.10.12.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.10.10.12.5.2. Hospital coverage;

6.10.10.12.5.3. Pharmacy coverage;

6.10.10.12.5.4. Dental coverage; and

6.10.10.12.5.5. Vision Coverage.

6.10.10.12.6 Begin date of insurance; and

6.10.10.12.7 End date of insurance (when terminated).

6.10.10.13. The MCO shall submit any new, changed, or terminated private insurance Confidential Data to the Department through file transfer on a monthly basis.

6.10.10.14. [Amendment #2:] The MCO shall not cost avoid claims for preventive pediatric services, including screening, diagnosis, and treatment services covered under the ~~(including~~ EPSDT~~)~~ benefit, as well as related medical benefit services ancillary to pediatric services covered under Medicaid fee-for-service (e.g., anesthesia for oral health services), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3).

6.10.10.15. [Amendment #2:] The MCO shall pay all preventive pediatric services, including screening, diagnosis, and treatment services covered under

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the EPSDT benefit, as well as related medical benefit services ancillary to pediatric services covered under Medicaid fee-for-service (e.g., anesthesia for oral health services), and collect reimbursement from private insurance after the Medicaid managed care claim adjudicates.

6.10.10.16. The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable or any other agreement to payment in the MCO/Provider contract.

6.10.10.17. [Amendment #3:] [Amendment #2:] Intentionally left blank. ~~The MCO shall disregard the TPL lesser of logic payment methodology for claims that require provider reimbursement at rates no less than Medicaid or Medicare minimum fee schedule rates under this Agreement as described in Section 4.16 (Provider Payments).~~

6.10.10.17.1 [Amendment #3] [Amendment #2:] Intentionally left blank. ~~The MCO shall pay the difference between the TPL amount and the minimum Medicaid or Medicare fee schedule amount required in accordance with separate guidance.~~

6.10.10.17.2 [Amendment #3:] Intentionally left blank. ~~If the TPL payment is more than the Medicaid or Medicare minimum fee schedule amount requirement, then the MCO pays nothing.~~

6.10.10.18. On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O: Quality and Oversight Reporting Requirements.

6.10.10.19. This report shall reflect the number of claims and billed dollar amount avoided by private insurance, including Medicare and Medicare Advantage plans for all types of coverage as follows:

6.10.10.19.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);

6.10.10.19.2 Hospital coverage;

6.10.10.19.3 Pharmacy coverage;

6.10.10.19.4 Dental coverage; and

6.10.10.19.5 Vision coverage.

6.10.11 **Pay and Chase Private Insurance**

6.10.11.1. If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company, including Medicare Advantage plans.

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6.10.11.2. The MCO shall submit quarterly TPL billed and recovery reports, in accordance with Exhibit O: Quality and Oversight Reporting Requirements.

6.10.11.3. These reports shall reflect detail and summary information of the MCO's billing, collection efforts, and recovery from Standards Medicare, Medicare Advantage Plans, and private insurance for all types of coverage as follows:

6.10.11.3.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

6.10.11.3.2 Hospital coverage;

6.10.11.3.3 Pharmacy coverage;

6.10.11.3.4 Dental coverage; and

6.10.11.3.5 Vision Coverage.

6.10.11.4. [Amendment #4:] The MCO shall have five (5) months ~~one-hundred-twenty (120) calendar days~~ from the original paid date to bill ~~initiate recovery of funds from~~ private insurance. The MCO shall have six (6) years to recover funds with the following exceptions:

6.10.11.4.1 The Department may, beginning one year from the date the MCO paid the claim, directly bill and recover the private insurance amount paid by the MCO but not collected. The Department shall inform the MCO in writing any claims in which the Department plans to pursue Pay and Chase recovery, and the Department shall retain any recovered funds.

6.10.11.4.2 If a recovery is closed on the Exhibit O: 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 closure, and retain any funds recovered.

6.10.11.4.3 [Amendment #4] The Department may directly bill and recover the private insurance amount paid by the MCO if the MCO has not billed the private insurance within five (5) months from the MCO original paid date. The Department shall inform the MCO in writing of any claims in which the Department plans to pursue Pay and Case recovery and retain any recovered funds.

6.10.11.5. The MCO shall treat funds recovered from private insurance and Medicare Advantage plans as offsets to claims payments by posting within the claim system.

6.10.11.5.1 The MCO shall post all payments to claim level detail by Member.

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6.10.11.5.2 Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.10.11.5.3 [Amendment #2:] The MCO shall submit amounts beyond a Member's outstanding MCO payment to the Department semi-annually to determine if the Department has any claims to apply the funds. If there are no claims in which to apply the funds, the MCO must return any remaining over payments to the Member annually.

6.10.11.6. The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.10.11.7. The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.11.8. The MCO or its Subcontractor shall follow up on any billed TPL that is not collected or properly denied by the other insurance once a $1,500 cumulative minimum threshold for medical claims is reached per member or single claim of fifty dollars ($50) and one hundred dollars ($100) per cumulative prescription is reached per member.

6.10.11.9. Subrogation Recoveries

6.10.11.9.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.10.11.9.2 The MCO is responsible for class action lawsuits when the member is enrolled in an MCO on the date of injury and only includes MCO claims related to the class action. If the class action has fee for service and MCO claims, the Department is responsible for the case and will settle for both MCO and fee for service claims and will retain all funds.

6.10.11.9.3 The MCO shall act upon any information from insurance carriers or attorneys regarding potential subrogation cases. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.10.11.9.4 The MCO shall establish detailed policies and procedures for determining, processing, and

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recovering funds based on accident and trauma Subrogation cases.

6.10.11.9.5 The MCO shall submit its policies and procedures, including those related to their case tracking system as described in Section 6.10.11.9.7 of this Agreement, to the Department for approval during the Readiness Review process. The MCO shall have in its policies and procedures, at a minimum, the following:

6.10.11.9.5.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party.

6.10.11.9.5.2. The claims required to be identified, at a minimum, should include ICD-10 diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y".

6.10.11.9.5.3. The MCO shall present a list of ICD-10 diagnostic codes to the Department for approval in identifying claims for review.

6.10.11.9.5.4. The Department reserves the right to require specific codes be reviewed by MCO.

6.10.11.9.5.5. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members.

6.10.11.9.5.6. The MCO shall submit a report of questionnaires generated and sent as described in Exhibit O: Quality and Oversight Reporting Requirements.

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6.10.11.9.5.7. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indictors.

6.10.11.9.5.8. The MCO shall respond to accident referrals and lien request within twenty-one (21) calendar days of the notice per RSA 167:14-a.

6.10.11.9.6 The MCO shall establish a case tracking system to monitor and manage Subrogation cases.

6.10.11.9.7 This system shall allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

6.10.11.9.7.1. Date inquiry letter sent to Member, if applicable;

6.10.11.9.7.2. Date inquiry letter received back from Member, if applicable;

6.10.11.9.7.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;

6.10.11.9.7.4. Date case is established;

6.10.11.9.7.5. Date of incident;

6.10.11.9.7.6. Reason for incident;

6.10.11.9.7.7. Claims associated with incident;

6.10.11.9.7.8. All correspondence and dates;

6.10.11.9.7.9. Case comments by date;

6.10.11.9.7.10. Lien amount and date updated;

6.10.11.9.7.11. Settlement amount;

6.10.11.9.7.12. Date settlement funds received; and

6.10.11.9.7.13. Date case closed.

6.10.11.9.8 The MCO shall submit Subrogation reports in accordance with Exhibit O: Quality and Oversight

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Reporting Requirements. [42 CFR 433 Sub D; 42 CFR 447.20]

6.10.11.9.9 DHHS shall inform the MCO of any claims related to an MCO Subrogation cases. The MCO shall pursue the Department's claim recovery as part of their case.

6.10.11.9.10 The MCO shall submit to the Department any and all information regarding the case upon request if the Department also has a Subrogation lien.

6.10.11.9.11 The MCO shall coordinate with the Department on any dual Subrogation settlement recoveries identified in writing by the Department.

6.10.11.9.11.1. The MCO shall pay the Department claims first in the event of any settlement less than the combined total MCO and Department lien amount.

6.10.11.9.11.2. The MCO shall be liable for repayment to the Department for the total Department lien amount in situations when the Department informed the MCO of the State's lien in advance of the settlement, regardless of whether the Department lien amount exceeds the total settlement amount recovered when the MCO settles a subrogation case and accepts a settlement amount without written authorization from the Department.

6.10.11.9.12 If the MCO notifies the Department that they have closed a case prior to the case settling, the Department reserves the right to pursue and retain payment of any remaining paid MCO and FFS claims related to the case.

6.10.11.9.13 The MCO shall submit to the Department for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement.

6.10.11.9.14 The Department shall have twenty (20) business days to review the case once the MCO provides all relevant

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information as determined by the Department to approve the settlement from date received from the MCO.

6.10.11.9.15 If the Department does not respond within twenty (20) business days, the MCO may proceed with settlement.

6.10.11.9.16 If the Department does not approve of the settlement agreement, then the Department may work with the MCO and other parties on the settlement.

6.10.11.9.17 The MCO must notify the Department TPL unit within ten (10) calendar days of a Subrogation case in which the Member was not eligible under the MCO for the date of incident. The MCO cannot close these cases with no lien letter until the Department responds to the notification.

6.10.11.9.18 The Department shall have exclusive rights to pursue subrogations in which the MCO does not have an active subrogation case within ninety (90) calendar days of receiving a referral, of sending the first questionnaire as referenced in 6.10.11.9.5.5 of this Agreement, or of claim paid date if no action was taken since claims paid date, or if the MCO closes the case, as noted on the MCO Subrogation.01 report which indicates the MCO is no longer pursuing the case.

6.10.11.9.18.1. The Department shall retain and manage any restitution cases.

6.10.11.9.18.2. The MCO shall notify the Department's TPL Unit within ten (10) calendar days of any new class action lawsuit.

6.10.11.9.19 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign the Department all rights to such cases to complete and collect on those Subrogation settlements.

6.10.11.9.20 The Department shall retain all recoveries after Agreement termination.

6.10.11.9.21 The MCOs shall report on all subrogation recoveries in a manner prescribed by the Department.

6.10.11.10. Medicare

6.10.11.10.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable.

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6.10.11.10.2 The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process. [42 CFR 438.3(t)]

6.10.11.10.3 A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.10.11.10.4 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.10.11.10.4.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

6.10.11.10.4.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.10.11.10.4.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and shall establish claims edits and deny part D for those part C Members.

6.10.11.10.4.4. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.10.11.10.5 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the Medicare timely filing requirements.

6.10.11.10.5.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.10.11.10.6 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.10.11.10.7 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4

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(Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment. The MCO shall not pay any member liability for Medicare Part D claims.

6.10.11.11. The MCO shall pay any wrap around services not covered by Medicare that are Covered Services under the Medicaid State Plan Amendment and this Agreement.

6.10.12 **Estate Recoveries**

6.10.12.1. 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 MCO:

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.

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7.2 Termination for Other Reasons

7.2.1 The MCO 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 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 MCO prompt written notice of such termination.

7.2.3 Notwithstanding the above, the MCO shall not be relieved of liability to the Department or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.4 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to the Department immediately on demand.

7.2.5 The Department may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if the Department determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.6 In such event, Section 4.7.9 (Access to Providers During Transitions of Care) shall apply.

7.3 Claims Responsibilities

7.3.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.5.2 (Service Authorization/Continuity of Care) of this Agreement, 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 MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the MCO's outstanding final financial obligations.

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7.4.2 If all financial obligations of the MCO have been satisfied, amounts due to the MCO for unpaid premiums, risk settlement, High-Cost Drug Risk Pool, and other risk mitigation initiatives identified in this Agreement by the Department shall be paid to the MCO 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 MCO 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 MCO shall work cooperatively with the Department and/or its designee to process service authorization requests received.

7.5.2.1.1 Disputes between the MCO 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 MCO shall give written notice to the Department of all service authorizations that are not decided upon by the MCO 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 4.7.9 (Access to Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.5.2.4. The Member shall be referred to appropriate Participating Providers.

7.5.2.5. The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization Confidential Data from the new MCO 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.

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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 MCO must;

7.6.1.9.1 Only use a State email address assigned to them with a "@ affiliate.DHHS.NH.Gov".

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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 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 Agreement, said End User may face removal from the Agreement, 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 Agreement. The solicitation or disclosure of PHI, PII, or other Confidential Information shall be

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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 this Agreement 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.

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EXHIBIT C – Payment Terms – Amendment #4

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit B. 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 of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

Eligibility Category **Medicaid Care Management**	**July-December 2025**
Foster Care / Adoption	$521.56
Severely Disabled Children	3,711.62
Low Income Children - Age 0-11 Months	516.60
Low Income Children - Age 1-18 Years	298.49
Low Income Adults	884.52
Elderly and Disabled Adults - Age 19-64	2,266.18
Dual Eligibles	331.69
Elderly and Disabled Adults - Age 65+	1,774.17
CHIP	256.42
Behavioral Health Population Rates	
Severe/Persistent Mental Illness - Dual	$1,850.85
Severe/Persistent Mental Illness - Non-Dual	3,253.46
Severe Mental Illness - Dual	1,240.34
Severe Mental Illness - Non-Dual	2,690.32
Low Utilizer - Dual	797.69
Low Utilizer - Non-Dual	2,488.18
Serious Emotionally Disturbed Child	1,368.33
Medicaid Expansion	
Granite Advantage - Medically Frail	$1,974.97
Granite Advantage - Non-Medically Frail	873.24
Maternity /Newborn Kick Payments	
Maternity Kick Payment	$7,114.07
Newborn Kick Payment	11,789.92
Neonatal Abstinence Syndrome Kick Payment	36,970.20

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EXHIBIT C – Payment Terms – Amendment #4

Eligibility Category **Medicaid Care Management**	**January-June 2026**
Foster Care / Adoption	$522.21
Severely Disabled Children	$3,715.47
Low Income Children - Age 0-11 Months	$517.18
Low Income Children - Age 1-18 Years	$298.84
Low Income Adults	$853.55
Elderly and Disabled Adults - Age 18-64	$2,245.97
Dual Eligibles	$330.34
Elderly and Disabled Adults - Age 65+	$1,772.69
CHIP	$256.72
Behavioral Health Population Rates	
Severe/Persistent Mental Illness - Dual	$1,849.22
Severe/Persistent Mental Illness - Non-Dual	$3,217.89
Severe Mental Illness - Dual	$1,240.45
Severe Mental Illness - Non-Dual	$2,663.70
Low Utilizer - Dual	$797.28
Low Utilizer - Non-Dual	$2,436.20
Serious Emotionally Disturbed Child	$1,369.64
Medicaid Expansion	
Granite Advantage - Medically Frail	$1,956.32
Granite Advantage - Non-Medically Frail	$856.45
Maternity /Newborn Kick Payments	
Maternity Kick Payment	$7,117.72
Newborn Kick Payment	$11,795.97
Neonatal Abstinence Syndrome Kick Payment	$36,989.15

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.

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Any rate adjustments shall be subject to the availability of State appropriations.

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for the twelve month contract period covering the State Fiscal Year 2026 period of July 1, 2025 – June 30, 2026 to be served among all contracts is 2,100,862. Accordingly, the price limitation increase for the twelve month contract period July 1, 2025 – June 30, 2026 among all contracts is $25,535,137 based on the projected members per month. The full price limitation is $2,768,763,464.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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Medicaid Care Management Services Contract
Exhibit N - Amendment 4
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 or quarterly, the liquidated damages shall be assessed based on the timeframe below. For example, if the MCO 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 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing or recurring failure to meet minimum Primary Care and Prevention Focused Model of Care general requirements (Section 4.10)	$25,000 per week of violation
	1.6 Continuing or recurring failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including the full continuum of care for members with substance use disorders	$25,000 per week of violation
	1.7 Continuing or recurring failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7)	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan; $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.9 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$10,000 per month of violation (for each month that DHHS determines the MCO is not substantially in compliance)
	1.10 Continuing or recurring failure to resolve member appeals and grievances within specified timeframes	$25,000 per violation
	1.11 Failure to submit timely, accurate, and/or complete encounter data records 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 MCO in that month until such time as the required submission is made)*	$5,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$25,000 per violation
	1.13 Failure to adhere to the Preferred Drug List requirements	$25,000 per violation
	1.14 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 2 violation	$25,000 per violation
	1.15 Continued or recurring failure to comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder	$50,000 per violation for continuing failure
	1.16 Continued or recurring failure to meet the requirements for minimizing psychiatric boarding	$5,000 per day for continuing failure

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.17 Failure to ensure non-emergency medical transportation (NEMT) driver services and vehicle safety requirements conform with Section 4.1.9.3; 4.1.9.8.1.1 - 4.1.9.8.1.7	$25,000 per violation
	1.18 [Amendment #1:] Failure to deliver or recover a confirmed NEMT ride, resulting in disruption to a Covered Service (Section 4.1.9.8.5.~~1~~)	$5,000 per violation for the first five (5) occurrences; $15,000 for each additional violation; No more than 50% of any liquidated damage amount for failing to meet this standard shall be imposed on the Subcontractor by the MCO
	1.19 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled; $500 per additional day provider is not suspended once MCO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.20 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 MCO, its Subcontractor or a Provider	$50,000 per violation
	1.21 Two or more Level 1 violations within a contract year	$75,000 per occurrence

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.22 [Amendment #2:] [Amendment #1:] Failure to make capitated payments to a Community Mental Health Program (CMH Program) or a Certified Community Behavioral Health Clinic (CCBHC) in accordance with Sections 4.16.2.3.1.1 through 4.16.2.3.1.1.2 and Section 4.16.2.3.3.1, respectively; and as directed by, and in amounts determined by, the Department. Any monthly interim payment made by the MCO to a CMH or CCBHC Program shall not be considered as compliance with this standard	[Amendment #1:] $100,000 per violation for the first month of non-compliance. Liquidated Damages double for each month of non-compliance after month 1. For example only, non-compliance in month 1, 2, and 3 would equal a Liquidated Damage of $500,000.
2. LEVEL 2 MCO action(s) or inaction(s) that jeopardize the integrity of the managed care program but does not necessarily jeopardize member(s) health, safety, and welfare or access to care.	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified)
	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 of such information and/or timely report violations in the access, use, and disclosure of PHI	$100,000 per violation
	2.3 Failure to meet prompt payment requirements and standards	$25,000 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	$50,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	provide adequate information to determine cost avoidance percentage as determined by DHHS	
	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	$50,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud or abuse to DHHS annually	$10,000 unless good cause determined by Program Integrity
	2.8 EQR reports with “not met” findings that have been substantiated by DHHS	$10,000 per violation
	2.9 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	2.11 Member in pharmacy “lock-in” program not locked into a pharmacy and no documentation as to waiver or other excuse for not being locked in	$500 per member per occurrence and total pharmacy claims amount paid while not locked-in
	2.12 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 3 violation	$25,000 per week of violation
	2.13 Failure to suspend or terminate providers when instructed by DHHS	$500 per day of violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	2.14 Failure to timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.15 Failure to meet any performance standards in the contract which may include, but not necessarily be limited to: 2.15.1 Care Coordination and Care Management measures (Sections 4.11.3.4, 4.11.5.7); 2.15.2 Claims processing (Sections 4.19.1.4, 4.19.1.5, 4.19.3.2, 4.19.4.2, 4.19.5.2); 2.15.3 Call center performance (Sections 4.4.10.3.1, 4.4.10.3.2, 4.4.10.3.3, 4.14.4.1.3.1, 4.14.4.1.3.2, 4.14.4.1.3.3); 2.15.4 [Amendment #1:] Non-emergency medical transportation (Sections 4.1.9.8.4, 4.1.9.8.4.1, and 4.1.9.8.5.1 ~~4.1.9.8.7 and 4.1.9.8.8~~); 2.15.5 Service authorization processing (Sections 4.2.4.9, 4.8.4.2.1.1, 4.8.4.3.1, 4.8.4.3.5); and 2.15.6 Childhood Lead Testing Requirements (Section 4.8.2.3.2)	$1,000 per violation
	2.16 Failure to meet 99% of claims financial accuracy requirements (Section 4.19.3.1, 4.19.3.2), and 95% of post service authorization processing requirements (Section 4.8.4.3.5)	$1,000 per violation
	2.17 Two or more recurring Level 2 violations within a contract year	$50,000 per occurrence
	2.18 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence
3. LEVEL 3	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories,	$10,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	provider agreements, etc. requiring DHHS review and/or approval or as requested by an audit	
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	$10,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	$10,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$10,000 per violation
	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$25,000 per violation
	3.7 [Amendment #1:] Failure to submit ~~and obtain DHHS review and~~ applicable Subcontract~~sor~~ contracts for Department review.	$25,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$10,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 4 violation	$25,000 per week of violation
	3.10 Failure to meet minimum social services and community care requirements, as described in Section 4.11.7 (Provider-Delivered Care	$10,000 per violation

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Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	Coordination and Integration with Social Services and Community Care) of the contract, with respect to unmet resource needs of members	
	3.11 Failure to ensure that clinicians conducting or contributing to a comprehensive assessment are certified in the use of New Hampshire's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within the specified timeframe	$10,000 per violation
	3.12 Two or more Level 3 violations within a contract year	$100,000 per occurrence
4. LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete, 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 submit timely, accurate, and/or complete files to NH CHIS per NH Code of Administrative Rules, Chapter Ins 4000	$2,500 per day the submission or resubmission is late
	4.3 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
	4.4 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

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Exhibit N - Amendment 4
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 or quarterly, the liquidated damages shall be assessed based on the timeframe below. For example, if the MCO 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
	4.5 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence
	4.6 Failure to meet staffing requirements of Key Personnel set forth in Section 3.11.1 of the Agreement	$25,000 per violation if the position is not filled on a full-time basis within 90 days of the start of the vacancy. In addition, if the position is not filled on a full-time basis in accordance with the terms of the Agreement within (i) 180 days an additional $50,000 penalty per violation shall apply; (ii) 240 days an additional $75,000 penalty per violation shall apply; and (iii) within 365 days an additional $100,000 penalty per violation shall apply. In addition, if the position is not filled on a full-time basis within 365 days of the initial vacancy a penalty of $100,000 shall be applied each quarter until the position is filled on a full-time basis
	4.7 Failure to ensure provider agreements include all required provisions	$10,000 per violation
	4.8 [Amendment #4:] Failure to meet adherence targets established by the Department for an applicable period as set forth in Section 4.2.3.1.1-4.2.3.1.3	[Amendment #4:] The Department may assess a penalty equal to the

Initial
Contractor Initials GMV
Date 12/5/2025

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

Medicaid Care Management Services Contract
Exhibit N - Amendment 4
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 or quarterly, the liquidated damages shall be assessed based on the timeframe below. For example, if the MCO 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
		full amount of the lost rebates for the adherence period

Contractor Initials Initial GMV

Date 12/5/2025

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders. Addressed through Senate Bill 313.	Legislative Presentation	Agreement Year	Annually	TBD			X						X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan	Varies	Annually	May 1st									X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table	Varies	Quarterly	4 Months after end of Measurement Period									X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report	Agreement Year	Annually	October 31st									X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X			X			
APPEALS.18	Services Authorized within 72 Hours Following a Reversed Appeal	Count and percent of services authorized within 72 hours following a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

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Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHDRUG.01	Severe Mental Illness (SMI) and Serious Emotional Disturbance (SED) Drug Prior Authorization	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table	Calendar Year	Annually	January 31st			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCO's program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. The initial Plan shall address but not be limited to how the MCO shall 1) assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare; 2) assure appropriateness of diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; 3) assure promotion of Integrated Care; 4) reduce Psychiatric Boarding; 5) reduce Behavioral Health Readmissions; 6) reduce Behavioral Health related emergency department utilization; 7) support the NH 10-Year Mental Health Plan; 8) assure appropriateness of psychopharmacological medication; 9) assure access to appropriate services; 10) implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and 11) other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.	Plan	Agreement Year	Annually	May 15th									X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table	Calendar Year	Annually	June 30th								X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.1H survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.1H Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.1H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.1H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.06	Adult CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Adult Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	July 15th				X					
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X					X	X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.1H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X					X	
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.1H Survey Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.1H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	
CAHPS_CCC.06	Child w CCC CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Child Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	July 15th				X					
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X	X				X	X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.1H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CARECOORD.05	Members Receiving Provider-based Care Coordination	Count and percent of members receiving provider-based care coordination during the measurement quarter.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.06	Members Receiving Provider-based Care Coordination by Provider Group Practice	Count and percent of members receiving provider-based care coordination at the end of the measurement quarter, by Provider Group Practice.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.09	Tracking for Social Service and Community Care Referrals	Standard template capturing quarterly counts of referrals for social services and community care provided to Required Priority Population Members by Member type.	Table	Quarter	Quarterly	TBD									X
CAREMGT.39	Members Enrolled in MCO-Delivered Care Management	Count and percent of members enrolled in MCO-delivered care management on the last day of the measurement period. This measure provides the total count of members receiving care management as a member in a Required Priority Population or at the option of the MCO.	Measure	Month	Monthly	1 Month after end of Measurement Period						X	X		X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.47	Comprehensive Plan: Provider-Delivered Care Coordination; MCO-Delivered Care Management; Health Risk Assessment Screening; and Primary Care and Prevention Focused Model	The MCO shall submit a plan at time of Readiness Review and implement procedures to 1) facilitate integrated Provider-Delivered Care Coordination and MCO-Delivered Care Management, 2) facilitate and operate systems of Provider-Delivered and MCO-Delivered health risk assessments screenings , and 3) implement, administer and facilitate the Primary Care and Prevention Focused Care Model, which must demonstrate authentic engagement between Members and PCPs to ensure each Member has an ongoing source of care appropriate to their needs, and includes procedures for confidentiality, consent, or informed consent. [42 CFR 438.208(b)] The MCO-Delivered Care Management portion must include the plan to implement and operate Care Management for the Required Priority Populations and include how the MCO will take social determinants of health into account.	Plan	Readiness and Agreement Year	Annually	May 1st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.48	Provider-based Care Coordination, MCO-Delivered Care Management, Health Risk Assessment Screening, and Primary Care and Prevention Focused Care Model Report	Narrative report describing: 1) the status of the Provider-based Care Coordination program, including successes and challenges, how it is going with provider engagement, what providers, etc. Include data to illustrate findings. 2) the status of the MCO care management program for Required Priority Populations and members enrolled in other MCO-Delivered Care Management, including successes and challenges, and how the MCO took social determinants of health into account. Include data to illustrate findings. 3) implementation, facilitation and operation of Provider-Delivered and MCO-Delivered health risk assessment screening systems. Include data to illustrate findings. 4) implementation, administration and facilitation of the Primary Care and Prevention Focused Care Model. Include data to illustrate findings and demonstrate the level of authentic engagement between Members and PCPs.	Narrative Report	Quarter for first Agreement Year, then Agreement Year	Quarterly for first Agreement Year, then Annually	2 Months after end of Measurement Period for first Agreement Year, then August 31st									X
CAREMGT.49	MCO-Delivered Care Management Enrollment	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by Required Priority Populations outlined in the Care Management section of the MCM Contract, and members enrolled in other MCO-Delivered Care Management.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
CAREMGT.50	Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.51	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Members with Behavioral Health Hospitalizations	Count and percent of members included in the Members with Behavioral Health Hospitalizations Required Priority Population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.52	Members Receiving MCO-Delivered Care Management in Required Priority Populations: DCYF-Involved Members	Count and percent of members included in the DCYF-Involved Members Required Priority Population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.53	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Low Birth Weight Infants	Count and percent of members included in the Low Birth Weight Infants required priority population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.54	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Adult Community Reentry Waiver Members	Count and percent of members with behavioral health needs (e.g., substance use disorder, mental health) who were incarcerated in the State's prisons and are eligible for participation in the Department's Community Reentry demonstration waiver who are enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.56	Members Receiving MCO-Delivered Care Management in Required Priority Populations: TBD	Count and percent of members included in Yet to Be Determined Required Priority Populations enrolled in MCO-based care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.58	Members Receiving MCO-Delivered Care Management in Required Priority Populations: NAS Infants	Count and percent of members included in the Neonatal Abstinence Syndrome (NAS) Infants required priority population enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.59	Members Receiving MCO-Delivered Care Management in Required Priority Populations: Youth Reentry Members	Count and percent of members who were incarcerated youth and are eligible for any Medicaid eligibility group, or determined eligible for the mandatory eligibility group for former foster care children, immediately before becoming an inmate of a public institution or while an inmate of a public institution who are enrolled in MCO-delivered care management on the last day of the measurement period.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period									X
CAREMGT.60	Priority Population Members Receiving MCO-Delivered Care Management	Count and percent of members enrolled in MCO-delivered care management on the last day of the measurement period, based on a deduplicated total of members included in one or more Required Priority Population group.	Measure	Rolling 12 Months	Monthly	2 Months after end of Measurement Period						X			X
CCBHC_AMM.01	Antidepressant Medication Management - Effective Acute Phase Treatment for CCBHC Clients	Count and percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_AMM.02	Antidepressant Medication Management - Effective Continuation Phase Treatment for CCBHC Clients	Percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months).	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CCBHC_GSD.01	Glycemic Status Assessment for Patients With Diabetes (<8.0%) (GSD-AD)	Provide, at DHHS direction, CCBHC oversample of GSD HEDIS measure to comply with CCBHC demonstration requirements. Applies to data reporting year 2025 forward. Since it is not yet clear if CCBHC reporting will require GSD or older HBD, we will retire unnecessary one once clarified.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_GSD.02	Glycemic Status Assessment for Patients With Diabetes: HbA1c Poor Control (>9.0%) (GSD-AD)	Provide, at DHHS direction, CCBHC oversample of GSD HEDIS measure to comply with CCBHC demonstration requirements. Applies to data reporting year 2025 forward. Since it is not yet clear if CCBHC reporting will require GSD or older HBD, we will retire unnecessary one once clarified.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_HBD.01	Hemoglobin A1c Control for CCBHC Patients with Diabetes: HbA1c Control (<8.0%) (HBD-AD)	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was less than 8.0% during the measurement year. *Utilize the hybrid methodology in the SAMHSA specification for this measure.*	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_HBD.02	Hemoglobin A1c Control for CCBHC Patients with Diabetes: HbA1c Poor Control (>9.0%) (HBD-AD)	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was greater than 9.0% during the measurement year. *Utilize the hybrid methodology in the SAMHSA specification for this measure.*	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CCBHC_MBR_LVL_DATA.01	CCBHC Demonstration Member Level Data	This file contains member/event level data for select CCBHC measures. Data will reflect the results for these measures in the corresponding CCBHC measures for the same measurement period. The list of DHHS-selected CCBHC measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year. There will be duplication of some data provided to DHHS in other Member Level Data Files.	Member Level Data File	Calendar Year	Annually	9 Months after end of Measurement Period							X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CCBHC_PCR.01	Plan All-Cause Readmissions for CCBHC Patients (PCR-AD)	CCBHC clinic specific calculation of PCR measure components	Measure	Calendar Year	Annually	6 Months after end of Measurement Period							X		
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure	Month	Monthly	110 Calendar Days after end of Measurement Period			X						X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.28	Timely Processing of Facility-to-Facility Transportation Claims: Thirty Days of Receipt	Count and percent of clean Facility-to-Facility Transportation claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Facility-to-Facility transportation claims are those rides where ambulance companies transport members from hospitals following discharge to other facilities such as rehabilitation facilities or nursing homes. The MCOs process these claims, NEMT brokers are not involved.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMHC.01	CMHC Capitation Payment Reporting	Template including data reflecting the following: Monthly units by rate cell for each CMHC and Total Monthly Payments by rate cell for each CMHC.	Table	Month	Monthly	1 Day after end of Measurement Period									X
CMHC.02	CMHC Capitation Payment Reporting: Same-Day Eligibility Reconciliations	Template reflecting the results of same-day eligibility reconciliations each quarter by CMHC and the pro-rated capitation amounts paid to each CMHC.	Table	Quarter	Quarterly	8 Months after end of Measurement Period									X
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported)	Measure	Calendar Year	Annually	September 30th				X			X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure	Calendar Year	Annually	September 30th				X	X				
CMS_A_GSD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%). The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_GSD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%). The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_ PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_INP_PQI15	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma in Younger Adults Admission Rate per 100,000 Member Months	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone. Also used for CCBHC Demonstration starting with MY 2025 RY 2026.	Measure	Calendar Year	Annually	September 30th				X	X		X		

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CH_DEV.02	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure	Calendar Year	Annually	September 30th				X					
CMS_CORE_ SET.01	CMS Core Set Member Level Data	This file contains member/event level data for select CMS Core Set measures. Data will reflect the results for these measures in the corresponding CMS Core Set measures for the same measurement period. The list of DHHS-selected CMS Core Set measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year.	Member Level Data File	Calendar Year	Annually	September 30th				X					X
CMS_PDS.01	Postpartum Depression Screening and Follow-Up: Depression Screening	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PDS.02	Postpartum Depression Screening and Follow-Up: Follow-Up on Positive Screen	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_PRS.01	Prenatal Immunization Status: Influenza	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PRS.02	Prenatal Immunization Status: Tdap	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CMS_PRS.03	Prenatal Immunization Status: Combination	CMS Adult Core Set - Will report for first time in 2025, will retire this if HEDIS measure meets the need.	Measure	Calendar Year	Annually	September 30th				X					
CULTURAL COMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan	Agreement Year	Annually	May 1st									X
DHHS_LEAD.01	Pediatric Lead Screening – One-Year Screenings Completed	Count and percent of pediatric members with a completed one-year lead screening. One-year screenings occur when a member is at least 11 months of age and less than 23 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X
DHHS_LEAD.02	Pediatric Lead Screening – Two-Year Screenings Completed	Count and percent of pediatric members with a completed two-year lead screening. Two-year screenings occur when a member is at least 23 months of age and less than 36 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X
DHHS_LEAD.03	Pediatric Lead Screening – Both One-Year and Two-Year Screenings Completed	Count and percent of pediatric members with both a completed one-year and two-year lead screening. One-year screenings occur when a member is at least 11 months of age and less than 23 months of age. Two-year screenings occur when a member is at least 23 months of age and less than 36 months of age.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period	X								X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan	Agreement Year	Annually	May 1st									X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan	Agreement Year	Annually	May 1st									X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report	6 Months	Semi-Annually	1 Month after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
FINANCIAL STMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report	MCO Financial Period	Annually	August 10th									X
FWA.02	Provider Fraud Log	Standard template log of all fraud related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table	Month	Monthly	15 Days after end of Measurement Period			X						X
FWA.04	Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
FWA.05	Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table	Quarter	Quarterly	1 Month after end of Measurement Period			X						X
FWA.06	Waste and Abuse Recovery Report	Standard template reporting waste and abuse identified and recovered by the MCO.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table	Quarter	Quarterly	15 Calendar Days after end of Measurement Period			X		X	X			
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period			X					X	
HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCQA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCQA audited results for all HEDIS measures and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.04	NCQA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCQA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in *Appendix AF - HEDIS Measures Included in HEDIS.06* and is subject to change each measurement year.	Member Level Data File	Calendar Year	Annually	June 30th					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure	1 Year Starting July 1 of Year Prior to Measurement Year to June 30 of Measurement Year.	Annually	June 30th				X			X	X	
HEDIS_AAF-E	Follow-Up After Acute Care and Urgent Care Visits for Asthma	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_ADD-E	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets and CCBHC Demonstration	Measure	1 Year Starting March 1 of Year Prior to Measurement Year to February 28 of Measurement Year.	Annually	June 30th				X			X	X	X
HEDIS_AIS-E	Adult Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CCBHC reporting.	Measure	May 1 of Year Prior to Measurement Year to Oct 31 of Measurement Year.	Annually	June 30th							X		X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X	X		X	X	X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X	X							X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	2 Calendar Years	Annually	June 30th				X				X	X
HEDIS_BPD	Blood Pressure Control for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X							X	X
HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2.	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_CCS-E	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	3 Calendar Years	Annually	June 30th				X				X	X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_CIS-E	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_COL-E	Colorectal Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year with a 10 Year Look-back	Annually	June 30th				X					
HEDIS_COU	Risk of Chronic Opioid Use	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_DDM	Disability Description of Membership (DDM)	HEDIS Measure (New Health Plan Descriptive Information Measure)	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_EED	Eye Exam for Patients with Diabetes (EED)	HEDIS Measure, also utilized for CMS Core Sets.	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_FMC	Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th									X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Substance Use	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th		X		X	X		X	X	X
HEDIS_FUH	Follow-Up After Hospitalization for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	January 1 to December 1 of Measurement Year	Annually	June 30th				X			X	X	X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	January 1 to December 1 of Measurement Year	Annually	June 30th								X	X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th		X		X			X	X	X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_GSD	Glycemic Status Assessment for Patients With Diabetes	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. Race and ethnicity breakouts as specified in HEDIS Volume 2.	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_IET	Initiation and Engagement of Substance Use Disorder Treatment (IET)	HEDIS Measure, also utilized for CMS Core Sets and CCBHC reporting. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th	X			X	X		X	X	X
HEDIS_IMA-E	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_LDM	Language Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_MSC	Medical Assistance with Smoking and Tobacco Use Cessation	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_PDS-E	Postpartum Depression Screening and Follow-Up	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_PND-E	Prenatal Depression Screening and Follow-Up	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure	1 Year Starting July 1 of Year Prior to Measurement Year to June 30 of Measurement Year.	Annually	June 30th								X	X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SNS-E	Social Needs Screening and Intervention	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X				X	X
HEDIS_TSC-E	Tobacco Use Screening and Cessation Intervention	The percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user. Two rates are reported: 1) Tobacco Use Screening. The percentage of persons who were screened for tobacco use. 2) Cessation Intervention. The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_W30	Well-Child Visits in the First 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets. CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th			X	X					X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets CMS Core Set requires Race and Ethnicity, Sex (biologic), and Geography stratifications starting with MY 2024 RY 2025 data.	Measure	Calendar Year	Annually	June 30th			X	X					X
HRA.12	Successful Completion and Review of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion and review of provider-based health risk assessment screenings during the 12 months tracked in the measurement period, as of the last day of the measurement period.	Measure	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period	X								X
HRA.13	Successful Completion, Review, and Referral or Follow-up as Needed on Provider-based Health Risk Assessment Screenings by Provider Group Practice	Count and percent of members for whom the MCO paid claims for completion, review, and referral or follow-up as needed on provider-based health risk assessment screenings during the measurement year, by provider group practice, as of the last day of the measurement year.	Table	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period									X
HRA.12	Successful Completion and Review of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion and review of provider-based health risk assessment screenings during the 12 months tracked in the measurement period, as of the last day of the measurement period.	Measure	Rolling 12 Months	Quarterly	5 Months after end of Measurement Period	X								X

EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
IMD DISCHARGE.01	New Hampshire Hospital Discharges - Intake Appointments for New CMHC Patients within 7 Days of Discharge	Count and percent of New Hampshire Hospital discharges where the member had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days post member discharge AND was not a patient of the applicable CMHC at admission to New Hampshire Hospital. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
IMD DISCHARGE.03	New Hampshire Hospital Discharges - Member Received Discharge Instruction Sheet	Count and percent of discharges from New Hampshire Hospital where the member received a discharge instruction sheet prior to discharge, or no later than the next business day following the discharge. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
IMD DISCHARGE.04	New Hampshire Hospital Discharges - Discharge Plan Provided to Aftercare Provider within 7 Days of Discharge	Count and percent of members discharged from New Hampshire Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. This measure excludes members who were transferred to a medical hospital for emergent care.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
INLIEUOF.02	In Lieu of Services: New or Modified Services and Annual Report	Standard report for MCO to submit requests for new or modified in lieu of services. This template will also be used for required annual reporting.	Table	Annually or Ad Hoc as Needed	Annually or Ad Hoc as Needed	March 15th, Ad Hoc			X						X
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan	Agreement Year	Annually	May 1st, Upon Revision			X						

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
INTEGRITY.02	Program Integrity Compliance and Fraud, Waste, and Abuse Narrative Report	A narrative report on the previous year's findings related to the MCO's internal fraud, waste, and abuse monitoring. The report should also include a description of how prior year's barriers to provider auditing were addressed.	Narrative Report	Agreement Year	Annually	August 31st									X
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked into a pharmacy for the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan	Agreement Year	Annually	May 1st									X
MCO_COMP_ ASSESS.02	MCO Comprehensive Assessments Completed for Required Priority Populations	Count and percent of members included in a Required Priority Population for which the MCO completed a comprehensive assessment during the measurement period, by age group and Required Priority Population category or Other MCO-Delivered Care Management.	Measure	Rolling 12 Months	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MCO_COMP _ASSESS.04	Timeliness of MCO Comprehensive Assessments	Count and percent of members for which the MCO completed the comprehensive assessments within 30 calendar days of identifying the Member as being part of one or more Required Priority Populations or in need of Other MCO-Delivered Care Management, based on a deduplicated total of members included in one or more Required Priority Population group and members enrolled in Other MCO-Delivered Care Management.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
MCO_COMP _ASSESS.05	Care Management Comprehensive Assessment Results within 14 Calendar Days	Count and percent of members with a comprehensive assessment completed during the measurement period, where the MCO shared the assessment results in writing with the member's care team within 14 calendar days of completion. The member's care team includes but is not limited to the member's PCP, specialists, behavioral health providers, and Area Agencies.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls received during the measurement period and answered by a live voice within 30 seconds, by health plan vendors as follows: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue during the measurement period, by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member calls received during the measurement period and answered by a live voice, by reason for inquiry as follows: A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages received after business hours and responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEM INCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEM INCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Plan	Agreement Year	Annually	May 1st									X
MHACT.04	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least six billed Assertive Community Treatment (ACT) services in each month of the measurement period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MH DISCHARGE.03	ED Visits for Mental Health Preceded by a State of NH IMD or Non-IMD DRF Hospital Stay in Past 30 Days	This file contains member/event level data reflecting mental health related emergency department (ED) visits where: 1) The member was discharged from a State of NH IMD Hospital or Designated Receiving Facility (DRF) up to 30 days prior to the ED visit, and 2) The primary diagnosis for the ED visit was mental health related, and 3) The ED visit did not result in an inpatient admission or direct transfer to a State of NH IMD Hospital or DRF. Data points will include PHI as well as indicators for follow-up received, CMHP Services Received, DCYF Involvement, and Medicare/Medicaid Dual Status. Given this file contains protected health information (PHI), MCOs will submit the file to DHHS via secure means.	Member Level Data File	Quarter	Quarterly	4 Months after end of Measurement Period									X
MH DISCHARGE.04	Follow-up Visits after Hospital Discharge for Mental Health-Related Conditions	This file contains member/event level data reflecting member discharges with a primary diagnosis for a mental health-related condition occurring in the measurement quarter where the member had at least one follow-up visit with a mental health practitioner within 7 and/or 30 days of discharge. Data points will include PHI as well as indicators for follow-up received, CMHP Eligibility (SMI/SED and Non-CMHC subpopulations), DCYF Involvement, and Medicare/Medicaid Dual Status.	Member Level Data File	Quarter	Quarterly	5 Months after end of Measurement Period						X			X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaiting placement within the prior 30, 60 and 90 days.	Table	TBD	TBD	TBD									X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	This template will provide DHHS with aggregate MCO member population data and member-level data. The MCO member population tab will provide DHHS with aggregate MCO member population data based on age group and member enrollment on the last day of the data period for the reporting period.	Table	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHREADMIT.08	Readmissions for Mental Health Conditions within 30, 90 and 180 Days of Discharge	This file contains member/event level data reflecting member admissions with a primary diagnosis for a mental health condition, where a previous discharge for a mental health-related condition occurred within 30, 90 and/or 180 days. Data points will include PHI as well as indicators for previous discharges, CMHP Services Received, DCYF Involvement, and Medicare/Medicaid Dual Status. Given this file contains protected health information (PHI), MCOs will submit the file to DHHS via secure means.	Member Level Data File	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan	Agreement Year	Annually	May 1st									X

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information.	Table	Quarter	Quarterly	9 Months after end of Measurement Period			X						
MONTHLYOPS.01	Monthly Operations Report	This report will include details about various operational components required by the MCO contract, as determined by DHHS.	Table	Month	Monthly	TBD									X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
NCQA.01	NCQA Accreditation Review Results	Copies of all sections of the most current NCQA accreditation results to reflect 1) accreditation status, to include survey type and level (as applicable); 2) accreditation results, to include recommended actions or improvements, corrective action plans (CAPS) and summaries of findings and 3) expiration date of the accreditation.	Narrative Report	NCQA Accreditation Cycle	NCQA Accreditation Cycle	Within one week of receipt from NCQA								X	

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NEMT.15	NEMT Legs Delivered by Covered Medical Service Provider Type	Count and percent of Non-Emergency Medical Transportation (NEMT) delivery legs completed during the measurement period, by primary covered medical service provider type for the leg. The measure includes nine submeasures: A: Hospital, B: Medical Provider, C: Behavioral Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G. Other, H. Dialysis and I. Medical or DME Supplier. This measure excludes return legs (e.g. legs back to the original pick-up location, typically the member's home).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.22	Family and Friends Program NEMT Legs	Count and percent of Non-Emergency Medical Transportation one-way legs delivered through the Family and Friends Mileage program.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.24	Timeliness of Scheduled and Delivered NEMT Legs	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with and delivered by a contracted transportation provider during the measurement period, with an outcome of delivered on time. This measure excludes legs for methadone treatment, Family and Friends Mileage Reimbursement Program legs, legs provided by Easter Seals or other providers that offer their own NEMT services and directly transport members, and legs scheduled by a medical provider with a vendor other than the health plan's NEMT broker.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
NEMT.25	NEMT Network Adequacy Report	A narrative report that describes at the county and transportation mode level how the MCO and/or NEMT broker determine fleet size, changes to the NEMT network during the measurement period, and any activities the MCO has performed to ensure adequate NEMT network adequacy.	Narrative Report	Quarter	Quarterly	1 Month after end of Measurement Period									X
NEMT.26	Timely Processing of Electronic NEMT Claims: Thirty Days of Receipt	Count and percent of clean electronic Non-Emergency Medical Transportation (NEMT) claims processed within 30 calendar days of receipt, for those claims received during the measurement period. This includes non-emergency ambulance rides for hospital discharges and any rides for individuals who require an ambulance for non-emergency transport.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.27	NEMT Network Adequacy Table	This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers. This is separate from NETWORK.01.	Table	TBD	TBD	TBD									X
NEMT.28	NEMT Complaint Log	Standard template providing a quarterly report of all Non-Emergency Medical Transportation (NEMT) complaints received from a member, medical provider, or transportation provider during the measurement quarter.	Table	Month	Monthly	15 Days after end of Measurement Period									X
NEMT.29	Timeliness of Scheduled NEMT Legs from Nursing Facilities	Count and percent of Non-Emergency Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests from nursing facilities scheduled and delivered during the measurement period, with an outcome of delivered on time.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
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NEMT.30	NEMT Legs Delivered	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with a contracted transportation provider during the measurement period where the final outcome was a delivered leg. This measure includes legs for Opioid Treatment Programs (OTPs).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.32	Scheduled NEMT Trips with Issues Impacting Delivery	Count and percent of Non-Emergency Medical Transportation (NEMT) legs scheduled with a contracted transportation provider during the measurement period where an issue occurred that either resulted in no delivery or extra steps to ensure delivery of the leg. This measure includes legs for Opioid Treatment Programs (OTPs). Issues include: A. Member Canceled or Rescheduled, B. Member No Show, C. Transportation Provider Canceled Outside of Broker Timeframes, D. Transportation Provider No Show, E. Broker Unable to Secure Transportation, F. Incorrect Mode of Transportation Dispatched, and G. Other Reason Leg Wasn't Delivered.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table	Calendar Year	Annually	45 Calendar Days after end of Measurement Period		X	X		X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table	Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X		X	X			

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NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table	Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X		X	X			
OTPAUDIT.03	OTP Record Audits – Opioid Treatment Program Providers	Case level data from the MCO's audit of clinical records for Members receiving services provided by Opioid Treatment Programs (OTP).	Table	Measurement Year	Biennially (Every Two Years)	November 30th									X
OTPAUDIT.06	Quality and Performance Improvement Monitoring Report for Opioid Treatment Program Providers	Biennial narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.03 and any other provider performance reviews conducted by the MCOs to ensure the Opioid Treatment Program (OTP) full continuum of care is appropriately provided and supports Member access to timely and quality services. The report will include an analysis of the effectiveness of provider engagement activities over the past 12 months toward meeting the desired improved outcomes.	Narrative Report	Measurement Year	Biennially (Every Two Years)	January 31st									X
OTPAUDIT.08	Quality Improvement Progress Report for Opioid Treatment Programs	Biennial narrative report describing the implementation and continued monitoring of the MCO quality improvement activities included in the OTPAUDIT.06 report.	Narrative Report	Measurement Year	Biennially (Every Two Years)	August 31st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PCP_VISITS.01	Member Visits with Designated PCP or PCP Provider Team in the Last 12 Months	Percent of members who had one or more visits with their designated PCP or PCP Provider Team during the measurement period, by age group. This measure includes Non-Symptomatic Office Visits, Non-Urgent, Symptomatic Office Visits, Urgent, Symptomatic Office Visits, and Wellness Visits. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age or Older.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.02	Member Wellness Visits with Designated PCP or PCP Provider Team in the Last 12 Months	Count and percent of members who had one or more wellness visits with their designated PCP or PCP Provider Team during the measurement period, by age group. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age or Older.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.03	New Member Visits with Designated PCP or PCP Provider Team within 90 Days of PCP Selection/Assignment	Percent of new members who had one or more visits with their designated PCP or PCP Provider Team within 90 days of PCP selection/assignment, by age group. Age groups include A. Less than 1 Year of Age, B. 1-4 Years of Age, C. 5-11 Years of Age, D. 12-17 Years of Age, E. 18-39 Years of Age, F. 40-64 Years of Age, and G. 65 Years of Age and Over.	Measure	Quarter	Quarterly	7 Months after end of Measurement Period									~~X~~

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.08	Private Duty Nursing Hospitalization and Network Adequacy Report	This template will capture member detail about hospitalized PDN members and PDN network adequacy.	Table	Month	Monthly	1 Month after end of Measurement Period									X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC-DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure	Calendar Year	Annually	April 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.10	Proportion of Days Covered - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure	Calendar Year	Annually	April 30th									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.14	Proportion of Days Covered - Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite count and composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure	Calendar Year	Annually	April 30th									X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.10A	Child Psychotropic Medication Monitoring Report - Aggregate Data	Standard template of aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.10B	Child Psychotropic Medication Monitoring Report - DCYF PHI Data	Standard template of member specific information related to children 0-18 who have DCYF involvement and have multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.19	Provider-based Comprehensive Medication Review and Counseling Completions	Percent of eligible polypharmacy members who completed one or more comprehensive medication review and counseling (CMR) sessions in the six (6) months following the "Polypharmacy Initiation Date" by age group. This measure excludes Medicare/Medicaid dual enrollees until Medicare data is available. Age Groups include: Age 0-17 Years, Age 18-64 Years, and Age 65 and Over.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PHARMQI.21	Comprehensive Plan for Member Medical Record Information Sharing, Pharmacy Data Sharing, Medication Management, and Comprehensive Medication Reviews	Plan for data sharing efforts between the MCO and PCPs and behavioral health providers for member pharmacy data.	Plan	Agreement Year	Annually	May 1st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.22	Pharmacy Data Sharing Report	Narrative report describing outcome of data sharing efforts with providers, including successes and challenges, of the data sharing efforts.	Narrative Report	Quarter for first Agreement Year, then Agreement Year	Quarterly for first Agreement Year, then Annually	2 Months after end of Measurement Period for first Agreement Year, then October 31st									X
PHARMQI.23	Comprehensive Medication Review (CMR) Outcome Summary	Quarterly template providing DHHS with a summary of outcomes for the 6-month period following member comprehensive medication reviews.	Table	Quarter	Quarterly	5 Months after end of Measurement Period		X							X
PHARMQI.26	Comprehensive Medication Review (CMR) Log	Quarterly template that will provide DHHS with a log of members and providers who completed CMRs during the reporting period.	Table	Quarter	Quarterly	3 Months after end of Measurement Period			X						
PHARM UTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM UTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM UTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PMP.01	Program Management Plan	The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.	Plan	Agreement Year	Annually	May 1st									X
POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PRERELEASE.01	Community Reentry Pre-release Activity Log	Standard template for the MCO to report critical pre-release activity for adult and youth community reentry members. Template also includes log of key post-release events.	Table	Month	Monthly	1 Month after end of Measurement Period					X				X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period			X						
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measurement period.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls received during the measurement period and answered by a live voice within 30 seconds by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Manager (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned while waiting in call queue during the measurement period by the following health plan vendors: A: Main Health Plan, B: Pharmacy Benefit Management (PBM), C: Non-Emergent Medical Transportation (NEMT) Manager, D: Behavioral Health Manager, E: Vision Manager	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider calls received during the measurement period and answered by a live voice by the following reasons for Inquiry: A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info., etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other	Measure	Month	Monthly	1 Month after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages received after business hours and responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROV COMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVOUTNET.01	Out of Network Providers	Standard template providing a listing of out of network providers for which the MCO had paid claims during the measurement month.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period			X						X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan	Calendar Year	Annually	November 30th			X						
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report	Calendar Year	Annually	September 30th			X						
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure	TBD	TBD	TBD									X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of Medical Service, Equipment, and Supply service authorization determinations for urgent requests, made within 72 hours after receipt of request for requests made during the measurement period. Exclude requests for non-emergency medical transportation from this measure. Exclude Pharmacy claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of Medical Service, Equipment, and Supply Service authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measurement period. Exclude authorization requests that extend beyond the 14-day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for Non-Emergency Medical Transportation (NEMT) from this measure. Exclude Pharmacy Claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period. Includes reporting by age breakouts (< Age 21 and Age 21+)	Table	Quarter	Quarterly	2 Months after end of Measurement Period					X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of Post-Delivery service authorization determinations made within 30 calendar days of receipt of routine requests for Medical Services, Equipment, and Supply services. Exclude requests for Non-Emergency Medical Transportation (NEMT) from this measure. Exclude Pharmacy Claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Count and percent of service authorization requests denied or partially denied during the measurement period, by each of the following waiver and non-HCBC waiver groups: A. Non-HCBC Waiver; B. Developmentally Disabled (DD) Waiver; C. Acquired Brain Disorder (ABD) Waiver; D. In-Home Supports (IHS) Waiver; E. Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Count and percent of Physical, Occupational and Speech Therapy service authorizations denied or partially denied during the measurement period, by each of the following waiver and non-HCBC waiver groups: A. Non-HCBC Waiver; B. Developmentally Disabled (DD) Waiver; C. Acquired Brain Disorder (ABD) Waiver; D. In-Home Supports (IHS) Waiver; E. Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.17	Service Authorization Annual Report	A report that lists all items and services requiring prior authorization for the previous calendar year and associated metrics for each item or service. This report will satisfy requirements for 42 CFR 438.210 (f) and will be used for federal MCPAR reporting. The report will be due to NH DHHS by February 28th annually for review and is required to be posted publicly on the MCO's website by March 31st annually.	Narrative Report	Calendar Year	Annually	2 Months after end of Measurement Period			X						X
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
STATEFAIR HEARING.01	MCM Member State Fair Hearing Request Log	Template to provide DHHS with a quarterly report of all member MCM State Fair Hearing requests in process and resolved during the quarter. Include the record in future quarterly reports until the State Fair Hearing request is reported resolved.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period			X						X
SUBROGATION.02	No Lien Report	List of members in which the MCO has a request for subrogation claims for which the MCO sent a letter stating there were no lien.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period									X
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers within their network with high opioid prescribing rates. The report should include the MCO's operational definition of a provider with a high opioid prescribing rate, and the process for identifying and intervening with providers. The report should include aggregate data about the number of providers that are identified with high morphine milligram equivalent dose (MME) rates and the interventions used. Age breakouts are 0-17, 18+; and should exclude duals.	Narrative Report	Federal Fiscal Year	Annually	2 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
SUD_CMS_ IMD.25	Readmissions among Members with SUD	Number of all-cause readmissions during the measurement period among Medicaid beneficiaries with substance use disorder (SUD), followed by an acute readmission within 30 days. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #25)	Measure	Agreement Year	Annually	4 Months after end of Measurement Period					X				X
SUDAUDIT.01	SUD Treatment Record Audits	This report will be used to provide DHHS with aggregate level data associated with the SUD audits conducted by the MCOs utilizing the NH MCO SUD Audit tool. Follow the instructions in the NH MCO SUD Audit tool to transfer data into the SUDAUDIT.01 report template.	Table	Measurement Year	Biennially (Every Two Years)	November 30th									X
SUDAUDIT.05	Quality and Performance Improvement Monitoring Report for SUD Treatment Providers	Biennial narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.01 and any other provider performance reviews conducted by the MCOs to ensure the SUD full continuum of care is appropriately provided and supports Member access to timely and quality services.	Narrative Report	Measurement Year	Biennially (Every Two Years)	January 31st									X
SUDAUDIT.07	Quality Improvement Progress Report for SUD Treatment Programs	Annual narrative report describing the implementation and continued monitoring of the MCO quality improvement activities included in the SUDAUDIT.05 report.	Narrative Report	Measurement Year	Biennially (Every Two Years)	August 31st									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or subcontractor credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period									X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.04	Coordination of Benefits: Dual State Medicaid Enrollment	This template will provide DHHS with a monthly log of active NH Medicaid members in which the MCO has determined that the NH Medicaid member is concurrently enrolled in the corporate entity's other state Medicaid plan(s) (as applicable), or to report any Members discovered to be enrolled in any other State Medicaid program.	Table	TBD	TBD	TBD									X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report	Agreement Year	Annually	2 Months after end of Measurement Period			X						X

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
WELLNESS.01	Adult Preventive Wellness Visits	Count and percent of members 22 years of age and over who had at least one comprehensive wellness visit during the measurement period, by age group. Age groups include 22-44 Years of Age, 45-64 Years of Age, and 65 Years of Age and Over.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X

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State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify GRANITE STATE HEALTH PLAN, INC. is a New Hampshire corporation registered on March 14, 2012. I further certify that articles of dissolution have not been filed with this office; and the attached is a true copy of the list of documents on file in this office.

INFORMATION REGARDING ANNUAL REPORTS AND/OR FEES MUST BE OBTAINED FROM THE NEW HAMPSHIRE INSURANCE DEPARTMENT.

Business ID: **667495**
Certificate Number: **0007196727**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 10th day of June A.D. 2025.

David M. Scanlan
Secretary of State

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

State of New Hampshire

Department of State

Business Name : **Granite State Health Plan, Inc.**

Business ID : **667495**

Filing History

Filing#	Filing Date	Effective Date	Filing Type	Annual Report Year
0005664059	02/08/2022	02/08/2022	Amendment	N/A
0005659865	02/04/2022	02/04/2022	Registered Agent Change	N/A
0002911553	03/14/2012	03/14/2012	Business Formation	N/A

Trade Name Information

Business Name	Business ID	Business Status
New Hampshire Healthy Families	688160	Active
NH Healthy Families	743061	Active

Name History

Name	Name Type
No Name Changes found for this business.	

Principal Information

Name	Title
No Principal Infromation found for this business.	

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

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 NH HEALTHY FAMILIES is a New Hampshire Trade Name registered to transact business in New Hampshire on April 12, 2016. 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; and the attached is a true copy of the list of documents on file in this office.

Business ID: **743061**

Certificate Number: **0007196729**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 10th day of June A.D. 2025.

David M. Scanlan

Secretary of State

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

State of New Hampshire

Department of State

Business Name : **NH Healthy Families**

Business ID : **743061**

Filing History

Filing#	Filing Date	Effective Date	Filing Type	Annual Report Year
0005254845	02/11/2021	04/12/2021	Trade Name Renewal	N/A
0005254844	02/11/2021	02/11/2021	Tradename Information Change	N/A
0005027826	10/14/2020	10/14/2020	Tradename - First Renewal Notice	N/A
0003296859	04/12/2016	04/12/2016	Trade Name Registration	N/A

Trade Name Information

Business Name	Business ID	Business Status

Name History

Name	Name Type
No Name Changes found for this business.	

Principal Information

Name	Title
No Principal Infromation found for this business.	

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

CERTIFICATE OF AUTHORITY

I, Kendra L. Archer, hereby certify that:

1. I am the duly elected Secretary of Granite State Health Plan, Inc. dba New Hampshire Healthy Families, a New Hampshire corporation (the "Company").

2. The following is a true copy of a vote taken by written consent of the Board of Directors of the Company in lieu of meeting on April 1, 2025:

VOTED: That Geraldine M. Vaughan, Chairman of the Board, President, and Chief Executive Officer of the Company, is duly authorized on behalf of the Company 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 her judgement 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:

November 12, 2025

Signature of Elected Officer
Name: Kendra L. Archer
Title: Secretary

Docusign Envelope ID: 774C150E-8716-43C7-87E7-457FE4E439E6

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
05/22/2025

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
Aon Risk Services Central, Inc.
St. Louis MO Office
4220 Duncan Avenue
Suite 401
St Louis MO 63110 USA

CONTACT NAME:
PHONE (A/C. No. Ext): (866) 283-7122 **FAX (A/C. No.):** (800) 363-0105
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	XL Insurance America Inc	24554
INSURER B:	Zurich American Ins Co	16535
INSURER C:	American Zurich Ins Co	40142
INSURER D:	American Guarantee & Liability Ins Co	26247
INSURER E:		
INSURER F:		

INSURED
Granite State Health Plan, Inc.
dba New Hampshire Healthy Families
7700 Forsyth Blvd.
Suite 600
St. Louis MO 63105 USA

COVERAGES **CERTIFICATE NUMBER:** 570112661088 **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.

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [X] LOC OTHER:			GL0014909907	06/01/2025	06/01/2026	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$2,000,000 $1,000,000 $10,000 $2,000,000 $4,000,000 $4,000,000
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	
A	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED X RETENTION			US00152789LI25A SIR applies per policy terms & conditions	06/01/2025	06/01/2026	EACH OCCURRENCE AGGREGATE Retention	$5,000,000 $5,000,000 $10,000
C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N: N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WC647833312	06/01/2025	06/01/2026	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE-EA EMPLOYEE E.L. DISEASE-POLICY LIMIT	 $1,000,000 $1,000,000 $1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Should General Liability policy be cancelled before the expiration date thereof, the policy provisions of each policy will govern how notice of cancellation may be delivered to certificate holders in accordance with the policy provisions of policy.

CERTIFICATE HOLDER

NH Department of Health and Human Services
Attn: Nathan White
Brown Building
129 Pleasant Street
Concord NH 03301 USA

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

Aon Risk Services Central, Inc.

Holder Identifier :

Certificate No : 570112661088

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THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

License No: 89278606

Presents that Granite State Health Plan, Inc.
is hereby authorized to transact HMO lines of Insurance
in accordance with State Statute RSA 420-B
Exclusions: 8. Restricted to Medicaid Managed Care

THE STATE OF NEW HAMPSHIRE • INSURANCE DEPARTMENT •

Effective Date: 06/15/2025
Expiration Date: 06/14/2026

David J. Bettencourt
Commissioner of Insurance

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