State of New Hampshire

REQUEST FOR PROPOSAL

For

ADMINISTRATION OF MEDICAL BENEFITS

RFP # 2017-192

RESPONSE DUE BY:
April 19, 2017 at 2:00 PM Eastern Time (ET)

Department of Administrative Services
Risk Management Unit
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SECTION I: INTRODUCTION

This Request for Proposal (“RFP”) is issued by the Department of Administrative Services, acting through the Risk Management Unit, for a contract for the administration of medical benefits as described herein.

A. BACKGROUND

The State of New Hampshire (“State”) self-funds and administers its Employee and Retiree Health Benefit Plan (HBP) for approximately 37,000 covered lives. The covered population consists of approximately 25,000 active employees/dependents located throughout New Hampshire and the surrounding New England states. Included in the active enrollment is a “Special Group” of approximately 300 subscribers and their dependents from other organizations that have been either legislatively or traditionally offered coverage under the State’s HBP. In addition, the State provides medical benefits to approximately 2,900 non-Medicare retirees/dependents and to 9,300 Medicare retirees. Retirees are located throughout the country.

The chart below outlines the December 2016 enrollment by population and type of plan:

<table>
<thead>
<tr>
<th>Active Plan Options</th>
<th>Subscribers</th>
<th>Dependents</th>
<th>Total Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Plan</td>
<td>8,646</td>
<td>13,508</td>
<td>22,154</td>
</tr>
<tr>
<td>POS Plan</td>
<td>1,173</td>
<td>1,607</td>
<td>2,780</td>
</tr>
<tr>
<td><strong>Total Actives</strong></td>
<td><strong>9,819</strong></td>
<td><strong>15,115</strong></td>
<td><strong>24,934</strong></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Retiree Plan Options</th>
<th>Subscribers</th>
<th>Dependents</th>
<th>Total Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicare Retiree (&lt;65) Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS Plan</td>
<td>1,934</td>
<td>662</td>
<td>2,596</td>
</tr>
<tr>
<td>PPO Plan</td>
<td>250</td>
<td>81</td>
<td>331</td>
</tr>
<tr>
<td><strong>Total Non-Medicare Retiree Plan</strong></td>
<td><strong>2,184</strong></td>
<td><strong>743</strong></td>
<td><strong>2,927</strong></td>
</tr>
<tr>
<td>Medicare Retiree (65+) Plan</td>
<td>9,298</td>
<td>N/A</td>
<td>9,298</td>
</tr>
<tr>
<td><strong>Total Retirees</strong></td>
<td><strong>11,482</strong></td>
<td><strong>743</strong></td>
<td><strong>12,225</strong></td>
</tr>
</tbody>
</table>

Anthem Health Plans of New Hampshire has administered the self-funded medical benefits since January 1, 2008. The State is currently under contract with Express Scripts for Pharmacy Benefit Management Services. Pharmacy benefits are not being considered in this RFP.

Every two years, the State collectively bargains employee health benefits, including plan design, health promotion programs and employee-facing initiatives, with the State’s unions. There are five unions represented including the New Hampshire State Employees’ Association of New Hampshire, SEIU 1984 (SEA), the New Hampshire Trooper’s Association (NHTA), NHTA – Command Staff, Teamsters Local 633 and the New England Police Benevolent Association (NEPBA) with multiple Locals. At this time, all unions have agreed to the same plan design and programs.

B. OBJECTIVE

The State has two main objectives for the RFP:

1. The State is seeking proposals to provide medical administration services for its self-funded Employee and Retiree Health Benefit Plan (HBP), including the services and programs described in Section III of this document.

   **Important Notice:** As a requirement of this RFP, the selected Bidder shall demonstrate their ability to offer “Site-of-Service” locations in all geographic regions of the State. (Section III.B provides a

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1 In this RFP document and the supporting information, the “Non-Medicare Retiree Plan” may also be referred to as the “Retiree <65 Plan” and the “Medicare Retiree Plan” may also be referred to as the “Retiree 65+ Plan”.
description of the current “Site-of-Service” program.) In the event that the Bidder does not have existing “Site-of-Service” locations in all geographic regions, the Bidder shall include in its bid (as requested in Section IX.F) a plan to execute contracts to establish “Site-of-Service” access to all geographic regions no later than August 1, 2017.

Bidders are encouraged to begin the process of negotiations for Site-of-Service coverage for all locations as soon as possible. Time is of the essence. In the event that the “Site-of-Service” locations are not in place by August 1, 2017, the State shall terminate contract negotiations with the selected Bidder and move to the next highest scoring Bidder. The State will not enter into an Agreement with a selected Bidder that cannot demonstrate “Site-of-Service” locations in all geographic regions of the State.

2. The State seeks to partner with its third-party medical plan administrator (TPA) to enhance the quality and cost-effectiveness of health care purchased by the State through a comprehensive, value-based approach to purchasing, contract management and payment. The partnership shall involve collaboration between the State and its TPA in all aspects of purchasing, provider contracting and activating members with the ultimate goal of changing the way healthcare is delivered to all members of the State’s plan in support of total population health.

As mentioned above, all unions have independently agreed to the same plan design and programs. The State requires Bidders to duplicate the current plan design for the active plans. (See Appendix A for the current active plan design.) It is important to note that the State is currently participating in collective bargaining and negotiations with all of the unions. The Collective Bargaining Agreements (CBA) are expected to be effective on July 1, 2017, however each CBA has an evergreen provision. Medical benefit changes are typically implemented on a calendar year basis. Therefore, if any plan design changes are agreed upon, they likely will be effective January 1, 2018.

The State’s contract with a third-party medical plan administrator (TPA) requires the TPA to implement any changes in plan design or coverage resulting from collective bargaining throughout the term of the contract. In addition, the TPA shall provide financial modeling to assist the State with consideration of plan changes. It is possible for the State to be required to manage multiple plan designs to comply with each of the collectively bargained units. The State reserves the right within any contract awarded under this RFP to re-negotiate elements of the contract as required under collective bargaining agreements.

The State also requires Bidders to duplicate the current retiree health benefit plans due to current legislative authorization. (See Appendix A for the current retiree plan design.) Additionally, the State’s contract with a TPA requires the TPA to implement any changes in plan design or coverage resulting from legislative authorization throughout the term of the contract. In addition, the TPA shall provide financial modeling to assist the State with consideration of plan changes. The State reserves the right within any contract awarded under this RFP to re-negotiate elements of the contract as required by legislative changes.

It is essential that the Bidder “duplicate” plan design, and provide similarity in services, statewide network and program access for plan members. See Section III and Appendix A for plan design, services, and programs and Section IV for network access and match.
Value-Based Purchasing and Contracting Objectives

As stated above, one of the State’s major objectives is to partner with its third-party medical plan administrator to enhance the quality and cost-effectiveness of health care purchased by the State through a comprehensive, value-based approach to purchasing, contract management and payment.

The State’s value-based purchasing (VBP) strategy will require the selected Bidder to work proactively and collaboratively with the State to achieve objective and measurable improvements in performance consistent with Value-Based Purchasing Specifications included in Appendix B. VBP involves ongoing performance measurement and actively working to move performance along a continuum at the TPA and healthcare provider levels. For example, the State will require the successful Bidder to develop and report on annual improvement goals and measures related to targeted Value-Based Purchasing Specifications (see Appendix B). The selected Bidder will participate in semi-annual meetings with the State to review its progress towards the improvement goals and its performance to contract standards.

Coordinated activity across the Bidder’s provider contracting, network management, and quality improvement functions will be required for the selected Bidder to be successful in this VBP approach. To meet the objectives for this procurement, the State seeks a partner who will:

- manage a network of providers that is accessible and responsive, assure continuity and quality of care; provide care management and service coordination, and maximize program efficiencies and patient activation;
- implement successful alternative payment models to create financial support and incentives for healthcare providers to focus on the value of healthcare services rather than the volume of services;
- improve and enhance primary care services and care coordination provided to members, including the integration of behavioral health services and physical health services;
- work collaboratively with the State to continuously improve health care provided to our members and improve their health status, including the methods of measurement used to demonstrate improvement along a continuum; and
- proactively offer suggestions and recommendations throughout the contract period for strategies that enhance the State and the TPA’s efforts to improve quality and cost effective healthcare purchasing, including but not limited to, encouraging healthcare provider engagement and member activation toward an overall improved health status and how it will be measured.

The State recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated selected Bidder performance. The State will develop a Performance Indicator Dashboard to assemble performance indicators that assess dimensions of the selected Bidder’s performance. It is the State’s objective to recognize the selected Bidder for their excellence in performance and improvement within existing financial constraints. Performance incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboard. See Section IV for more detail and the required clinical quality measures.

Contract Length & Specifics

The State seeks to contract with a qualified Bidder commencing on or about September 6, 2017 and ending on December 31, 2020 with the option to extend for up to two additional years as mutually agreed and approved by the Governor and Executive Council. The administrative services outlined in this RFP shall commence on January 1, 2018. Implementation activities shall commence within seven days of Governor and Executive Council (G&C) approval but in no event earlier than September 6, 2017. Payments for contractual services shall commence January 1, 2018 and shall not be made during the implementation period.
SECTION II: BIDDING INSTRUCTIONS AND CONDITIONS

A. PROPOSAL CONDITIONS FOR THE STATE OF NEW HAMPSHIRE, DEPARTMENT OF ADMINISTRATIVE SERVICES, RISK MANAGEMENT UNIT

1. RFP SCOPE

The Department of Administrative Services, Risk Management Unit, is soliciting proposals for Medical Administration Services as described in these procurement documents.

2. MANDATORY INSTRUCTIONS FOR BIDDERS

It is required that you complete all sections of the RFP and provide your proposal by the stated proposal submission deadline. **Do not alter any parts of this RFP, to include the questions and the question numbering.**

Failure to follow these instructions may be grounds for rejection of your RFP response.

3. POINT OF CONTACT

Purchasing Agent, Danielle Bishop, or her designee, shall be the single point of contact for this RFP, whether verbal or written.

4. RFP INQUIRIES

The State will host a Bidding Instructions and Conditions conference call on March 15, 2017. The purpose of the call is to answer any procedural questions related to submitting a bid. Questions related to specifications contained herein or the services requested will not be addressed during this call.

All technical questions regarding this RFP, including questions related to the form contract P-37, must be submitted to Danielle Bishop at Danielle.Bishop@nh.gov. All questions must be submitted in writing prior to the deadline for Bidder Inquiries and/or Requests for Clarification deadline of March 22, 2017 at 3:00PM ET. Responses will be posted online in the form of an Addendum on or before March 31, 2017.

The Bidder must include complete contact information including the Bidder’s name, telephone number, fax number, and e-mail address. The State shall attempt to provide any assistance or additional information of a reasonable nature, which might be required by interested Bidders. The questions and answers will be consolidated and responded to via a written addendum, or addenda that will be posted on the State’s website by March 31, 2017. The Agency may consolidate and/or paraphrase questions for sufficiency and clarity.

RFP inquiries must be submitted by an individual authorized to commit the organization to provide the services necessary to meet the requirements of this RFP.

Appendix J is a Data Request Form which must be filled out and faxed to 603-271-2700 or scanned and emailed to Danielle.Bishop@nh.gov to obtain data referred to in Appendices D and E.

5. ADDENDA

In the event it becomes necessary to add to or revise any part of this RFP prior to the scheduled proposal submittal deadline, the Risk Management Unit shall post any Addenda on the State’s vendor website. Before your submission and periodically prior to the RFP closing, check the website for any addenda or other materials that may have been issued affecting the RFP. The web site address is https://das.nh.gov/Purchasing/vendorresources.asp.
6. **BIDDER CERTIFICATIONS**

All Bidders must be duly registered as a vendor authorized to conduct business in the State of New Hampshire. Bidders shall comply with the certifications below at the time of submission and through the term of any contract which results from said proposal. Failure to comply shall be grounds for disqualification of proposal and/or the termination of any resultant contract.

- **STATE OF NEW HAMPSHIRE VENDOR APPLICATION:** Prior to bid award, Bidders must have a completed Vendor Application Package on file with the NH Bureau of Purchase and Property. See the following website for information on obtaining and filing the required forms (no fee): [https://das.nh.gov/Purchasing/vendor.asp](https://das.nh.gov/Purchasing/vendor.asp)

- **NEW HAMPSHIRE SECRETARY OF STATE REGISTRATION:** A bid award, in the form of a contract(s), will **ONLY** be awarded to a Vendor who is registered to do business **AND** in good standing with the State of New Hampshire. Please visit the following website to find out more about the requirements for registration with the NH Secretary of State: [http://sos.nh.gov/corp_div.aspx](http://sos.nh.gov/corp_div.aspx)

- **CONFIDENTIALITY & CRIMINAL RECORD:** If Applicable, by the using agency, the Vendor shall have signed by each of employees or its approved sub-contractor(s), if any, working in the office or externally with the State of New Hampshire records a Confidentiality form and Criminal Record Authorization Form. These forms shall be returned to the individual using agency prior to the start of any work.

7. **PUBLIC DISCLOSURE**

A. **Introduction**

Pursuant to RSA 21-G:37, all responses to this RFP shall be considered confidential until the award of a contract. At the time of receipt of proposals, the Agency will post the number of responses received with no further information. No later than five (5) business days prior to submission of a contract to Governor & Executive Council pursuant to this RFP, the Agency will post the name, rank or score of each Bidder.

The State of New Hampshire has made it a priority through the Right-to-Know law (RSA 91-A), the TransparentNH initiative, and other statutes and practices to ensure that government activity is open and transparent. In general, these requirements allow for public review, disclosure and posting of government and public records. As such, the State is obligated to make public the information submitted in response to this RFP, any resulting contract, and information provided during the contractual relationship. The Right-to-Know law obligates the State to conduct an independent analysis of the confidentiality of the information submitted, regardless of whether it is marked confidential.

In addition, the Governor and Council (G&C) contract approval process more specifically requires that pricing be made public and that any contract reaching the G&C agenda for approval be posted online.

B. **Disclosure of Information Submitted in Response to RFP**

Information submitted in response to this request for proposal (RFP) is subject to public disclosure under the Right-to-Know law after a contract is actually awarded by G&C. Notwithstanding the Right-to-Know law, no information concerning the contracting process, including but not limited to information related to proposals, communications between the parties or contract negotiations, shall be available until a contract is actually awarded by G&C.

Confidential, commercial or financial information may be exempt from public disclosure under RSA 91-A:5, IV. If you believe any information submitted in response to this request for proposal should be kept confidential, you must specifically identify that information where it appears in your submission in a manner that draws attention to the designation. You must also provide a letter to the person listed as
the point of contact for this RFP, identifying the specific page number and section of the information you consider to be confidential, commercial or financial and providing your rationale for each designation. Marking or designating an entire proposal, attachment or section as confidential shall neither be accepted nor honored by the State.

Pricing and other information that relates to your contractual obligations in your proposal or any subsequently awarded contract shall be subject to public disclosure regardless of whether it is marked as confidential.

Notwithstanding a Bidder’s designations, the State is obligated by the Right-to-Know law to conduct an independent analysis of the confidentiality of the information submitted in a proposal. If a request is made to the State by any person or entity to view or receive copies of any portion of your proposal, the State shall first assess what information it is obligated to release. It will then notify you that a request has been made, indicate what, if any, information the State has assessed is confidential and will not be released, and specify the planned release date of the remaining portions of the proposal. To halt the release of information by the State, a Bidder must obtain and provide to the State, prior to the date specified in the notice, a court order valid and enforceable in the State of New Hampshire, at its sole expense, enjoining the release of the requested information.

By submitting a proposal, you acknowledge and agree that:

- The State may disclose any and all portions of the proposal or related materials which are not marked as confidential and/or which have not been specifically explained in the letter to the person identified as the point of contact for this RFP;
- The State is not obligated to comply with your designations regarding confidentiality and must conduct an independent analysis to assess the confidentiality of the information submitted in your proposal; and
- The State may, unless otherwise prohibited by court order, release the information on the date specified in the notice described above without any liability to you.

C. Electronic Posting of Resulting Contract

RSA 91-A obligates disclosure of contracts resulting from responses to RFPs. As such, the Secretary of State provides to the public any document submitted to G&C for approval, and posts those documents, including the contract, on its website. Further, RSA 9- F:1 requires that contracts stemming from RFPs be posted online. By submitting a proposal you acknowledge and agree that, in accordance with the above mentioned statutes and policies, (and regardless of whether any specific request is made to view any document relating to this RFP), any contract resulting from this RFP will be made accessible to the public online via the State’s website without any redaction whatsoever.

8. TERMS OF SUBMISSION

The State assumes no responsibility for understandings or representations concerning conditions made by its officers or employees prior to and in the event of the execution of a contract, unless such understanding or representations are specifically incorporated into this RFP. Verbal discussions pertaining to modifications or clarifications of this RFP shall not be considered part of this RFP unless confirmed in writing. Any information provided by the Bidder verbally shall not be considered part of that Bidder’s response. By submitting a Proposal, a Bidder agrees that in no event shall the Agency be either responsible for or held liable for any costs incurred by a Bidder in the preparation of or in connection with the Proposal, or for Work performed prior to the Effective Date of a resulting Contract.
9. SUBMISSION FORMAT

Instructions, formats, and approaches for the development of RFP information contained within the RFP are designed to ensure that the submission of data essential to the understanding of the Bidder’s response is received in a consistent and comparable format.

Your RFP response must be clearly sectioned and tabbed as outlined within this RFP document. (e.g. Section II. Step 1, Step 2, etc.) There is no intent to limit the content of the responses in other than the Bidder’s favor, only to assist the evaluation committee in reviewing each response.

10. PROPOSAL SUBMISSION DEADLINE

All RFP submissions must be received at the Bureau of Purchase and Property no later than 2:00 PM ET on Wednesday, April 19, 2017. Submissions received after the date and time specified will be marked as late and will not be considered.

All offers shall remain valid from the proposal submission deadline until the earlier of the contract award, or September 6, 2017. A Bidder’s disclosure or distribution of proposals other than to the Department of Administrative Services, Bureau of Purchase and Property, shall be grounds for disqualification. No more than one (1) proposal per respondent shall be submitted.

Bidders shall submit their proposal to:

State of New Hampshire
C/O Danielle Bishop, Administrative Services
New Hampshire Bureau of Purchase and Property
25 Capitol Street
Concord, NH 03301-6312
(603) 271-2201

Proposal responses shall be marked as:
State of New Hampshire, RFP # 2017-192
Due Date: April 19, 2017 @ 2:00 PM ET
Administration of Medical Benefits

11. RFP DELIVERY

Your RFP response must conform to the following criteria in order to be considered for evaluation:

a. RFP submissions shall be hard copies.

b. RFP responses shall be addressed as described in Item 11 above

c. Exterior of the package shall be permanently marked identifying the submitting party’s name and address.

d. Package shall be sealed (tape, glue etc.).

e. RFP submissions may be hand delivered, mailed, or sent via package delivery service (UPS, FedEx, courier). In all cases, the Bureau of Purchase and Property must receive your submission no later than the due date and time.

f. Bidders are encouraged to confirm delivery of their submissions by calling 603-271-2201 or by emailing prchweb@nh.gov.

g. RFP responses must include:

i. One (1) original (clearly identified as such) of your RFP responses to Sections II to IX, including Appendix F (Plan Deviations Form), “SONH RFP Attachment” workbook file, and any Addenda in numerical sequence and signed;
ii. Six (6) conforming copies (clearly identified as a copy) of your RFP responses; and

iii. Two (2) electronic* copies of your RFP responses on secure thumb drives.
   a) The two (2) electronic copies of your RFP shall include responses to all questions in Sections II to IX of this RFP document in MS Word format. DO NOT PDF your response.
   b) The two (2) electronic copies of your RFP shall also include the “SONH RFP Attachment” workbook file in MS Excel format. DO NOT PDF your response.

iv. The original RFP response must include Appendix G, State of NH Transmittal Letter, signed by a person authorized to bind the company to all commitments made in the RFP response. Failure to submit the Transmittal Letter with your response will result in rejection of your response.

v. RFP responses transmitted by facsimile or e-mail shall not be accepted or reviewed.

* In the event of a discrepancy between a proposal response received in paper and electronic copy, the paper copy identified as the ‘original’ shall prevail.

The State shall not be held liable for any costs incurred by the Bidder in preparing or submitting an RFP response. Any and all damage, which may occur due to shipping, is the Bidder’s responsibility.

12. ADDITIONAL INFORMATION

The State reserves the right to:

- Make a written request for additional information in writing from a Bidder to assist in understanding or clarifying a proposal response;
- Waive minor or immaterial deviations from the RFP requirements, if determined to be in the best interest of the State;
- Omit any planned evaluation step if, in the Agency’s view, the step is not needed;
- Reject any and all proposals, or any part thereof.

13. RIGHT TO CONSIDER AVAILABLE INFORMATION

The State reserves the right to consider available information regarding the Bidder, whether gained from the Bidder’s proposal, question and answer conferences, references, or any other source during the evaluation process. This may include, but is not limited to, information from the New Hampshire Department of Insurance, as well as any other state or federal regulatory entity.

14. RESTRICTION OF CONTACT WITH STATE EMPLOYEES

From the release date of this RFP, all contact with personnel employed by or under contract with the State related to this RFP, except the point of contact specifically mentioned in this Section II, Item 3 of this RFP, is prohibited. Improper contact is grounds for rejection of your response.

15. CANCELLATION

The State reserves the right to cancel all or any part of this RFP at any time. Cancellation of this RFP, in whole or in part, shall not bar the State from issuing an RFP for the same services or from purchasing the same services through other means.

16. ETHICAL REQUIREMENTS

From the time this RFP is published until a contract is awarded, no Bidder shall offer or give, directly or indirectly, any gift, expense reimbursement, or honorarium, as defined by RSA 15-B, to any elected official, public official, public employee, constitutional official, or family member of any such official or employee who will or has selected, evaluated, or awarded an RFP, or similar submission. Any Bidder that violates RSA 21-G:38 shall be subject to prosecution for an offense under RSA 640:2. Any Bidder
who has been convicted of an offense based on conduct in violation of this section, which has not been
annulled, or who is subject to a pending criminal charge for such an offense, shall be disqualified from
bidding on the RFP, or similar request for submission and every such Bidder shall be disqualified from
bidding on any RFP or similar request for submission issued by any state agency.

17. REQUIRED CONTRACT TERMS AND CONDITIONS

a. The form contract P-37 (attached hereto as Appendix H) shall form the basis for any resulting
contract. The successful Bidder and the State, following notification of award, shall promptly
execute the P-37 contract, as amended by the parties to incorporate the service requirements of
this RFP, price conditions established by the Bidder’s offer, and any other reasonable
administrative practices and services.

b. The form contract Business Associate Agreement (attached hereto as Appendix I), is required to
comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and
with the Standards for Privacy and Security of Individually Identifiable Health Information, 45
CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates, shall
be promptly executed by the successful Bidder and State, following notification of contract award.

B. ESTIMATED RFP TIMETABLE

<table>
<thead>
<tr>
<th>Action</th>
<th>Due Date (Eastern Time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RFP Released</td>
<td>Thursday, March 9, 2017</td>
</tr>
<tr>
<td>Bidder Conference Call for Procedural Questions</td>
<td>Tuesday, March 15, 2017</td>
</tr>
<tr>
<td></td>
<td>3:00 PM ET</td>
</tr>
<tr>
<td></td>
<td>Call-In Number: 1-415-655-0001</td>
</tr>
<tr>
<td></td>
<td>Access Code: 738 430 249</td>
</tr>
<tr>
<td>Deadline for Bidder Inquiries and/or Requests for Clarification and Proposed Specification Changes</td>
<td>Wednesday, March 22, 2017</td>
</tr>
<tr>
<td></td>
<td>at 3:00 PM ET</td>
</tr>
<tr>
<td>Response to Bidder Inquiries and/or Requests for Clarification and Proposed Specification Changes</td>
<td>No later than</td>
</tr>
<tr>
<td></td>
<td>Friday, March 31, 2017</td>
</tr>
<tr>
<td>Proposal Submission Deadline</td>
<td>Wednesday, April 19, 2017</td>
</tr>
<tr>
<td></td>
<td>at 2:00 PM ET</td>
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<tr>
<td>Notification of Intent to Award</td>
<td>Wednesday, August 23, 2017</td>
</tr>
<tr>
<td>Contract Effective Date</td>
<td>Wednesday, September 6, 2017 or Upon Governor</td>
</tr>
<tr>
<td></td>
<td>&amp; Executive Council (G&amp;C) approval</td>
</tr>
<tr>
<td>Contract Implementation Period</td>
<td>G&amp;C Approval through December 31, 2017</td>
</tr>
<tr>
<td>TPA Effective Date</td>
<td>January 1, 2018</td>
</tr>
</tbody>
</table>

C. EVALUATION PROCESS

Segal Consulting (with assistance from Bailit Health) has been retained by the State to assist in the
evaluation of each Bidder’s responses for completeness and responsiveness to the RFP and to assist in the
review of such responses. The State’s designated evaluation team will review and score Bidder responses
and select the highest ranking proposal. All proposals will be evaluated in accordance with the State
procedures set forth in Steps #1 through #4 below.
STEP #1: MINIMUM QUALIFICATIONS

Each proposal shall be evaluated initially to determine compliance with the State of New Hampshire’s Minimum Qualifications. Any proposal that fails to meet one (1) or more of the following six (6) qualifications shall be eliminated from further consideration for this contract. Any proposal that meets all of the minimum qualifications shall be further evaluated in accordance with the State’s selection criteria. Therefore, to receive further consideration, a proposal must check “YES” to each of the following questions and comply fully with the “Submission Requirement(s)” for each such qualification.

1. Is the Bidder able and willing to demonstrate its financial stability?
   
   [ ] YES [ ] NO

   Submission Requirements: a) Bidder’s most recent financial report; b) most recent independent auditor’s report; and c) SSAE 16, SAS-70, or equivalent external audit of Bidder’s operations. Attach to proposal.

2. Has the Bidder provided as part of its proposal the fee and cost information requested in this RFP including the information requested in the Financial Section VIII?

   [ ] YES [ ] NO

   Submission Requirements: Full and complete responses to the Financial worksheets and information requested in Section VIII of this RFP.

3. Has the Bidder sufficient access to network providers (physicians, specialists and hospitals)? Bidders must meet the following access standards:

   Physician Provider Access: 90% of eligible members access to two network physicians within 15 miles

   Hospital Provider Access: 90% of eligible members access to one network hospital within 15 miles

   [ ] YES [ ] NO

   Submission Requirements: Full and complete responses to the provider network information requests made in Section VII of this RFP.

4. Is the Bidder able and willing to agree to all of the performance guarantees set forth in the Required Performance Guarantees Section V of the RFP?

   [ ] YES [ ] NO

   Submission Requirement: Completion of, with affirmative responses, the Required Performance Guarantees Section V.

5. Has the Bidder provided as part of its proposal all information requested in this RFP including all information requested in the Technical Questionnaire Section IX?

   [ ] YES [ ] NO

   Submission Requirements: Full and complete responses to all of the information requests made in Section IX of this RFP.
6. Has the Bidder provided as part of its proposal complete client reference information requested in the Client References Section X?

[ ] YES [ ] NO

Submission Requirements: Full and complete responses to all of the information requested in Section X.

STEP #2: FINANCIAL SCORING (50 TOTAL POINTS)

A. **Total Projected Costs Score (40 Points of Financial Scoring) – Sections VIII.A and VIII.C**

The proposals will be scored based on the total projected costs (i.e., claims and administrative costs) as determined by the State for the three-year period from January 1, 2018 to December 31, 2020. The lowest cost proposal will receive 100% of the 40 points allocated for the “Total Projected Costs” (TPC) Financial Score. All other financial proposals will be scored on a sliding scale where the bidder’s score will be reduced by 1 point for every percentage point it is higher than the lowest cost proposal. As the scale is sliding, scores will be adjusted for partial percentage differences.

The following exhibit illustrates how the “Total Projected Costs” (TPC) financial score will be calculated from the 40 points available:

<table>
<thead>
<tr>
<th></th>
<th>Formula</th>
<th>Example, where:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Cost Difference = (Bidder’s TPC / Lowest Bid TPC) – 1</td>
<td>Lowest Bid TPC = $1,000 and Bidder TPC = $1,025</td>
<td>( (\frac{1,025}{1,000}) - 1 = 0.025 )</td>
</tr>
<tr>
<td>B</td>
<td>Convert Decimal to Percent Value = A x 100</td>
<td>( 0.025 \times 100 = 2.5 )</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>1 Point Reduction per Percentage Higher = 1 x B</td>
<td>( 1 \times 2.5 = 2.5 )</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bidder’s TPC Score = 40 - C</td>
<td>( 40 - 2.5 = 37.5 )</td>
<td></td>
</tr>
</tbody>
</table>

B. **Alternative Payment Models Score (10 Points of Financial Scoring) – Section VIII.D**

Ten (10) of the financial score points are based on the bidder’s experience with Alternative Payment Models. Your proposal shall be scored in consideration of the following:

- Provided evidence that the bidder has implemented three population-based contracts with providers involving downside risk sharing for commercial lives (fully insured and/or self-funded) with completed performance periods.
- The extent to which the three contracts have produced positive financial results. That is, the total medical spending associated with the contract, including any PMPM payments made to the provider for care management or other provider functions, was less than the contractual spending target established by the contractual terms.
- Provided evidence that any quality measures associated with the three cited population-based contracts produced statistically significantly improved performance during the contractual performance period. For example, the Bidder demonstrates that the percentage of members with diabetes whose blood pressure was <140/90 during a contractual performance period increased over the prior performance year percentage and the increase was statistically significant at a p < .05 level.
STEP #3: TECHNICAL SCORING (45 TOTAL POINTS)

The Bidder’s response to information requested in Section IX of the RFP will be evaluated based on the extent to which the Bidder documents conformance with specifications, as well as the completeness, soundness, and creativity of the Bidder’s response, all as evaluated by the State.

The State will evaluate proposals based on technical criteria, including:

- Value-Based Purchasing – the extent to which the Bidder demonstrates its experience and commitment to value-based purchasing. (10 Points; Section IX.A)

- Administrative, Member, Claims Paying Services, Reporting Services – the extent to which the Bidder demonstrates its competence in providing the requested administrative and member support services. (10 Points; Sections IX.B and IX.C)

- Health Management Programs – the extent to which the Bidder demonstrates its ability to provide the utilization, case, and disease management programs requested by the State. (10 Points; Section IX.D)

- Wellness Services – the extent to which the Bidder demonstrates its ability to administer the State’s current wellness program and benefits. (10 Points; Section IX.E)

- Tiered-Networks/Site-of-Service – the extent to which the Bidder demonstrates its ability to offer a plan provision comparable to the State’s “Site-of-Service” benefit and offer locations in all geographic regions of the State of New Hampshire. (5 Points; Section IX.F)

STEP #4: CONTRACT AWARD

The State shall award a contract, if at all, to the Bidder submitting the highest ranked proposal. Formal and final selection of the Bidder, however, is contingent upon the successful negotiation and the proper execution of all contract documents (acceptable to the State) and the approval of the Governor and Executive Council. If the State is unable to reach agreement with the Bidder, the State may, at its sole discretion and at any time and without liability to the Bidder, immediately terminate such contract discussions with the Bidder and undertake discussion with the Bidder submitting the next highest ranked proposal, and so on.

Evaluation of the proposals shall include, the criteria below. Bidders will receive scores up to the maximum points allocated to each item outlined below.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Points</th>
<th>Section(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FINANCIAL</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Projected Costs</td>
<td>40</td>
<td>VIII.A and VIII.C</td>
</tr>
<tr>
<td>Alternative Payment Models</td>
<td>10</td>
<td>VII.D</td>
</tr>
<tr>
<td><strong>TECHNICAL QUESTIONNAIRE</strong></td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Value-Based Purchasing</td>
<td>10</td>
<td>IX.A</td>
</tr>
<tr>
<td>Administrative, Member, Claims Paying Services, Reporting Services</td>
<td>10</td>
<td>IX.B and IX.C</td>
</tr>
<tr>
<td>Health Management Programs</td>
<td>10</td>
<td>IX.D</td>
</tr>
<tr>
<td>Wellness Services</td>
<td>10</td>
<td>IX.E</td>
</tr>
<tr>
<td>Tiered-Networks / Site-of-Service</td>
<td>5</td>
<td>IX.F</td>
</tr>
<tr>
<td><strong>CLIENT REFERENCES</strong></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>TOTAL POINTS</strong></td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

* All fees to be assumed by the State for all the requested services shall be included in the financial section of this RFP.
D. SUBCONTRACTING

Subcontracting of services shall require prior approval by the State. If your organization plans to utilize subcontractors for any portion of the services identified in this RFP, please include the subcontractor information, to include an outline of the services or functions in which you would plan to subcontract, the length of your relationship with the subcontractor, and a brief company profile.

Bidder shall be accountable for the performance of all subcontractors and shall be responsible for all performance guarantee penalties (See Section V) that may result from underperformance of the subcontractor.

E. BIDDER CONTACTS

Designate the individual(s) with the following responsibilities:

The individual(s) representing your company during the RFP process:

Representative Name:______________________ Phone #:______________ Email: ___________________

The individual(s) responsible for day-to-day service (if different):

Representative Name:______________________ Phone #:______________ Email: ___________________
SECTION III: REQUIRED PLAN DESIGNS, SERVICES AND PROGRAMS

A. PLAN DESIGN

Due to the existence of collective bargaining agreements and required legislative authorization, the State requires Bidders to duplicate the active and retiree plan designs.

Please review the attached Summaries of Benefits and complete the “Plan Deviations Form” located in Appendix F. If no deviations are provided on this form, it will be assumed that your organization can administer the current plan designs exactly as written in the following attached Summary of Benefits.

- State of NH Active HMO Plan.pdf
- State of NH Active POS Plan.pdf
- State of NH Ret 65+ Plan.pdf

B. “SITE-OF-SERVICE” PLAN PROVISION

The State’s Active Plans have an option that allows members to avoid paying the deductible on lab tests and outpatient surgery services if the member chooses to use a low-cost “Site-of-Service” lab or Ambulatory Surgery Center. The “Site-of-Service” provision functions similarly to a tiered-network in that plan participants reduce (or avoid) out-of-pocket costs for using preferred providers and the plan benefits from utilization of low-cost providers.

See design summaries and the “Site-of-Service” benefit information in Appendix A.

The State’s Active Plans are collective bargained with this plan provision. Your proposal must offer a benefit comparable to the current “Site-of-Service” feature. The following link provides “Site-of-Service” program information: https://www11.anthem.com/stateofnhsaves/.

- Confirm that you are able to offer this feature.
- Provide a description of your Site-of-Service program including how pricing differentials factor into tiering.
- Indicate which providers are your proposed “Site-of-Service” providers in your response to the network section of this RFP (see Section VII).
- As a requirement of this RFP, the selected Bidder shall demonstrate their ability to offer “Site-of-Service” locations in all geographic regions of the State. In the event that the Bidder does not have existing “Site-of-Service” locations in all geographic regions, the Bidder shall include in its bid (as requested in Section VIII.F) a plan to execute contracts to establish “Site-of-Service” access to all geographic regions no later than August 1, 2017. In the event that the “Site-of-Service” locations are not in place by August 1, 2017, the State shall terminate contract negotiations with the selected Bidder and move to the next highest scoring Bidder. The State will not enter into an Agreement with a selected Bidder that cannot demonstrate “Site-of-Service” locations in all geographic regions of the State.
C. GENERAL SERVICES

To be eligible to receive a score for the Technical Questionnaire in Section IX, Bidders are required to offer comprehensive medical administration services with a full range of customer (client and member) service including, but not limited to:

*Indicate the name and address of the legal entity providing any of the services below, if different that the bidding entity.*

- Maintain medical networks – HMO and POS/PPO
- Claims Adjudication, including the ability to process multi-tier benefit levels for preferred networks/providers if selected
- Member Enrollment and Eligibility Maintenance (providing necessary support to the State’s eligibility, dental, flexible spending account (FSA), Health Reimbursement Arrangement (HRA), and pharmacy benefit management vendors)
- Receive pharmacy claims data feed from the State’s Pharmacy Benefits Manager to be used as directed by the State
- Wellness and related ancillary programs
- Patient and Provider Education
- Disease Management
- Systematic Prospective, Concurrent and Retroactive Utilization Review
- Pre-certification, Case management, second surgical opinion
- Network Physician and Facility Management
- Data Sharing and Reporting*
  - Comprehensive on-line member services website including member specific deductible and out-of-pocket accumulator information
  - Exclusive 800# customer service number to be staffed by trained customer service representatives familiar with state benefits and related programs for members
  - Distribution of ID Cards and benefit plan information as needed and requested
  - Access to Provider Directories, including (but not limited to) state specific directories and/or preferred “sites-of-service” (or equivalent) locations

* Note: For the purpose of this analysis, “Data Sharing” is referenced in relation to requests for data and reports from either party (the State or the selected medical Bidder). This also refers to data sharing between the medical administrator and Rx administrator and the State’s other vendors, including a data warehousing vendor if retained by the State.

The requirements set forth below shall be minimum service requirements to be provided by the successful Bidder:

1. The State requires that the Bidder administer run-out claims for 18 months following termination of the contract. The cost of run-out administration must be included in your proposed administration fees.
2. The State requires that Bidder agree to accept payment of claims and administrative expense invoices via Electronic Funds Transfer.

3. The State requires a minimum of 23 group breakouts for purposes of reporting. In addition, a lesser number of COBRA breakouts will be required.

4. The State requires that the Bidder work with the State’s eligibility systems. The State utilizes the Global Human Resources and Human Resources Management modules of the Infor/Lawson ERP (enterprise resource planning) software for human resources, benefits and payroll functions to manage the State Plan’s eligibility.

5. The State requires that the Bidder’s system(s) shall be able to give credit for deductibles or charges applied to out-of-pocket maximums and plan maximums that accumulated with a prior carrier.

6. The State requires that the Bidder attend monthly meetings with the State to discuss plan performance and address account and member service issues, and the like. Additionally, the State requires an annual performance or “stewardship” meeting within 180 days after contract year-end at which time the Contractor will, as directed by the State, summarize activities and performance for the year ended.

7. The State requires the assignment of a dedicated Account Executive who shall be accountable to the State for proactive management of all aspects of the Bidder’s performance to the State and its members. The Account Executive shall remain constant, within the Contractor’s control, for at least the first 18 months of the contact period. The Bidder shall not change assignment of the Account Executive without written notice provided to the State with a minimum of fourteen (14) days prior to such change. The State reserves the right to request assignment of a new Account Executive and the Bidder shall make such change within 30 days of receipt of written notice from the State.

8. The State requires the Bidder to attend all open enrollment meetings at all State locations, as well as attendance at all Agency and benefit fairs.

9. The State expects the Bidder to have the ability to produce ID cards and/or temporary proof of benefit letters in “real time”.

10. The State requires that the Bidder provide a designated customer service toll-free phone number to be answered by a live person in the United States. The State’s currently has weekday hours from 8AM to 8PM ET Monday to Thursday and 8AM to 5PM ET on Fridays. The State requires comparable hours to those currently provided. In addition, the State is interested in having coverage on the weekend. (Please respond to Section IX.B question 15 for your proposed customer service hours.)

11. The State requires that the Bidder provide automated services, which are available 24/7.

12. The State requires the Bidder provide members access to EOB statements at no cost to the State.

13. The State requires that the Bidder have the ability to have an independent audit performed of your claim operation.

14. The State requires that Bidders guarantee adherence to New Hampshire RSA 420-J:8-a regarding prompt pay. The law mandates timeframes for all claims [15 days electronic, 30 days paper claims, overdue (interest payment required if timeframes are not met), denied and pended (inform providers within 15 days (electronic claims) or 30 days (paper claims) and adjudicate with 45 days of receipt of additional].
15. The State requires you provide dedicated staff in the following specialties:
   a. Implementation Manager
   b. Clinical Director
   c. Account Executive
   d. Finance/Billing Manager
   e. Customer Service Manager

16. The State requires that the Bidder administer COBRA for all benefits subject to that law and for all beneficiaries including, but not be limited to, mailing initial COBRA notice to all new hires/rehires. The Bidder shall retain the 2% administrative fee authorized by COBRA regulations. The State should have a dedicated account manager assigned for COBRA administration. A summary of COBRA services should be provided, along with a sample service agreement.

D. VALUE-BASED PURCHASING SERVICES

The State's Responsibilities

The State shall designate the Commissioner of the Department of Administrative Services (DAS), or his or her designee(s), to act as a liaison between the Contractor and the State for the duration of the Contract. The State reserves the right to change its representative, at its sole discretion, during the term of the Contract, and shall provide the Contractor with written notice of such change. The State representative shall be responsible for:
   a. representing the State on all matters pertaining to the Contract. The representative shall be authorized and empowered to represent the State regarding all aspects of the Contract;
   b. monitoring compliance with the terms of the Contract;
   c. responding to all inquiries and requests related to the Contract made by the Contractor, under the terms and in the time frames specified by the Contract;
   d. meeting with the Contractor’s representative on a periodic or as-needed basis and resolving issues which arise, and
   e. informing the Contractor of any discretionary action taken by the State pursuant to the provisions of the Contract.

The State shall:
   a. monitor and evaluate the Contractor’s compliance with the terms of the Contract;
   b. in consultation with the Contractor, develop a Performance Indicator Dashboard to assemble performance indicators that assess important dimensions of the Contractor’s performance, identify which Dashboard measures will be linked to the Performance Withhold (See Section IV. Required Clinical Quality Measures and Withhold), and identify the standards by which the Contractor’s performance will be assessed on each measure;
   c. meet with the Contractor at a minimum of twice a year for formal contract management meetings to comprehensively assess the performance of the Contractor relative to the annual Improvement Goals and the performance of the Contractor on Performance Dashboard measures and according to specified performance standards;
   d. review reports submitted by the Contractor. The State shall determine the acceptability of the reports. If they are not deemed acceptable, the State shall notify the Contractor and explain the deficiencies and require resubmission;
e. request additional reports that the State deems necessary for purposes of monitoring and evaluating the performance of the Contractor under the Contract;

f. perform periodic programmatic and financial reviews of the Contractor’s performance of responsibilities. This may include, but is not limited to, on-site inspections and audits by the State or its agent of both the Contractor’s and Providers’ records;

g. give the Contractor prior notice of any on-site visit by the State or its agents to conduct an audit, and further notify the Contractor of any records which the State or its agent may wish to review;

h. inform the Contractor of the results of any performance evaluations conducted by the State and annually complete the reconciliation of withheld funds consistent with Section IV. Required Clinical Quality Measures and Withhold;

i. inform the Contractor of any dissatisfaction with the Contractor’s performance and include requirements for corrective action, and

j. terminate the Contract, if the State determines that the Contractor is not in compliance with the terms of the Contract.

**Contractor Responsibilities**

The Contractor shall:

a. agree to meet the requirements of each Value-Based Purchasing Specification contained in Appendix B. The Purchasing Specifications include:
   - Value-Based Activity Regarding Care Delivery
   - Enrollee Services
   - Claim Administration and Services
   - Other Reporting

b. agree to implement all plans, strategies, and timelines described in the Contractor’s response to this RFP;

c. agree to develop with the State, by a date specified in the Contract, Improvement Goals and associated Measures related to the Contractor’s performance of Contractor responsibilities and the Value-Based Purchasing Specifications contained in Appendix B.

d. identify and propose Improvement Goals for the State’s prior review and approval no later than six weeks prior to the end of each Contract Year, including Measures and time frames for demonstrating that such Quality Improvement Goals are met;

e. implement, with the State’s approval, processes to achieve the Improvement Goals over the course of Contract Year;

f. ensure that key staff participate in meetings with the State and/or contracted providers or subcontractors to develop strategies to ensure that the Improvement Goals are met;

g. participate in semi-annual meetings with the State during each Contract Year for the primary purpose of reviewing progress towards the achievement of the annual Improvement Goals and the Contractor’s performance to contract standards. For the purposes of such meetings, the Contractor shall:
   i. provide the State with a written update and presentation, detailing progress toward meeting the annual Improvement Goals, no later than fourteen business days prior to each semi-annual meeting;
   ii. review its Contract performance with regards to the requirements of the annual Improvement Goals;
iii. collaborate in advance with the State to develop a presentation of the annual improvement goals’ results to ensure targeted messages are clear and concise for the broader audience;
iv. meet with the State at the time and place requested by the State;
v. if the State determines that the Contractor is not in compliance with the requirements of the annual Improvement Goals, prepare and submit a corrective action plan to the State for its approval.

h. cooperate in any audits that may be required and conducted by the State, or its designee.

E. WELLNESS PROGRAM

The State requires that the Bidder administer the State’s Wellness Program that includes many features that are collective bargained and must be provided. The Bidder must provide the following Wellness Program:

a. Implement and support an online Health Risk Assessment (or Health Assessment Tool (HAT)) that offers health management tools as an interactive approach to help all eligible members address key health behaviors and set appropriate goals associated with identified health risks.
   o Member HAT final reports must include an individualized risk score, the ability to compare their scores/results to previous HAT score/results (if available), and recommendations for specific actions that the member can take to maintain and/or improve their health.
   o Include a sample HAT member results report within your proposal as well as a sample HAT annual report demonstrating aggregate responses to HAT questions from members.
   o Send eligibility information of members that have completed a HAT to other State vendors for health reimbursement account administration at no additional cost.

b. Monthly emails and marketing pieces distributed to eligible members about health improvement/wellness services such as the HAT, lifestyle management programs, and incentive offerings. Develop materials in consultation with State staff and mail materials to employee and retiree subscribers about health benefits such as tobacco cessation, weight management, mental health, preventive care, and care management. Mailings shall consist of four (4) quarterly correspondences per calendar year with these mailings occurring no more than 15 business days after the start of the quarter. All mailings must be approved by the State.

c. HAT, lifestyle management and wellness programs, as well as health promotion incentive activities are compliant with the Americans with Disabilities Act (ADA), Genetic Information Nondiscrimination Act (GINA), state and federal laws.

d. Develop paper-based and online tutorials outlining how members engage and complete a HAT, online lifestyle management programs, and health promotion incentive programs.

e. Provide quarterly member satisfaction results regarding health improvement/wellness services including the HAT, lifestyle management, incentive program.

f. Administer a workplace influenza vaccination program during the months of September, October, and November. Specific program services to be outlined and approved by the SONH.

g. Administer a $150 per plan Annual Community Health Education Reimbursement benefit as directed by the State.

h. Administer a $450 per plan Annual Fitness Facility Reimbursement benefit and a $200 per plan Fitness Equipment Reimbursement benefit (HMO only) as directed by the State.
i. Administer a voluntary health promotion incentive program that offers payments not to exceed $300 per eligible employee per calendar year for participation in health activities, health management programs, biometric screenings, preventive care screenings, and education program administered by the Medical Third-Party Administrator and subcontractors.

- The capability to award eligible employees with incentives for completing State-sponsored health education and well-being programs or tutorials and administer health promotion incentive offerings for participation.
- The capability to award monetary payments such as consumer gift cards and debit cards that do not expire to members eligible for health promotion incentive programs.
- Process claims-based preventive screenings such as well-adult visit, well-woman visit, colorectal cancer screening, and mammogram screening for member health promotion incentive offerings.
- The capability to accept data feeds from vendors and health care providers as a means for members to meet incentive offerings for biometric screening outcomes as well as participatory alternative activities for members that do not achieve biometric outcomes set such as completion of weight management programs, diabetes prevention programs, validated weight loss percentage, consultation with a health care provider on health behaviors or treatment plan for biometric category, or consultation with a Registered Dietician Nutritionist.

j. Administer a worksite biometric screening program that shall provide eligible members the opportunity for screening involving a finger stick blood sample by competent professional staff for at least the following biometrics: total cholesterol, high density lipids, blood pressure, body mass index, waist circumference, and blood glucose. At the conclusion of the biometric screening, members will have the opportunity to have their results reviewed by a staff member providing education on managing any identified biometric health outcomes that are in unhealthy ranges and referring them to primary care follow-up, or health programs and benefits that help reduce health risks.

k. Develop and distribute a State employee new hire packet that educates new employees on the HRA, health benefits, wellness services and incentives. New hire kit must be approved by the State and be mailed to new subscribers within 30 business days after enrollment.

l. Provide a full-time dedicated Wellness Coordinator to assist the State in worksite wellness programs and education. The Wellness Coordinator shall assist the State account among the following responsibilities:

- Attend worksite biometric screenings to facilitate signup and registration of the event.
- Attend worksite health fairs to manage a table and display of information for employees about health benefit programs and incentive opportunities.
- Manage the scheduling and facilitation of worksite flu vaccination clinics.
- Develop employee wellness programs and present on health education topics.
- Participate in monthly and quarterly meetings of the Health Benefit Committee, Health Benefit Committee Workgroup, and Wellness Coordinator Training Sessions.

m. Provide a URL and ten (10) user name/passwords for demonstration purposes of your HRA, online lifestyle management program, and health promotion incentive programs.

F. “VITALS SMARTSHOPPER” PROGRAM

The State is required to provide a voluntary employee incentive program that offers taxable cash payments to employees and non-Medicare retirees who utilize cost-effective health care providers. See “Vitals SmartShopper” program information in Appendix A.

Your proposal must offer a benefit comparable to the current “Vitals SmartShopper” program.

- Confirm that you are able to administer this type of program.
- Provide a description of your program, including but not limited to:
  - a listing of all services included in the program
  - how services are evaluated to be added/dropped from program
  - how savings are calculated
  - how new members are educated on this program
  - promotional materials to members, including monthly mailings, emails, etc.

G. IMPLEMENTATION

Implementation activities shall commence within seven days of Governor and Executive Council (G&C) approval but in no event earlier than September 6, 2017.

The Bidder shall provide an implementation plan in its bid and identify its implementation team members, as well as the State resources required for the implementation. The timeline shall include a pre-implementation readiness audit to be performed by the State’s designee (See Section VIII.A for the requested allowance.) No later than one week after Governor & Executive Council approval, the Bidder shall submit a detailed implementation plan subject to the State’s approval that will include but not be limited to the following:

- Key implementation team member(s), including their contact information
- Development of eligibility and enrollment interface between Bidder and State system, including all special campaigns per the collective bargaining agreements
- Import and testing of existing enrollment data from State and current Medical TPA, as needed
- Successful test of claims adjudication
- Testing of Rx data transfer from the State’s Pharmacy Benefits Manager (PBM) to the medical contractor
- Testing of wellness program eligibility data transfer from medical TPA/wellness contractor to HRA contractor, as needed
- Development of process for ongoing data transfer between the State’s claims data management system (when determined and in place) and the Bidder
- Establish process for data and reporting access by the State
- Development of a Comprehensive Communication plan with defined targeted audiences to include but not be limited to DAS, employees, retirees, state agencies, providers and other plan participants.
- Support of the State’s October 2017 Open Enrollment
- Include examples of proposed employee communications newsletters, posters, etc.
- Delivery of medical benefit program information and ID cards prior to 1/1/2018 to plan participants
- Access to the Bidder’s online client and member portals as directed by the State
The project plan shall be updated thereafter as the State and Bidder mutually agree. Implementation activities shall be conducted in close collaboration and with the approval of the DAS.
SECTION IV: REQUIRED CLINICAL QUALITY MEASURES AND WITHHOLD

The State shall withhold 5 percent of monthly payments to the Contractor to be earned and distributed according to the Contractor’s performance relative to performance expectations for clinical quality priorities established by the State.

The State shall annually reconcile withhold distributions on a contract year basis following assessment of Contractor performance to the specified contract standards. If the Contractor fails to meet defined performance expectations, the State may impose financial sanctions including, but not limited to, retention of all or a portion of the Withhold. If the Contractor meets all specified performance expectations, the State shall distribute the full amount of the withheld funds to the Contractor.

Performance Expectations for Clinical Quality Priorities.

The Contractor will be able to earn back withheld dollars in one of two ways. For a group of State-specified quality measures, the Contractor may either:

a) demonstrate performance expectation achievement; or

b) demonstrate a statistically significant improvement relative to its prior year performance.

The Contractor’s performance shall be assessed based on all of its New Hampshire commercial members (i.e., not limited to State’s plan members). The clinical quality priority measures will be specified annually by the State following consultation with the Contractor. For the first year (CY 2018) of the contract, the measures, their associated targets, and the measure-specific amount of withhold at risk will be as follows.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Expectation*</th>
<th>Withhold at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>88.64% (CY2015 HMO 50th percentile)</td>
<td>1%</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>84.25% (CY2015 HMO 50th percentile)</td>
<td>1%</td>
</tr>
<tr>
<td>Asthma Medication Ratio (Total)</td>
<td>79.14% (CY2015 HMO 50th percentile)</td>
<td>1%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Blood Pressure Control &lt;140/90</td>
<td>76.17% (CY2015 HMO 75th percentile)</td>
<td>1%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>76.39% (CY2015 HMO 75th percentile)</td>
<td>1%</td>
</tr>
</tbody>
</table>

* Performance expectations are based on Anthem NH’s commercial book-of-business rates for calendar year 2015.

Should the Contractor not have prior experience in New Hampshire or not have generated the above measures prior to the contract start date, the statistically significant improvement test (“b” above) will not apply in the first year of the Contract and the Contractor would need to meet the performance expectation measures in the chart above.
SECTION V: REQUIRED PERFORMANCE GUARANTEES

The State requires that each Bidder agree to the following performance standards and guarantees. As such, the following are minimum performance guarantee requirements and shall be included as part of your proposal.

Note that if a subcontractor is used to provide any of the contracted services, the Bidder is accountable for the subcontractors’ performance. Therefore, the Subcontractor’s performance is held to the same performance standards and Subcontractor failure to perform places the Contractor at risk.

Reconciliation of all performance guarantees shall be completed annually within 180 days of policy year-end.

The performance guarantees may be subject to verification by audit.

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Category</th>
<th>Guarantee</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>Service</td>
<td>85% of member calls resolved on first call</td>
<td>$20,000 per year</td>
</tr>
<tr>
<td>S2</td>
<td>Service</td>
<td>Average speed to answer ( \leq 45 ) seconds</td>
<td>$20,000 per year</td>
</tr>
<tr>
<td>S3</td>
<td>Service</td>
<td>Call abandonment rate ( \leq 3% )</td>
<td>$20,000 per year</td>
</tr>
<tr>
<td>S4</td>
<td>Service</td>
<td>95% of written inquiries received from plan participants responded to within ten (10) business days</td>
<td>$25,000 per year</td>
</tr>
<tr>
<td>S5</td>
<td>Service</td>
<td>Service outage (website, customer service, etc.) of 24 hours or more, or any outages that exceed 4 hours that occur more frequently than twice per month unless caused by force majeure (ex, acts of God, power outage, cyberattack) other than routine maintenance.</td>
<td>$2,000 per day, maximum $20,000 per occurrence</td>
</tr>
<tr>
<td>S6</td>
<td>Service</td>
<td>Notification of service outage (website, customer service, etc.) at maximum within 4 business hours and notification of outage resolution within 2 business hours</td>
<td>$10,000 per occurrence</td>
</tr>
<tr>
<td>O1</td>
<td>Operations</td>
<td>90% of paper claims received from plan participants not requiring clarification processed within 10 business days</td>
<td>$25,000 per year</td>
</tr>
<tr>
<td>O2</td>
<td>Operations</td>
<td>Timeliness of non-investigated(^2) claims paid (paper and electronic) – minimum of 90% within 14 calendar days</td>
<td>$60,000 per year</td>
</tr>
<tr>
<td>O3</td>
<td>Operations</td>
<td>Timeliness of non-investigated(^2) claims paid (paper and electronic) – minimum of 99% within 30 calendar days</td>
<td>$60,000 per year</td>
</tr>
<tr>
<td>O4</td>
<td>Operations</td>
<td>Financial accuracy of claims payments 99%</td>
<td>$100,000 per year</td>
</tr>
<tr>
<td>O5</td>
<td>Operations</td>
<td>Payment accuracy of claims payments 97%</td>
<td>$100,000 per year</td>
</tr>
<tr>
<td>O6</td>
<td>Operations</td>
<td>100% of all marketing materials not specific to plan enrollees must be pre-approved by the State prior to distribution to plan enrollees</td>
<td>$20,000 per occurrence</td>
</tr>
<tr>
<td>O7</td>
<td>Operations</td>
<td>100% of all plan enrollee communications accurate</td>
<td>$5/erroneous document up to $75,000 penalty per contract year</td>
</tr>
<tr>
<td>O8</td>
<td>Operations</td>
<td>99% of eligibility updates received from the State processed within forty-eight (48) hours of receipt of a clean and complete eligibility file in an agreed upon format</td>
<td>$50,000 per year</td>
</tr>
<tr>
<td>O9</td>
<td>Operations</td>
<td>Contractor will respond to all independent auditor requests for clarification, following claims audits within 30 calendar days</td>
<td>$25,000 at risk per audit</td>
</tr>
<tr>
<td>O10</td>
<td>Operations</td>
<td>Timely and accurate implementation of all programs and program changes required by the State</td>
<td>$5,000 per day, maximum $100,000 per occurrence</td>
</tr>
<tr>
<td>O11</td>
<td>Operations</td>
<td>Documentation provided to the State of quality control testing prior to implementation of all programs and program changes</td>
<td>$10,000 per occurrence</td>
</tr>
<tr>
<td>R1</td>
<td>Reporting</td>
<td>Settlement reports delivered within 180 days of policy</td>
<td>$25,000 per year</td>
</tr>
</tbody>
</table>
State of New Hampshire

SECTION V

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>Reporting: 95% of standard reports within 3 business days</td>
<td>$25,000 per year</td>
</tr>
<tr>
<td>R3</td>
<td>Reporting: 90% Adhoc reports within 7 business days</td>
<td>$25,000 per year</td>
</tr>
</tbody>
</table>

1. “At Risk” figures are defined as amounts payable to the State as described for each reference number (Ref #).

2. “Non-investigated” means a claim in which all information is present that is required to adjudicate the claim. (A “clean” claim would be an appropriate description.)
SECTION VI: REQUIRED PROTECTION OF CONFIDENTIAL INFORMATION AND DATA SECURITY

This section includes expectations on how the State’s confidential information will be protected by its Business Associate(s) as well as required contract language and required insurance coverage levels.

Confidential Information. In performing its obligations under the Agreement, and applicable Business Associate Agreement (“BAA”), the Business Associate, inclusive of any subsidiaries and any related entities (“BA”) shall gain access to information of the State, including personal health information (PHI) personally identifiable information (PII), and other personal, private, and/or sensitive information, hereinafter collectively referred to as “Confidential Information.” The BA shall not use the State’s Confidential Information developed or obtained during the performance of, or acquired, or developed by reason set forth within the Agreement and applicable BAA, except as is directly connected to, and necessary for, the BA’s performance under the Agreement, or unless otherwise permitted under the Agreement and/or applicable BAA.

Data Protection. Protection of Confidential Information which may be provided to the BA as part of the Agreement and applicable BAA shall be an integral part of the business activities of the BA. The BA shall ensure that there is no inappropriate or unauthorized use of the State’s information at any time. To this end, the BA shall develop and implement policies and procedures to safeguard the confidentiality, integrity and availability of the State’s information. The BA also will comply with the following terms and conditions:

a) Confidential Information obtained by the BA shall become and remain property of the State and shall at no time become the property of the BA unless otherwise explicitly permitted under the Agreement and applicable BAA;

b) At no time shall any data, information, or processes which either belong to, or are intended for the use of, the State be copied, disclosed, or retained by the BA, or any party related to the BA by business (subcontractor) for subsequent use in any transaction that does not relate to the delivery of Services to the State (See the applicable BAA);

c) The BA shall not provide any information collected in the connection with the provision of Services under the Agreement and applicable BAA for any purpose other than performing its obligations to provide the contracted Services, unless otherwise explicitly permitted under the Agreement;

d) In the event that the BA stores Confidential Information, including but not limited to PHI, and PII, this data shall be encrypted by the BA while both at Rest or in Motion.

The BA shall have proper security measures in place for the protection of the State’s data. The BA shall also ensure that any BA subcontractor(s) has proper security measure in place for protection of the State’s data. Such security measures shall comply with the HIPAA Privacy Rule, Standards for Privacy of Individually Identifiable Health Information, HIPAA Security Rule, Security Standards for the Protection of Electronic Protected Health Information, the Health Information Technology for Economic and Clinical Health Act (“HITECH), and all other applicable data protection and privacy laws, including privacy laws of the State of New Hampshire and any other applicable state, which may apply now or in the future.

Controls. The BA shall, and shall ensure that any subcontractor(s) used by the BA shall, have, maintain, and use at all times proper controls for secured storage of, limited access to, and rendering unreadable prior to discarding, all records containing the State’s Confidential Information, including but not limited to PHI, and PII. The BA shall not store or transfer Confidential Information collected in connection with the services rendered under this Agreement outside of the North America. This includes backup data and disaster recovery locations.

Data Breach Notification. The BA shall, and shall ensure that any subcontractors used by the BA shall, inform the State of any security breach, or potential breach, that jeopardizes, or may jeopardize the State’s data or
processes (i.e. any “Security Incident”). For purposes of reporting under this Section, the definition of a Security Incident shall be limited to the successful unauthorized access, use, disclosure, modification, or destruction of information, or the interference with system operations in an information system, and/or the potentially successful unauthorized access, use, disclosure, modification or destruction of information, or the potential interference with systems operations in an information system.

Notification of a data breach, or potential data breach, shall be given to the State within 24 hours of its discovery by the BA or the BA’s subcontractor(s). Full disclosure of the Security Incident shall be made and include all available information. The BA shall cooperate fully with the State, including but not limited to: make efforts to investigate the causes of the breach or potential breach; promptly take measures to prevent any future breach; and minimize any damage or loss resulting from the breach, or potential breach. In addition, the BA shall inform the State of the actions it is taking, or will take, to reduce the risk of further loss to the State. HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, the Federal Trade Commission’s Health Breach Notification Rule 16 CFR Part 318, and RSA 359-C:20 require public breach notification to individuals whose information has been or may be misused. All legal notifications required as a result of a breach of information, or potential breach, collected pursuant to this Contract shall be coordinated with the State. The BA shall ensure that any subcontractors used by the BA shall similarly notify the State of a data breach, or potential data breach within 24 hours of discovery, shall make a full disclosure, including providing the State with all available information, and shall cooperate fully with the State, as defined above.

Data Security Breach Liability. In addition to the BA’s obligations as set forth in the form contract P-37 (attached hereto as Appendix H) and the Business Associate Agreement (attached hereto as Appendix I) if the BA, or any subcontractor(s) used by the BA, is determined by any forensic analysis or report, to be the likely source of any loss, disclosure, theft or compromise of State’s data or information, and regardless of the BA’s belief that the BA, or subcontractor used by the BA, has complied with all data Security and Breach rules, or any other security precautions and is not responsible for the assessments, fines, losses, costs, and penalties and reimbursements resulting from said loss, the State shall recover from the BA all costs of response and recovery resulting from the Breach or potential Breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services that are necessary due to the Breach or potential Breach.

Data Breach Insurance. In addition to the BA’s insurance obligations as set forth in the form contract P-37 (attached hereto as Appendix H), the BA shall carry Data Security & Cyber Insurance coverage for unauthorized access, use, acquisition, disclosure, failure of security, breach of confidential information, of privacy perils, in an amount not less than $10 million per annual aggregate, covering all acts, errors, omissions, at minimum, during the full term of this Agreement and the applicable BAA. Such coverage shall be maintained in force at all times during the term of the Agreement and applicable BAA and for a period of two years thereafter for services completed during the term of the Agreement and consistent with the governing BAA. The State shall be given at least thirty (30) calendar days’ notice of the cancellation or expiration of the aforementioned insurance for any reason, at the address provided in the P-37.

Data Recovery. The BA shall be responsible for ensuring backup and redundancy of the State’s data, including but not limited to Confidential Information for recovery in the event of a system failure or disaster event within the BA’s data storage system(s) and/or a BA subcontractor(s’) data storage system(s).

Process Upon Conclusion/Termination of Services. At the conclusion of the Agreement, either through completion or termination, the BA shall implement an orderly return of State’s data in a format defined by the State at no additional cost to the State. At the State’s request, the BA shall destroy all data in all forms. Data shall be permanently deleted and not recoverable according to National Institute of Standards and Technology approved methods. The BA shall provide State with certificates of destruction and/or certificates verifying that all information has been returned and none retained.
**Destruction /Disposal of State’s Data.** Upon termination of the Agreement and applicable BAA for any reason, the BA, with respect to any Confidential Information, including but not limited to PHI, or PII, either received from the State, or created, maintained, or received by the BA on the State’s behalf, shall:

a) Where feasible, return or destroy the Confidential Information the BA still maintains in any form, at the sole discretion of the State, except where certain types of information must be retained for the State’s benefit, such as records of actuarial determinations, which will be maintained as agreed upon by the State;

b) Continue to use appropriate safeguards as identified in the Data Protection provisions above with respect to any Confidential Information that is retained as agreed upon by the BA and the State;

c) Not use or disclose Confidential Information retained other than for purposes for which such information has been retained, and subject to the same terms and conditions as set forth in the original Agreement and/or BAA, as amended in writing, by both parties, if applicable.

**Access to System Logs.** The BA shall allow the State access to system security logs, latency statistics, etc., that affect the Agreement and applicable BAA, the State’s data and/or processes. This includes the ability of the State to request a report of the records that a specified user accessed over a specified period of time.

**Import/Export Data.** The State shall have the ability to import or export data in piecemeal manner or in its entirety at its discretion without interference from the BA and with the BA’s assistance, at no additional cost to the State.

**Notification of Governmental Authorities.** With respect to instances in which the BA, or BA subcontractor(s) consider notifying Governmental Authorities concerning civil acts, the BA or BA subcontractors shall notify the State in writing and consult with the State prior to making any such notification; and immediately endeavor in good faith to reach agreement on the need and nature of such notification. If such agreement cannot be reached within seventy-two (72) hours after the BA, or BA subcontractor(s) has provided the State with written notice, the BA or BA subcontractor(s) shall have the right to inform Government Authorities solely to the extent required by applicable law.

**Damages in the event of a breach or potential breach:** A Security Incident, including a potential breach, or potential privacy-related compliance issue, may cause the State irreparable harm for which monetary damages would not be adequate compensation. In the event of such a Security Incident, the State is entitled to seek equitable relief, including a restraining order, injunctive relief, specific performance and any other relief that may be available from any court, in addition to any other remedy to which the state may be entitled at law or in equity. Such remedies shall not be deemed exclusive, but shall be in addition to all other remedies available at law or in equity, subject to any express exclusion or limitations in the Agreement to the contrary.

This Section VI Required Protection of Confidential Information and Data Security shall survive termination or conclusion of the Agreement and applicable BAA.
SECTION VII: NETWORK ACCESS AND NETWORK MATCH

This information needed to respond to this section must be requested in writing. Appendices D and E include instructions on requesting access to this data.

NETWORK ACCESS

Complete the network access table using driving distance as the measurement of distance, not as the crow flies. Please complete a network access match (such as GeoAccess) for the member (employee/retiree/dependent) zip code data provided in the census located in Appendix E, based on the following criteria:

- Travel distance:
  1) 1 network hospital within 15 miles
  2) 2 network PCP physicians within 15 miles
  3) 2 network Specialist physicians within 15 miles

Complete the table below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>% of Members Meeting the Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians: 2 network PCPs within 15 miles</td>
<td></td>
</tr>
<tr>
<td>Physicians: 2 network Specialists within 15 miles</td>
<td></td>
</tr>
<tr>
<td>Hospitals: 1 network hospital within 15 miles</td>
<td></td>
</tr>
</tbody>
</table>

Your analysis is to be based on all eligible participants, not only those participants located in your network service area.

Your detailed network access reports (i.e. GeoAccess Reports) must be included with your proposal.

1. Indicate software used (i.e. GeoAccess): ________________

2. What geographic areas are not in your current service areas where the State’s enrollees reside? List by state and county.

<table>
<thead>
<tr>
<th>State</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. NETWORK MATCH

- Indicate with a “Y” for Yes and “N” for No whether the Providers are in your HMO, POS and PPO networks [See the “Network” Tabs in SONH RFP Attachment.xlsx]

- Note: The Network tabs in the SONH RFP Attachment.xlsx file are not populated with data. The populated Network tabs must be requested in writing. See Appendix D.

Responses are due in the electronic Excel format provided.
1. Is your POS network the same as your HMO Network (besides out-of-network option)? Are the same discounts negotiated?

2. Is your PPO network the same as your POS network? Are the same discounts negotiated?

4. **“SITE-OF-SERVICE” IDENTIFICATION**

- Indicate with a “Y” for Yes and “N” for No whether the Providers are in your proposed “Site-of-Service” network [See “SOS” tabs in SONH RFP Attachment.xlsx]

- Note: The SOS tabs in the SONH RFP Attachment.xlsx file are not populated with data. The populated SOS tabs must be requested in writing. See Appendix D.

**Important Note:** The “Site-of-Service” identification files include the State’s Active Plans utilization for all lab tests and outpatient surgery. Your proposed “Site-of-Service” network should not include all providers of these services. In other words, if you have indicated a “Yes” for all the providers in these files, you are indicating that you do not understand the State’s program.

**Responses are due in the electronic Excel format provided.**
SECTION VIII: FINANCIAL

Bidders must propose fees for all the requested services. Your fee proposal needs to indicate the separate and distinct fees for each of the services requested. You must complete each of the charts located in the SONH RFP Attachment.xlsx file.

Responses are due in the electronic Excel format provided.

(See Financial Scoring in Section II, Step2)

A. ADMINISTRATIVE FEES, NETWORK ACCESS CHARGES, AND WELLNESS

Included in “Total Projected Costs” Score of 40 points

The “Total Projected Costs” financial scoring is described in Section II.C. Evaluation Process – Step #2.

Administrative & Program Fees

Complete the Administrative Fees and Wellness Charts in the attached Excel spreadsheet assuming a January 1, 2018 effective date. Fees should be on a per subscriber (contract) per month basis. Please provide answers only as applicable for quote. Fees must be provided in the format provided. [See the “Administrative Fee – Medical” and “Administrative Fee – Wellness” Tabs in SONH RFP Attachment.xlsx]

All fees to be included in monthly billing are to be broken out in detail for each service proposed or provided, i.e. specific for disease management; case management, utilization review, etc. Additionally, provide detail on any service fees that may be charged on per claim basis, i.e. subrogation, MRI review services, etc.

Please complete separate charts for the following: Active Plans (HMO and POS), Non-Medicare Retiree Plan (POS/PPO), and Medicare Retiree Indemnity Plan. If only one administration chart is completed, it will be assumed the same fees apply for all requested plans.

Pre-Implementation Audit Allowance

As indicated in Section III.G, the State intends to hire a firm to conduct a pre-implementation audit to ensure that the State’s plan designs are programmed correctly in the Contractor’s claims system and the claims are being correctly adjudicated. The State will not be charged by the Contractor for this audit process.

The State requests that Bidder’s provide a pre-implementation audit allowance of $40,000 to reimburse the State for any expenses incurred for conducting such audit. Please check one box below.

- We agree to a reimbursement allowance of up to $40,000
- We are proposing a different reimbursement allowance of $________
- We are not proposing an allowance
**Right to Remove or Add Services**

**IMPORTANT NOTE** – The State reserves the right to remove services from the medical administration contract. If your proposed fees would be different if any of the following are removed from the contract, you must complete additional copies of the Administrative Fee exhibits reflecting the different fees.

<table>
<thead>
<tr>
<th>Possible services removed from medical administration contract</th>
<th>Indicate which of the two scenarios below applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness program administration</td>
<td>Proposed fees unchanged  Proposed fees change and alternative Administrative Fee exhibits are included</td>
</tr>
<tr>
<td>COBRA program administration</td>
<td></td>
</tr>
<tr>
<td>Non-Medicare Retiree Plan administration</td>
<td></td>
</tr>
<tr>
<td>Medicare Retiree Plan administration</td>
<td></td>
</tr>
</tbody>
</table>

The State reserves the right to add services to the medical administration contract. If your proposed fees would be different if any of the following were added to the contract, you must complete additional copies of the Administrative Fee exhibits reflecting the different fees.

<table>
<thead>
<tr>
<th>Possible services added to medical administration contract</th>
<th>Indicate which of the two scenarios below applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Reimbursement Arrangement (HRA) administration</td>
<td>Proposed fees unchanged  Proposed fees change and alternative Administrative Fee exhibits are included</td>
</tr>
</tbody>
</table>

**B. CLAIMS TREND GUARANTEE**

Provide the non-Medicare participant (active and retiree plans) claims trend your organization is willing to guarantee for each year of the contract. Your guarantee should state the percentage of your administration fee that will be at risk.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount at Risk for not meeting Trend Guarantee</th>
<th>% of your administrative fee</th>
<th>% of your administrative fee</th>
<th>% of your administrative fee</th>
</tr>
</thead>
</table>

Bidder should provide an explanation of the basis for their proposed trend guarantee, including if they are willing to tie their trend guarantee to an index (e.g., CPI-Urban less food and energy plus X%) which is preferred by the State.

Trend guarantee will be based on the following methodology:

- The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all non-Medicare participants (active and retiree plans).
- The actual 2018 incurred claims number will be measured using medical claims that were incurred during the 2018 calendar year and paid during that calendar year and a six month run-out period through June 2019, removing claims in excess of 250,000. This total will be divided by the actual enrollment during the policy year. (Same methodology applies for CY 2019 and 2020.)
The actual 2017 incurred claims number will be measured using medical claims that were incurred during the 2017 calendar year and paid during that calendar year through June 2018, removing claims in excess of $250,000. This total will be divided by the actual enrollment during the policy year. All the necessary supporting claims and enrollment data for the 2017 calendar year will be obtained by the State from its current medical administrator and provided to the Contractor.

Claims will include the amounts that are the responsibility of both the member and the employer to mitigate distortions created by plan design changes. The actual 2018 trend will be calculated by dividing the adjusted 2018 incurred claims per member per month (calculated as described above) by the adjusted 2017 incurred claims per member per month (calculated as described above) less 1. (Same methodology applies for CY 2019 over 2018 and for CY 2020 over CY 2019.)

A member continuously enrolled 12 months would count as 12 member months.

As a point of reference, the State’s estimated non-Medicare participant medical claims trend for the last three fiscal years ended June 30, 2016 are summarized in the chart below. These represent the change in per capita paid claims adjusted to remove the estimated influence of any plan changes.

<table>
<thead>
<tr>
<th>Fiscal Years Ended June 30</th>
<th>FY 2016 (over FY 2015)</th>
<th>FY 2015 (over FY 2014)</th>
<th>FY 2014 (over FY 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Trend</td>
<td>5.7%</td>
<td>0.8%</td>
<td>-0.9%</td>
</tr>
</tbody>
</table>

C. CLAIM COSTS - PROVIDER REIMBURSEMENT & DISCOUNTS

Included in “Total Projected Costs” Score of 40 points

The “Total Projected Costs” financial scoring is described in Section II.C. Evaluation Process – Step #2.

This section refers to spreadsheets that must be completed based on your current network provider contracts and experience. Worksheets should be completed separately for the indicated locations.

Claims Repricing Analysis

Please reprice the claims provided in detailed claims experience files referenced in Appendix D. The repricing should be based on eligible charges (column “ELIGIBLE_CHARGES” on the repricing claims files) and your current (as of March 1, 2017) network provider contractual fee arrangements. The claims repricing amounts shall be based on actual data and shall not include any assumptions regarding projected discounts or assumed increases in billed charges.

- Provide the sum of all repriced claims by plan (HMO, POS/PPO), by category (Inpatient, Outpatient, Professional, Other) and by in-network and out-of-network based on the eligible charges in the column “ELIGIBLE_CHARGES”. [See the “Claims Repricing” Tabs in SONH RFP Attachment.xlsx]

Responses are due in the electronic Excel format provided.

- Provide an explanation detailing how you repriced the claims, noting any and all adjustments and methodologies.

- Provide a reconciliation that ties your claims repricing back to the total eligible charges provided for each product (HMO and POS/PPO).

1. Confirm your repricing is based on your current network provider contractual fee arrangements. “Current” is defined as the discounts the State would achieve through your network as of March 1, 2017. The repriced amounts should reflect what you would have paid a provider if the claim was incurred on March 1, 2017.
2. Confirm your repricing is based on actual data and does not include any assumptions regarding projected discounts or assumed increases in billed charges.

3. Confirm that you have provided an explanation summarizing how you repriced claims, noting any and all adjustments and methodologies.

4. Confirm you have not omitted any adjustments or methodologies from your explanation on how you repriced the claims.

5. Confirm that you have provided the claims reconciliation for all charges provided in the claims file.

**Physician Reimbursement**

1. **Physician Discount Analysis.** Complete this spreadsheet for network physicians only. Provide your current (as of March 1, 2017) average physician discounts negotiated in the state of New Hampshire as well as your average physician negotiated discounts specific to 3-digit zip codes 031, 032, 033, 037, 038. These discount percentages shall be based on actual achieved discounts and shall not be based on projected or expected discounts. Provide separate charts if physician discounts vary by plan (HMO vs. POS vs. PPO). [See “Physician Discount” Tab in SONH RFP Attachment.xlsx]

Responses are due in the electronic Excel format provided.

2. Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement for the POS/PPO Plan.

3. Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other).

**Hospital and Outpatient Facility Charges**

**Hospital Discount Analysis.** Complete this spreadsheet for network hospitals only. Provide your current (as of March 1, 2017) average inpatient and outpatient hospital discount negotiated in the state of New Hampshire as well as your average inpatient and outpatient negotiated hospital discounts specific to Merrimack, Hillsborough and Grafton Counties in New Hampshire and also Boston, Massachusetts. **These discount percentages shall be based on actual achieved discounts and shall not be based on projected or expected discounts.** Provide separate charts if hospital discounts vary by plan (HMO vs. POS vs. PPO). [See “Hospital Discount” Tab in SONH RFP Attachment.xlsx]

Responses are due in the electronic Excel format provided.

**Capitation Arrangements**

1. Are any of the benefits or services you offer reimbursed through a capitated arrangement? If yes, please list all services that are capitated.

2. For any of the capitated services listed in the prior question, does the State have the option of paying for these services on a fee-for-service basis as opposed to a capitated basis?

3. Confirm that the State will have access to reports which will show the actual fee-for-service claims experience and utilization for any benefits or services that are under a capitated arrangement?
D. ALTERNATIVE PAYMENT MODELS

“Alternative Payment Models” Score = 10 points

The “Alternative Payment Models” financial scoring is described in Section II.C. Evaluation Process – Step #2.

• Provide documentation of three population-based contracts that the Bidder has held with providers involving downside risk sharing for commercial lives (fully insured and/or self-funded) with completed performance periods and positive financial results. Include the following details:
  i. Service area (state(s))
  ii. Performance period
  iii. Number of contracted commercial attributed lives for the performance period
  iv. % savings off of the contractual population PMPM spending target
  v. Quality measures with statistically improved performance during the performance period (if any)
SECTION IX: TECHNICAL QUESTIONNAIRE

(See Technical Questionnaire Scoring in Section II, Step3)

The State requires a response to the following questions:

A. VALUE-BASED PURCHASING

“Value-Based Purchasing” Score = 10 points

The “Value-Based Purchasing” technical score shall be scored in consideration of:

- the completeness of responses to the questions in this section
- demonstrated past experience and competence in performing specified Value-Based Purchasing activities on behalf of the State and/or on behalf of Bidder’s other clients as demonstrated in their response to the questions in this section
- the degree to which proposed strategies developed in response to questions in this section, and with consideration of the Purchasing Specifications in Appendix B, are judged by the State to be:
  - creative,
  - experience-informed, and/or
  - likely to succeed relative to the performance requirements specified in this RFP and to State objectives related to cost savings and high quality health services.

In responding to the following technical questions, the Bidder shall document its current performance with regard to the applicable Value-Based Purchasing Specifications and Purchasing Specification Measures in Appendix B. Measurement data should be provided for those Purchasing Specifications and Measures which are quantitatively defined.

Adherence to qualitatively defined specifications and responses to specification measures in Appendix B should be described completely, but succinctly. Written policies, correspondence, and other documentation of how the Bidder meets a Purchasing Specification should be provided where requested. If the Bidder is not in compliance with a Purchasing Specification or cannot respond to a Purchasing Specification Measure, then the Bidder should identify how and when the Bidder intends to achieve full compliance with that Purchasing Specification and/or obtain the required measurement data.

1) Quality Indicators: Provide CY2015 HEDIS® performance measurement rates for the measures listed below for the Bidder’s New Hampshire fully insured and/or self-funded (separated by funding arrangements, as available) commercial population, specifying the population being reported. If the Bidder does not operate in New Hampshire, provide comparable data from another comparable state in New England or in the northeast.

<table>
<thead>
<tr>
<th>Adult BMI Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
</tr>
<tr>
<td>Asthma Medication Ratio (Total)</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Blood Pressure Control &lt;140/90</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical Attention to Diabetic Nephropathy</td>
</tr>
<tr>
<td>Comprehensive diabetes care – HbA1c Poor Control (&gt;9.0%)</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>Use of Spirometry Testing in the Assessment &amp; Diagnosis of COPD</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile</td>
</tr>
</tbody>
</table>
Breast cancer screening
Cervical cancer screening
Colorectal cancer screening
Follow-up after hospitalization for mental illness
Physical activity in older adults
Medical assistance with smoking use and tobacco cessation

2) **Network Management:** Describe how the Bidder measures, or will measure, provider performance (including that of individual physicians, hospitals, and ancillary providers) using quality indicators that are objective, measurable, informed by current scientific knowledge, clinical experience. Further, explain how the measures are used to monitor and evaluate each important aspect of care.

   a) Submit the following information for the Bidder’s proposed Network Primary Care Clinicians (PCCs), and for all other Providers (e.g., behavioral health providers, specialists, hospitals, home health providers) for which it will conduct Provider profiling and performance evaluations:

      i) a list of provider types for which profiling and/or performance evaluations will be conducted, and the criteria used to identify specific providers that are subject to such profiling and/or evaluations (e.g., panel size, grievances filed, access issues etc.);

      ii) a description of the Bidder’s proposed Provider performance evaluation process that includes the evaluation methodology, measures utilized, and frequency of the process;

      iii) examples of provider profile reports to be utilized for different types of providers.

   iv) how the Bidder will reward Providers who demonstrate continued excellence and/or significant performance improvement over time, through non-financial and/or financial means, and

   v) how the Bidder will take action with Providers who demonstrate continued unacceptable performance and performance that does not improve over time.

3) **Alternative Payment Models (APMs):** Describe how the Bidder proposes to increase the use of APMs within provider network contracts, including performance-based shared savings and risk sharing arrangements with providers, as applicable. In the description, include:

   a) Bidder capabilities, experience and strategy for implementing APM contracting arrangements with providers, including sharing data with providers;

   b) the types of data to be shared with providers and the frequency of sharing such data;

   c) technical support to assist providers in operating successfully under APM approaches, and

   d) the Bidder’s strategy, proposed approach, and timeline for meeting APM requirements in the scope of work, including strategies to pursue and support more performance-based shared savings and risk-based APM contracts with provider entities.

      i) by the end of Contract Year One, at least 30% percent of Members shall be covered under a multi-year ACO population-based contract with risk sharing arrangements that meet standards identified by the State in consultation with the Contractor, and

      ii) the Contractor shall work with the State and its provider network to evaluate and implement episode-based payment strategies designed to bundle a set of services together that are related to a defined condition or treatment (e.g., knee replacement surgery).

4) **Misuse and Overuse of Services:**

   a) Describe techniques, policies, procedures or initiatives Bidder will have in place to effectively and appropriately control avoidable hospital and emergency department admissions.

   b) Describe and provide examples of how the Bidder analyzes variation in care delivery patterns and costs across its network and uses that information to improve delivery of care by its Network.
c) Describe and provide examples of how the Bidder identifies and applies research on treatment effectiveness to inform policy regarding medical necessity. Provide examples of both new services as well as long-standing services.

5) Patient-Centered and Integrated Care:
   a) Describe policies, procedures or initiatives the Bidder has in place to effectively and appropriately manage transitions of care for members being discharged from inpatient care and how these techniques control hospital readmission.
   b) Describe Bidder experience related to the use of Patient-Centered Medical Homes involving Primary Care Clinicians (PCCs), as well as any planned use if selected for award.
   c) Describe how the Bidder will support the advancement of integrative care that addresses behavioral health needs and social determinants of health concurrently with physical health needs, and provide examples of how it has done so in the past, if at all.
   d) Describe how Bidder will support the providers with billing and coding related to care coordination and management (ex. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Billing and coding related to this screening and other behavioral health screenings is often a barrier to reimbursement for providers.)

6) High-Cost Condition Management and Care Coordination:
   a) Propose at least three programs designed to optimize the health status of members with high-cost, high-frequency diseases or conditions. At a minimum, the Bidder should propose programs designed for diabetes, depression, and low back pain. Such description shall include the particular approach or program the Bidder proposes, including any use of Clinical Protocols, and its experience and results in implementing such programs.
   b) Explain how the Contractor uses data analytics to stratify its population, identifies individuals in need of care coordination and how it provides care coordination to the identified individuals.
   c) Explain how the proposed high-cost conditions programs and the non-condition-specific care coordination activities will complement and not duplicate provider-based efforts aimed at the same Members, including the efforts of Patient-Centered Medical Homes and providers operating under APMs.

7) Service Guarantees: In addition to the guarantees indicated in Section V, the Bidder shall provide a description of any value-based purchasing related service guarantees which it wishes to include within its proposal.
B. ADMINISTRATIVE, MEMBER, & CLAIM PAYING SERVICES

“Administrative, Member, Claims Paying Services, Reporting Services” Score = 10 points

The “Administrative, Member, Claims Paying Services, Reporting Services” technical score shall be scored in consideration of:

- the completeness of responses to the questions in Section B and Section C in the Technical Questionnaire
- the degree to which responses are judged by the State to indicate that the Bidder would provide high quality member services, including:
  - trained customer service staff with State Plan specific knowledge
  - maximizing hours of customer service operation
  - assurance of member satisfaction
- the degree to which responses are judged by the State to indicate that the Bidder would provide high quality account services, including:
  - flexibility with the State in regards to payment options
  - optimum account service hours of operation
  - level of reporting (standard and ad-hoc) available to the State
  - claims payment practices (e.g., coordination of benefits, appeals processes)
  - quality assurance and auditing

The State requires a response to the following questions:

1. Which sales office would handle the general servicing of the State?

2. What are the standard office hours for the sales and service office?

3. You will provide dedicated clinical, account management, and customer service staffing to the State. Specify the number and location of the dedicated individuals.

4. Confirm that account management personnel, as needed, will be available during regular business hours and during emergencies including being available for frequent telephone and on-site consultation with the State.

5. For the customer service center proposed for the State provide the following for 2016:
   - Percent of calls abandoned
   - Percent of calls handled by live representative
   - Number of seconds to reach a live customer service representative

6. Do you have a formal training process for customer service reps? Please describe.

7. Do customer service reps have online access to real time claim processing information?

8. Do customer service reps have authority to approve claims?

9. Check all items below which pertain to calls handled by the customer service representatives:
   - [ ] All calls are recorded
   - [ ] CSRs document all calls
☐ CSRs can make adjustments to claims during a call
☐ Calls are documented verbatim
☐ Calls are documented in summarization

10. Do you offer clients online access to information and services via the Internet or through CRT interface?

11. If yes, what information is accessible that is included in your financial cost proposal?

12. Can your organization send recovery letters to members who continue to use their medical card after their termination? Provide a description of your recovery process for claims incurred by members who continue to use their medical ID card after their termination.

13. Do you survey clients annually regarding program administration satisfaction?
   If yes, provide most recent aggregate results.

14. How many toll free numbers are available to the State and its members to handle claims or other member service issues?

15. In addition to the requirement hours indicated in Section III, what hours will the telephone lines be staffed? Please indicate if you are able to offer staffed hours on one or both weekend days and the proposed hours. Also, indicate if there is an additional cost to weekend hours in your response to the Financial Section. Note that the State has not decided to extend hours to the weekend, but is interested in the availability.

16. Do you currently perform membership satisfaction surveys? Provide a copy of the latest results of the survey. What percent of members indicated that they were “satisfied or very satisfied” with the overall program?

17. Describe the escalation process for Member Service satisfaction and complaints.

18. Will you provide a quarterly summary of the types of member services calls received, including resolutions for reoccurring issues?

19. Do you provide member support services for selecting and/or locating network providers?

20. Please describe how your organization will assist the State in marketing how employees can get the most of their medical benefits. The described services must be included in your quoted administrative fees.

21. Are you able to customize messaging on point of sale EOB’s specific to the client’s plan?

22. How are out-of-network claims processed?

23. Do you have a program available for subscribers who may have dependents living out of state temporarily or permanently? Describe program and how claims incurred are processed, including claims pricing.
C. REPORTING, IT & DATA INTEGRATION

“Administrative, Member, Claims Paying Services, Reporting Services” Score = 10 points

See the prior Technical Questionnaire section (B. Administrative, Member, & Claims Paying Services) for scoring considerations.

The State requires a response to the following questions:

1. Indicate for each report noted below whether you can provide such a report at no additional cost. If you can provide the requested report as part of the services included in your financial cost proposal, indicate the frequency the report will be available.

<table>
<thead>
<tr>
<th>Report</th>
<th>Will this be provided at no additional cost?*</th>
<th>If yes, indicate frequency</th>
<th>Will the State have online access to this information?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Eligibility Report which shows accuracy of updates and changes</td>
<td>☐ Yes ☐ No</td>
<td>☒ Will this be available upon request?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>b. Paid Claims Summary (by plan and by subgroups)</td>
<td>☐ Yes ☐ No</td>
<td>☒</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>c. Detail Claim Listing (Utilization by individual claim, listing the provider information, submitted charge, allowable charge, paid)</td>
<td>☐ Yes ☐ No</td>
<td>☒</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)</td>
<td>☐ Yes ☐ No</td>
<td>☒</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>e. Detailed Utilization Report</td>
<td>☐ Yes ☐ No</td>
<td>☒</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>f. High Amount Claimant report</td>
<td>☐ Yes ☐ No</td>
<td>☒</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

* If applicable, indicate any costs associated with these reports in your response to the financial section.

2. Describe any other claim/management reports you would be able to supply to the State or its designee regularly at no additional charge and the frequency with which they could be provided. Please provide sample reports.

3. Describe any other reports either Clinical or Financial in nature that would be provided to the State or its designee in order to help manage benefit costs. Please provide sample reports.

4. Describe in detail any programs designed to integrate medical and pharmacy data in order to create patient management and cost savings opportunities.

5. On average, what percentage of all claims are audited by your internal audit group?

6. Are audits performed on a pre- or post-disbursement basis?
   ☐ Pre-Disbursement
   ☐ Post-Disbursement
   ☐ Both

7. Would there be a charge to the State for the required independent audit performed of your claim operation?
8. Explain your Coordination of Benefits (COB) procedures.
   A) Do you pursue COB prospectively or retrospectively to payments?
      □ Prospectively
      □ Retrospectively
   B) How often are records updated for new information on other coverage? Please describe how this data is gathered.

9. Please complete the following table of fraud detection programs:

<table>
<thead>
<tr>
<th>Task</th>
<th>Formal Written Program</th>
<th>If yes, provide total # of events per 1000 covered lives</th>
<th>Describe Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Ineligible Claimant</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
<tr>
<td>B. Assure that service billed is actually rendered</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
<tr>
<td>C. Over billings</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
</tbody>
</table>

10. Do you retain medical consultants for the review of any unusual claims or charges?
    □ Yes
    □ No

    If yes, explain the method in which such consultants are used and describe their qualifications, any affiliations and how they are compensated.

11. How do you reimburse multiple surgical procedures being performed during one operation?

    Is a reduced scale used for the 1st and subsequent procedures? *(Check only one)*
    □ Yes
    □ No

12. How are claims, customer service, case management, utilization review and case management systems linked? *(Check only one)*
    □ Same system
    □ Integrated, but different systems
    □ Different systems, but accessible to all
    □ Not linked
    □ Some linked
    □ Other, please specify:

13. Does your claims system have the capability to automatically match claims with utilization management information both in- and out-of-network?
    □ Yes
    □ No
14. Do you have an automatic audit process for large claims?
   - Yes
   - No

   Indicate how you define a large claim and provide detail of the audit review process.

Claims and Appeals

15. Do you have a formal written appeal/grievance/reconsideration process for both self-funded and fully insured plans? (Check only one)
   - Yes
   - No

   If yes, please describe these processes, including how the appeal providers are chosen, who is retained for external appeals and what the turnaround time is from the time an appeal is submitted to when a decision on the appeal is reached.

16. Is there information regarding the option for an appeal, the timeframe, and the mailing address and all other information required by ACA claims and appeal rules in either the body of or attached to all claim and appeal notification letters? (Check only one)
   - Yes
   - No

17. Have your claims and/or UR staff been educated and trained on how to process claims and/or pre-certification review under NHRSA 420-J:5 and the new ACA guidelines? (Check only one)
   - Yes
   - No

18. Are you fully compliant with ACA claims and appeals regulations and NHRSA 420-J:5? (Check only one)
   - Yes
   - No

19. Are there any differences between your fully insured and self-funded claims processing systems? (Check only one)
   - Yes
   - No

20. Who is the fiduciary? Who is responsible for the second level of appeal?
D. HEALTH MANAGEMENT PROGRAMS

“Health Management Programs” Score = 10 points

The “Health Management Programs” technical score shall be scored in consideration of:

- the completeness of responses to the questions in the section
- the degree to which responses are judged by the State to have demonstrated that the Bidder would provide affective:
  - utilization management
  - case management
  - disease management

The State requires a response to the following questions:

Utilization Management

1. If your contracted physician requested that a Pap smear be evaluated by the following techniques, which ones would be considered payable under your organization? (Check all that apply)
   - a. ThinPrep
   - b. PapNet
   - c. AutoPap
   - d. Other device to perform Pap smear evaluation (List): __________.
   - e. None of the above or unknown.

2. The National Institute of Health has classified the following services as Alternative Medicine practices. These practices are currently under NIH investigation to determine efficacy. Indicate whether any of the following services, when requested by enrollees are commonly considered eligible expenses by your organization. (Check all that apply)
   - a. Homeopathic services
   - b. Naturopathic services
   - c. Biofeedback
   - d. Herbal medicine
   - e. Chiropractic/spinal manipulation
   - f. Acupuncture
   - g. Acupressure
   - h. Yoga
   - i. Therapeutic massage
   - j. Rolfing
   - k. Trager/Feldenkrais manual healing techniques
   - l. Ayurvedic medicine
   - m. Nutritional therapy: macrobiotics, megavitamin
   - n. None of the above.
   - o. Other: ____________________________________________

3. How long has your organization been performing Utilization Management services? (Check only one)
4. Are your services local, national, or international? *(Check only one)*

- a. Local only
- b. National, some states*
- c. National, all states
- d. National, all states plus international

* Indicate the states you SERVE or DO NOT SERVE (whichever is shorter).

5. Are there any specific reporting or administrative procedures you would require of the State prior to implementation of your program?

- a. Yes, explain:
- b. No

6. Complete the grid to indicate the number of physicians (MD, DO) ROUTINELY available to your organization to assist in review.

<table>
<thead>
<tr>
<th></th>
<th>Full Time</th>
<th>Part Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Number of physicians on staff in your Utilization Review office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Number of physicians retained as consultants to review as needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Would you be agreeable to a periodic (e.g., twice a year) “round table” meeting with the State, Utilization Management firm, claims payor and consulting organization to discuss both positive and negative areas of the working relationship? *(Check only one)*

- a. Yes, cost included in fees
- b. No

8. If medical records are needed and a facility/provider charges your Utilization Management firm for the photocopy/postage expense, who pays that bill? *(Check only one)*

- b. Patient
- c. Employer/State

9. Does your Utilization Management firm subcontract for any portion of the following? *(Complete all rows)*
### Service

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>To Whom</th>
<th>No</th>
<th>Service Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Preservice review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Concurrent review</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. Discharge planning</td>
<td></td>
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<td></td>
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<tr>
<td>d. Psychiatric/substance abuse review</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>e. Case management</td>
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</tr>
<tr>
<td>f. Bill audits</td>
<td></td>
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</tr>
<tr>
<td>g. Coding (ICD/DRG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Data entry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Computer programming</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Physician advisor review</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>k. HIPAA EDI services</td>
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</table>

10. Do you have educational material, which informs enrollees regarding your U.R. services and procedures? *(Check only one)*
   - a. Yes, available for the State at no added cost
   - b. No, but can develop at no added cost
   - c. No, not available

11. Is your firm willing to assist the State if a dispute arises over payment/nonpayment for health care services which your firm recommended were not medically necessary, appropriate and/or reasonable? *(Check only one)*
   - a. Yes, within our proposed fees
   - b. No, explain:

12. Does your utilization management firm have any affiliations with other business entities?
   - a. No
   - b. Yes, explain the nature of these affiliations:
Preservice Review

13. Indicate which services are reviewed under your preservice (precertification) review program (Check all applicable to your program):

☐ a. Elective inpatient medical/surgical admissions
☐ b. Elective outpatient surgery
☐ c. Diagnostic services
☐ d. Durable medical equipment
☐ e. Corrective appliances/prosthetics
☐ f. Skilled nursing facility
☐ g. Home health/home enteral/parental therapy
☐ h. Musculoskeletal services (e.g., chiropractic)
☐ i. Medical services (e.g., physical therapy, Dr’s office visits)
☐ j. Psychiatric admissions (acute and residential)
☐ k. Psychiatric outpatient therapy services
☐ l. Substance abuse (e.g., detoxification, rehabilitation)
☐ m. Other:
☐ n. No preservice review offered

14. Precertification includes analysis and determination of which of the following (may check more than one):

☐ a. Appropriate Level of Care (e.g., inpatient versus outpatient)
☐ b. Reasonable Length of Stay for inpatient confinement
☐ c. Actual Medical Necessity and appropriateness of the surgery or service being requested (e.g., does service require performance)
☐ d. Necessity for the services of an Assistant Surgeon with each operative procedure analysis
☐ e. Necessity for a proposed Preoperative hospital day
☐ f. Necessity for a proposed 23-hour observation stay following outpatient surgery
☐ g. Patient resources for self-care
☐ h. Other: Explain
Case Management

15. Does your firm have an ACTIVE case management program?
   - a. Yes
   - b. No

16. What criteria are used to identify cases for medical case management? (Check only one)
   - a. No criteria used – we rely on our staff’s clinical experience
   - b. Internally developed written criteria: Please describe and provide sample (or example) of how that criteria would apply to certain situations
   - c. Other purchased case management criteria: Please describe and provide sample (or example) of how that criteria would apply to certain situations

17. How and when are medical specialists involved in the case management process? Describe their credentials.

18. During case management, check which services your staff routinely performs on each case. (Check all that apply)
   - a. Redirect/channel patient/provider to correct in-network provider (e.g., non-network DME vendor redirected to use network DME vendor)
   - b. Negotiate discounts with non-network providers and vendors
   - c. Steer patient/physician to your firm’s contracted vendors in order to obtain discounts
   - d. Evaluate and alter the proposed treatment plan toward a more creative treatment plan
   - e. Staff functions as patient ombudsman to answer questions and reassure patient/family
   - f. Staff functions to gather information from the patient’s caregivers and physicians to report the status to the State or claims administrator
   - g. Discuss community resources
   - h. Identify the case manager available for call in questions
   - i. Other: _____________________________________________

19. Indicate the frequency with which your firm sends summary data on case management services to the State. (Check only one)
   - a. No reports currently provided
   - b. Quarterly
   - c. Quarterly with an annual summary
   - d. Other: ______________________

Quality Control of Utilization Management Services

20. Are you able to provide an annual summary of the State’s utilization statistics and your firm’s overall savings?
   - a. Yes
   - b. No
21. Are you able to provide quarterly and ad-hoc reports of the State’s utilization statistics and your firm’s overall savings?
   - [ ] a. Yes
   - [ ] b. No

**Telemedicine**

22. Are you able to provide telemedicine services? If so, what types of services are available?
   - [ ] a. Yes
   - [ ] b. No

**Disease Management**

For the purpose of the following questions, “disease management” will refer to a **formal** program designed to improve the health, outcomes & quality of life of enrollees, as well as lower costs through a systematic approach to actively manage a population of enrollees with a specific disease.

23. Complete the following grid regarding your organization’s FORMAL Disease Management (DM) program. *(Check all that apply and complete columns b, c, d, and e)*

<table>
<thead>
<tr>
<th>Check the programs currently in place.</th>
<th>b) Number # of years program in place?</th>
<th>c) Number of members currently participating in program?</th>
<th>d) Performed by in-house Staff or Outsourced</th>
<th>e) What data or results are you currently tracking to demonstrate the effectiveness of each Disease Management Program? (Attach added documentation as needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Pre-Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Adult-onset diabetes</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>c) Hypertension</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d) Pediatric asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Juvenile diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Rheumatoid arthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Chronic obstructive pulmonary (COPD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Osteoarthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Adult asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Migraine headache</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) Chronic renal failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) Peptic Ulcer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n) Major Depression</td>
<td></td>
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</tr>
</tbody>
</table>
24. Indicate the items that your organization incorporates into each disease management program that you administer. *(Check all that apply)*
   - b. Periodic calls to discuss enrollee’s compliance and health status.
   - c. Practice guidelines to develop consistency and effectiveness in treatment planning.
   - d. Provider survey on satisfaction with the disease management protocol.
   - e. Recommended drug therapy regimens.
   - f. Enrollee satisfaction with your disease management program.
   - g. Enrollee educational material (e.g., brochure, cards, video).
   - h. Patient’s return demonstration of techniques or equipment taught to them.
   - i. Outcome measures indicating the CLINICAL effectiveness of program.
   - j. Outcome measures indicating the COST effectiveness of program.
   - k. Other: _______________________________________________

25. An enrollee’s entrance into your organization’s disease management programs is typically prompted by which of the following: *(Check all that apply)*
   - a. A referral from the enrollee’s physician.
   - b. Evidence of at least one bill (claim/encounter) for a pertinent diagnosis.
c. Enrollees identified via a health risk assessment survey.

d. Enrollees who have had at least one hospital admission for a pertinent diagnosis.

e. Enrollees identified by their prescription usage.

f. Enrollees with at least one ER visit for a pertinent diagnosis.

g. Enrollees who desire participation.

h. Other: _____________________________________________________

26. Do you receive any fees or revenue from any drug manufacturer, medical equipment provider, or other medical service provider or other third party for directly sponsoring or promoting any of your DSM programs?

   a. No

   b. Yes, describe: __________________________________________

27. Indicate how and when you use a Health Risk Appraisal (HRA) in the course of your disease management services.

E. WELLNESS SERVICES

“Wellness Services” Score = 10 points

The “Wellness Services” technical score shall be scored in consideration of:

• the completeness of responses to the questions in this section

• the degree to which responses are judged by the State to have demonstrated that the Bidder would provide affective wellness services, including:
   o administration of the Health Assessment Tool (HAT)
   o administration of biometric screening
   o participant incentives and their tracking

The State requires a response to the following questions:

General

1. Provide a summary of the company’s wellness services history and experience.

2. Do you offer cost savings guarantees for any health improvement/coaching services offered?

3. Please provide any reporting and/or case studies documenting risk reduction and/or health improvement results for clients that engage in your wellness services.

4. Please describe how your organization will assist members with behavior change and healthy habit formation.

5. Will you offer subject matter experts to assist the State with health improvement and wellness integration efforts? If yes, would these experts be able to join the State Health Benefit Program and
Wellness Workgroup for monthly meetings in person or by phone? Please indicate any additional fees that may apply in your response to the Financial Section.

**Scope of Work**

6. Provide an overview of your organization’s following wellness services that are currently available:
   I. Health Risk Assessment
   II. Telephonic Health Consultation
   III. Online Health Consultation
   IV. On-site (in person) Health Coaching
   V. Group or Social Media Events and Peer Support activities
   VI. Self-Help Health Literacy
   VII. Incentive Administration
   VIII. Learning Modules On Health Topics (e.g., Nutrition, Weight Management, Diabetes, Medical Self-Care)
   IX. Mobile apps, online tools, trackers, calculators, etc.

7. List industry accreditations or National certifications for each of the above programs you offer.

8. Describe any other services or programs available for future consideration by the State.

**Program Design, Implementation, and Administration**

9. Describe the engagement process from a user’s perspective. Is there a single sign on portal for users or multiple websites and points of entry?

10. How does your company encourage/incentivize participation in health and wellness programs?

11. Describe your program(s) or targeted campaign(s) towards pre-diabetics, cardio-vascular disease, obesity, and any other specific programs you offer.

**Health Risk Assessment or Health Assessment Tool (HAT)**

12. How do you administer and collect your HAT?

13. Indicate if your HAT includes any academic institution collaboration.

14. How does your HAT guide member health management and risk reduction?

15. Indicate the methods that a member can complete the HAT (e.g. paper, online, telephonic).

16. Describe how your disease management and wellness programs are integrated together for a member with co-morbidities (e.g. member with obesity and diabetes).

**Biometric Screening**

17. Describe all biometric screening options you provide, with any requirements for each one. Can these be customized to the State’s needs and budget?

18. Can your company provide on-site and off-site biometric screenings?
19. Are there any minimum participation requirements for a screening event? Any maximum participation limits?

20. Are biometric screenings available to all employees? Only health plan participants? Employees? Spouses? Dependents?

21. Can your company use/integrate outside biometric data in lieu of your standard biometric screenings?

22. How is scheduling, sign up, and day-of registration handled for screening events?

23. Do you electronically integrate the data you collect from a member at an onsite health screening program into the member’s HAT, health coaching program, incentive program, personal health record, etc.?

**Incentive/Participation Tracking**

24. Does your company track the active participation, new enrollees, drops, incentive, and progress of participants?

25. How do you validate member completion of preventive care screenings, wellness competitions, health education, health risk reduction, and outcomes based health screening results and/or improvements?

26. Is there an appeals process? If so, how does it work?

**Pricing Proposal**

27. Can your fee be retroactively adjusted to account for lower than expected health improvement/coaching service utilization?

28. Are you willing to put your fee at risk relative to performance guarantees? If so, what percentage amount of your fee will you return to the State if savings estimates are not reached? How will savings be measured?

**F. TIERED-NETWORKS / SITE-OF-SERVICE**

“Tiered-Networks/Site-of-Service” Score = 5 points

The “Tiered-Networks/Site-of-Service” technical score shall be scored in consideration of:

- the completeness of responses to the questions in this section
- the degree in which the bidder demonstrates they are able to offer a benefit comparable to the current “Site-of-Service” plan provision
- the bidder demonstrates it has “Site-of-Service” locations in all geographic regions of the State of New Hampshire or provides their plan to expand its program to cover all geographic regions prior to August 1, 2017
- the bidder’s response to the “Site-of-Service” provider identification in Section IV

The State requires a response to the following:
1. Confirm you currently offer a tiered-network / site-of-service product comparable to the State Plan’s site-of-service provision.

2. Demonstrate your proposed “Site-of-Service” comparable product has locations in all geographic regions of the State of New Hampshire. If not, provide your plan to expand your program to cover all geographic regions prior to August 1, 2017.

3. Illustrate that your “Site-of-Service” providers offer lower cost lab and outpatient surgery services than the other providers in their geographic location.

4. What type of reporting will you provide to the State regarding:
   a. Your proposed “Site-of-Service” product
   b. Your high quality, high performance medical providers?

5. What impact do you expect the tiered network / your proposed “Site-of-Service” comparable product will have on trend in 2018?

6. Provide a brief overview of your high quality or high performance network capabilities.
   a. Provide a listing of the markets where the network is currently available, including plans for future expansion.
   b. What types of medical providers/facilities are in your high performance network?
   c. Provide a detailed list of physician subspecialties that are included in your high performance network.

7. Will the information regarding State of New Hampshire providers and their designated tier category be made available to the State’s members so they can make informed decisions about the cost and quality of the provider they choose?
SECTION X: CLIENT REFERENCES

“Client References” Score = 5 points

The “Client References” score shall be scored in consideration of the degree to which, as judged by the State, the information obtained from the five clients demonstrate the bidder’s ability to provide the services requested and the objectives outlined in this RFP.

Provide the name of your five (5) largest public sector (states, municipalities, etc.) clients for which you provide comparable services as requested in this RFP.

For these five clients, provide:
- Key contact’s name, including phone number and email address
- Address
- Number of active members (i.e., employees and dependents)
- Number of non-Medicare retiree members
- Number of Medicare retiree members
- A summary of the services provided by the Bidder to the client

The State reserves the right to contact any or all of these clients for references and consider the references’ experiences with the bidder in the Client References score.

Additionally, the State also reserves the right to use itself as a reference and consider its own experiences with the bidder in the Client References score.
## APPENDICES – GROUP INFORMATION

**APPENDIX A**  REQUESTED PLAN DESIGNS  
**APPENDIX B**  VALUE-BASED PURCHASING SPECIFICATIONS – REQUESTED CONTRACT LANGUAGE  
**APPENDIX C**  DEFINITION OF TERMS  
**APPENDIX D**  NETWORK MATCH, SITE-OF-SERVICE IDENTIFICATION, CLAIMS REPRICING  
**APPENDIX E**  EMPLOYEE CENSUS, MONTHLY ENROLLMENT, MONTHLY CLAIMS EXPERIENCE  
**APPENDIX F**  PLAN DEVIATION FORM  
**APPENDIX G**  STATE OF NH TRANSMITTAL LETTER  
**APPENDIX H**  P-37 FORM CONTRACT  
**APPENDIX I**  BUSINESS ASSOCIATE AGREEMENT  
**APPENDIX J**  DATA REQUEST FORM
REQUESTED PLAN DESIGNS, SERVICES & PROGRAMS

Please see plan design information in the following files attached to this RFP:

- **Active Plan Summary of Benefits** are provided for the current HMO and POS plan designs effective since January 1, 2015. Currently, all the active groups have the same HMO and the same POS plan design.
  - State of NH Active HMO Plan.pdf
  - State of NH Active POS Plan.pdf

- **Site-of-Service Plan Provision**
  - Anthem Website: [https://www11.anthem.com/stateofnhsaves/](https://www11.anthem.com/stateofnhsaves)
  - Participant Step-by-Step Instructions: [https://das.nh.gov/hr/documents/Anthem%20Site%20of%20Services%20Step%20by%20Step%20Instructions.pdf](https://das.nh.gov/hr/documents/Anthem%20Site%20of%20Services%20Step%20by%20Step%20Instructions.pdf)

- **Retiree Plan Summary of Benefits** are provided for the current plan designs effective since January 1, 2012. The State offers only one Non-Medicare Retiree Plan design. The POS Open Access and the PPO Plan designs for the Non-Medicare Retiree Plan are exactly the same. Due to the network design of the current carrier, retirees that live outside of New England are enrolled in the PPO product.
  - State of NH Ret 65+ Plan.pdf

- **Wellness Program**
  - Website – [https://das.nh.gov/wellness/](https://das.nh.gov/wellness/)

- **Vitals SmartShopper Program** – program available for Active Plans and Non-Medicare Retiree Plan participants)
  - [https://das.nh.gov/hr/Vitals_SmartShopper.html](https://das.nh.gov/hr/Vitals_SmartShopper.html)

HISTORIC PLAN CHANGES

Active Plan Changes
- January 1, 2014 – Implemented deductible of $500 per member, to no more than $750 per family
- January 1, 2015 – Max deductible per family increased to $1,000
Non-Medicare Retiree Plan Changes – January 1, 2012

- Specialist office visit copayment increased from $20 to $30
- Emergency room copayment increased from $50 to $150
- Implemented High Cost Radiology copayment of $150
- Implemented deductible of $500 per member, to no more than $1,000 per family

Medicare Retiree Plan Changes – January 1, 2012

- Participants responsible for Medicare Part B deductible
APPENDIX B

VALUE-BASED PURCHASING SPECIFICATIONS – REQUESTED CONTRACT LANGUAGE

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A. Primary Care Transformation
B. Value-Based Payment (Alternative Payment Models)
C. Performance Measurement
D. Clinical Performance Data
E. Engaging Members in Improving Care and Health Status
F. Quality Improvement
G. Utilization Management
H. Clinical Pathways and High-Cost Condition Management Programs
I. Provider Network and Access
J. Behavioral Health Services
K. Member Services

All work conducted pursuant to the following Purchasing Specifications is subject to review and approval by the State. The State may require the Contractor to take corrective action if it finds the Contractor is not providing services in conformance with the Value-Based Purchasing specifications.
A. Primary Care Transformation

1. The Contractor shall support primary care transformation, ensuring that the level and method of compensation support Patient-Centered Medical Home primary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.
   a. The Contractor shall report annually on specific steps it has taken to support transformed primary care practice, including through value-based payment arrangements.

2. Primary Care Clinician. The Contractor shall ensure that each Member, including those Members enrolled in HMO, PPO and POS products, has an identified Primary Care Clinician (PCC) and that the PCC establishes a relationship with every attributed Member if one does not already exist at the time of enrollment.
   a. The Contractor shall annually report on the percentage of Members electing a PCC.

3. Patient-Centered Medical Home (PCMH). The Contractor shall encourage its contracted primary care practices to operate as high-functioning Patient-Centered Medical Homes.
   a. The Contractor’s contracted PCMHs shall be encouraged to provide patient-centered, team-based care across appropriate disciplines, including behavioral health, in part through the application of a common, shared care plan and clinical information exchange.
   b. The Contractor shall ensure providers are knowledgeable in the clinical evidence for patient-centered team-based care and are increasingly practicing in such manner over the term of the contract.
   c. The Contractor shall support PCMHs with needed data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization (e.g., inpatient care, emergency and urgent care services), quality information, utilization measures and cost measures for attributed Members.
   d. The Contractor shall hold PCMHs accountable for performance, including for operating as a PCMH and for quality and cost efficiency.
   e. The Contractor shall annually report on the percentage of Members electing a PCC that operates as a PCMH.

4. PCMH care coordination. The Contractor shall ensure the provision of care coordination by PCMHs for patients at high-risk of future intensive service use. Because care coordination is frequently provided by entities in addition to PCMHs, including hospitals, behavioral health providers, ACOs and the Contractor, the Contractor shall ensure these efforts are coordinated and not duplicative. See Section H below for language specific to Contractor care coordination activity.

B. Value-Based Payment (Alternative Payment Models)

1. Population-based contracting (total cost of care). The Contractor in coordination with and on behalf of the State shall pursue population-based shared risk ACO contracts with providers serving a substantial number of Members.
   a. The contract shall be a total cost of care contract that includes nearly all, if not all, covered services, including physician services, hospital services and prescription drugs.
   b. The distribution of any shared savings shall be contingent on achievement of clinical quality performance expectations, with greater reward for higher levels of demonstrated meaningful quality improvement over time.
c. To support providers entering into population-based contracts with the Contractor, the Contractor shall furnish claim data to the contracting provider entity in a manner approved by the State.

d. By the end of Contract Year One, claims for at least 30% percent of Members shall be covered under a multi-year population-based contract with risk sharing arrangements that meets standards identified by the State in consultation with the Contractor.

2. Pay providers differentially according to performance. Contractor shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Payment to effective and efficient providers should reflect their performance. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.

3. Develop episode-based payment strategies. Contractor shall work with the State and its provider network to evaluate and implement episode-based payment strategies designed to bundle a set of services together that are related to a defined condition or treatment (e.g., knee replacement surgery). Priority shall be placed on referral services delivered by providers not participating in a population-based contract on behalf of the State and with high Member service volume.

4. Design payment and coverage approaches that cut medically unnecessary spending while not diminishing quality, including by reducing unwarranted payment variation. Contractor shall evaluate, and propose to the State for implementation, successful approaches to payment designed to cut medically unnecessary spending while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital-acquired infections, lower payment for non-indicated services and warranties on discharges for patients who undergo procedures.

C. Performance Measurement

1. Aligned measure set. If so directed by the State, the Contractor shall collaborate with New Hampshire providers, payers and employer purchasers to adopt an aligned set of performance measures to which Network Providers will be held accountable, including commonly defined measures in each of the following domains: a) access, b) quality, c) patient experience, e) service utilization, and f) cost.

2. Contractor health informatics. The Contractor shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or Clinical Pathways, d) patients at risk for future high-intensity service use. Results shall be presented to the State in writing and during meetings with interpretation and recommendations.

3. Contractor-level measurement. The Contractor shall measure performance across all provider types and providers with meaningful volume for the Contractor’s book of business. For high-volume providers, the Contractor shall create provider profile reports for use in network management and Quality Improvement (QI) activity. Results shall be presented to the State in writing and during meetings with interpretation and recommendations.

4. Provider-level measurement. The Contractor shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.

D. Clinical Performance Data

1. The Contractor shall annually report its complete HEDIS data set inclusive of CAHPS, and including State-specific data for claims-based measures, and total Contractor New Hampshire commercial book-of-business data, including enrollment, quality, Member satisfaction, and utilization data. Such a report shall be provided and presented to the State no later than July 1 of each year for performance during the preceding calendar year.

2. The Contractor shall collect and report to the State on performance using the aligned measure set referenced above in C.1, including performance of high-volume providers.

3. The Contractor shall report on performance related to annual Quality Improvement Goal achievement, consistent with the terms of the Goals and Measures approved by the State.

E. Engaging Members in Improving Care and Health Status

1. The Contractor shall collaboratively design and implement a State-approved strategy for activating Members to manage their health and to be prudent purchasers of health care through education, including health care and health insurance literacy education and through health promotion activities.

2. The Contractor shall provide education to Members on the important role a Member-PCC relationship plays in their health to encourage Member PCC selection, even when not required under the plan design.

3. The Contractor shall provide education to Members on how to access and use comparative provider price and quality information including but not limited to information available at https://nhhealthcost.nh.gov/.

4. The Contractor shall promote use of behavioral health services programs to support behavioral health and wellness to Members and remove the social stigma associated with behavioral health illness and services. Such efforts shall also make mention of the State’s Employee Assistance Program and how its services may be accessed.

5. The Contractor shall evaluate the impact of health promotion programs and act on such information by adding, eliminating, or altering programs, based on such evaluations. At a minimum, evaluations should study effectiveness/impact, attendance and Member satisfaction resulting from such programs. The plan shall demonstrate that such findings were used in a meaningful way to improve the quality of health promotion programs.

F. Quality Improvement (QI)

1. Organizational arrangements and responsibilities for QI process are clearly defined and assigned to appropriate individuals. It is clearly indicated which persons are physicians or other clinicians.

2. There is an annual QI work plan for New Hampshire, submitted to the State, that includes the following:
   a. Objectives, scope and planned projects or activities for the year;
   b. Planned monitoring of previously identified issues, including tracking of issues over time; and
   c. Planned evaluation of the QI program.

3. Hospital Quality Improvement. The Contractor shall develop a program to manage quality of care provided by network hospitals. At a minimum, such a program shall include:
   a. identification of data-driven opportunities to improve quality; and
   b. collection of Leapfrog survey responses from hospitals.
Using this, and other available information, the Contractor shall actively manage its contracted network hospitals. If the Contractor identifies deficiencies in data obtained through this process, the Contractor shall take appropriate actions (e.g., plan of correction and follow-up, financial penalties) with such hospitals.

4. **Clinician Quality Improvement.** The Contractor shall develop a program to manage quality of care provided by network primary care, specialty care physicians and non-physician behavioral health clinicians. At a minimum, such a program shall focus on data-driven opportunities to improve quality through active management of network physicians. If the Contractor identifies deficiencies in data obtained through this process, the Contractor shall take appropriate actions (e.g., plan of correction, financial penalties) with such clinicians.

5. **Health Information Exchange.** Contracted physician, behavioral health and hospital providers shall be encouraged to use real-time electronic clinical information exchange across all care settings.

**G. Utilization Management**

1. The Contractor shall have policies and procedures in place to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs, and devices, as well as long-standing treatments. Procedures should include careful consideration of Comparative Effectiveness Research in order to a) protect the health and safety of Members, and b) reduce unnecessary spending.

2. The Contractor shall have a process for assessing patient compliance with prescriptions.

3. The Contractor shall have a process for assessing under-utilization and over-utilization.

4. The Contractor shall produce an annual report of the findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for physical and behavioral health, including pharmaceutical use. The following measures set shall be reported in the annual report:
   a. potentially preventable hospitalizations, including readmissions, and
   b. potentially avoidable emergency department visits.

5. The Contractor shall annually track programs that traditionally include utilization management/review so that it can be reviewed by the State, e.g., prior approval of advanced imaging, prior approval of physical therapy. The Contractor shall annually identify and report to the State the cost-effectiveness of such activity, and opportunities to improve program effectiveness.

**H. Clinical Pathways and High-Cost Condition Management Programs**

1. The Contractor shall be accountable for adopting and using Clinical Pathways or explicit criteria that are based on reasonable scientific evidence and reviewed by Contractor-contracted providers. The Contractor shall implement a process for updating the guidelines periodically and for communicating the Clinical Pathways to the Contractor’s network. The Contractor shall assess provider performance against the Clinical Pathways and act on the performance results. The results of the assessment and ensuing action shall be reported to the State annually.

2. Contracted providers shall be required to specify and implement Clinical Pathways reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse. For example, a Clinical Pathway may include treatment steps for treating an individual with COPD.
3. The Contractor shall develop and implement a program of care coordination for Members one or more high-cost, high-frequency conditions or diseases to maximize their health status and ensure appropriate service utilization. The Contractor shall implement such programs based on a) the profile of high-risk Members, and b) the prevalence of associated conditions and diseases in the enrolled population. Such conditions and diseases might include: High-Risk Pregnancy, Chronic Obstructive Pulmonary Disease, Diabetes, Depression, Cardiovascular Disease, Low Back Pain, and/or Hypertension.

4. The Contractor shall stratify high-risk Members based on consideration of clinical and social determinant-of-health factors.
   a. The Contractor shall report annually on its method for stratifying the Member population to identify potentially high-cost Members, including how it is capturing and considering social-determinant-of-health factors.

I. Provider Network and Access

1. The Contractor maintains and monitors a network of qualified providers in sufficient numbers, mix, and geographic locations throughout the state, and where appropriate in regions contiguous to the state, for the provision of all covered services.
   a) The Contractor will maintain the following geographic access standards from the individual patient’s residence:
      i. Hospital – Licensed medical-surgical, pediatric, obstetrical and critical care services associated with acute care hospital services within 45 miles
      ii. Primary Care – Two open-panel primary care providers within 15 miles
      iii. Outpatient mental health and substance use treatment – One provider within 25 miles
      iv. Specialist Care – One provider within 45 miles for: Allergists, Cardiologists, General surgeons, Neurologists, Obstetrician/gynecologists, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Psychiatrists, and Urologists
   b) The Contractor shall adopt NH Insurance Department (NHID) standards of access for all other services and maintain provider network data and shall submit provider network data to the State annually. The provider network data will support Member PCC selection and shall therefore include an accurate provider directory. The Contractor may be required to participate in testing of provider network and directory functionality.

2. The Contractor shall establish and comply with access standards that are no longer than the following (standards shall be measured from the initial request for an appointment):
   a) Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.
   b) Urgent, symptomatic office visits shall be available within twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not emergent.
   c) Non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services, shall be available within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
d) Non-symptomatic (i.e., preventive care) office visits within ninety (90) calendar days. A non-
symptomatic office visit may include, but is not limited to, well/preventive care such as physical
examinations, annual gynecological examinations, or child and adult immunizations.

e) Transitional health care services by a PCC shall be available for clinical assessment and care
planning within 48 hours of discharge from inpatient or institutional care for physical or behavioral
health disorders or discharge from a substance use disorder treatment program.

The Contractor shall report on compliance with these requirements in a manner and frequency defined
by the State after consultation with the Contractor. Failure to meet network or appointment access
standards may, at the State’s sole discretion, result in sanctions.

3. Within the first 12 months of the contract start, the Contractor shall provide the State with information
on strategic options for implementing Centers of Excellence, and including options regarding how to
engage Members if a Centers of Excellence program is implemented voluntarily for members. Should
the State decide to pursue a Centers of Excellence program, the Contractor will support the State by
creating such a program.

J. Behavioral Health Services

1. The Contractor shall provide direct access without referral to behavioral health service providers within
the network and communicate such availability to Members.

2. The Contractor shall employ a process to ensure that early detection and referral for depression and/or
substance use problems in Members occurs and that primary care physicians are adequately trained to
perform, code and bill such screenings.

3. Treatment shall be delivered based upon clinical assessment of individual patient need.

4. The Contractor shall take action to support the advancement of integrated care that addresses behavioral
health needs and social determinants of health concurrently with physical health needs. The Contractor
shall do so:

   a) through innovative contracting and payment models that support integrated care in both co-located
   and non-co-located arrangements and foster joint accountability for physical and behavioral health
   needs;
   b) through training and technical assistance opportunities regarding best practice in integrated care,
   including but not limited to the Collaborative Care Model, and
   c) protocols for provider information exchange of behavioral health data to support improved patient
care, as permitted by law.

5. The Contractor shall address New Hampshire’s opioid epidemic by a) making conformance with the
New Hampshire Board of Medicine guidelines for physicians who prescribe opioids a contractual
requirement, and b) facilitating Member access to Medication-Assisted Treatment and other appropriate
modalities of care.

K. Member Services

1. 24/7 Availability. The Contractor shall have the following services available on a 24-hour-a-day, seven-
day-a-week basis by telephone or other tele-health modalities.
a. medical or behavioral health advice for Members from licensed health care professionals;
b. triage concerning the emergent, urgent or routine nature of medical and behavioral health conditions by licensed health care professionals;
c. authorization of urgent and emergency services, including emergency care for behavioral health conditions and services provided outside the Contractor’s service area;

2. Customer Service. The Contractor shall provide dedicated staff that are knowledgeable of the State’s plans to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m., Eastern Time, Monday through Friday, year-round and shall provide customer service on all dates that are recognized as work days for state employees.

   a. The Contractor and its subcontractors, provider help desks, authorization lines, and member customer service centers, shall comply with the following customer service performance standards:
      (i) Telephone abandonment rate – less than 3%.
      (ii) Telephone response time - average speed of answer within 30 seconds.

3. The Contractor must have a timely and organized system(s) for resolving Members’ complaints and formal grievances. The Contractor must inform members through a member handbook about services provided, access to services, charges, and scheduling, and must be in compliance with all State and Federal laws that are required of self-insured plans. The handbook describes the translation services available to non-English speaking Members. Member information must be comprehensible and well-designed as determined by the State.

4. All printed and/or published material addressed to members must be approved by the State in advance of the mailing or publication of such documents.

5. The Contractor shall actively seek and utilize input from consumers as an integral part of its quality management programs. Consumer input must include data obtained from individuals who are either chronically ill or who utilize a substantial amount of services. The Contractor must also obtain input from information available within the plan including, but not limited to, data on the resolution of member inquiries, complaints, grievances and appeals as well as from at least one of the following sources:

   a. Member focus groups;
   b. Member surveys (telephone and/or mail or email), and
   c. open meetings to obtain Member input.
APPENDIX C

DEFINITION OF TERMS

**Bidder** – The entity responding to the request for proposal. The Bidder that is awarded the contract will become the “contractor”.

**Behavioral Health** – Services related to both mental health and substance use disorder.

**Clinical Pathways** – Standardized tools designed for a particular chronic condition or procedure provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

**Collaborative Care Model** – The treatment of common mental health conditions such as depression and anxiety by trained primary care providers and embedded mental health professionals. See https://aims.uw.edu/collaborative-care.

**Comparative effectiveness research (CER)** - Direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms.

**Contractor** – The entity responsible for providing third-party Plan administration services on behalf of the State and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Plan Participants.

**Episode-based Payment** - Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g., hip replacement) or condition (maternity care). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers may assume financial risk for the cost of services for a particular procedure/condition and related services for a specified time period, as well as costs associated with preventable complications.

**Improvement Goals** - The Contractor’s annually defined objectives to improve the value generated to the State and Enrollees, including to satisfy the requirements of the Contract. Such Improvement Goals are based on the State’s and the Contractor’s identification of opportunities for improvement in the Contractor’s management of health services to successfully meet the Value-Based Purchasing Specifications (contained in Appendix B).

**Measure** - The means by which the State determines the Contractor’s compliance with the Purchasing Specifications and achievement of the Contractor’s annual Improvement Goals. A Measure should be defined in quantitative terms whenever possible, with both 6-month and 12-month targets.

**Patient-Centered Medical Home** - The patient-centered medical home (PCMH) is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults. Through the medical home model, practices seek to improve the quality, effectiveness, and efficiency of the care they deliver while responding to each patient’s unique needs and preferences. (source: AAFP)

**Population-based Payment** – A comprehensive payment to a group of providers to account for all or most of the care that will be received by a group of patients for a defined period of time.

**Primary Care Clinician** – A Provider focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a Plan Participant’s diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Contractor.
Value-Based Purchasing Specifications - A detailed description of performance requirements and Measures. The Purchasing Specifications are contained in Appendix B.

Shared Risk - A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care.
INFORMATION BELOW NEEDS TO BE REQUESTED

Please see Appendix J: Data Request form and contact Danielle Bishop at Danielle.Bishop@nh.gov to request this information. Access to this data on the State’s FTP site shall be provided to prospective Bidders who manifest a reasonable likelihood of meeting the minimum qualifications of this RFP. Such likelihood shall be evidenced by the apparent provider network of the prospective Bidder.

PROVIDER UTILIZATION DATA FOR NETWORK MATCH

- Network Match – HMO Tabs with Data.xlsx
  - Network - HMO Inpatient
  - Network - HMO Outpatient
  - Network - HMO Professional
  - Network - HMO Other

- Network Match – POS+PPO Tabs with Data.xlsx
  - Network - POS+PPO Inpatient
  - Network - POS+PPO Outpatient
  - Network - POS+PPO Professional
  - Network - POS+PPO Other

“SITE-OF-SERVICE” IDENTIFICATION – LAB AND OUTPATIENT SURGERY UTILIZATION

- Site-of-Service Identification Tabs with Data.xlsx
  - SOS Lab - Active HMO
  - SOS Outpatient Surgery - Active HMO
  - SOS Lab - Active POS
  - SOS Outpatient Surgery - Active POS

DETAILED CLAIMS EXPERIENCE FOR REPRICING

Repricing - HMO Inpatient.xlsx
Repricing - HMO Outpatient.xlsx
Repricing - HMO Professional.xlsx
Repricing - HMO Other.xlsx
Repricing - PPO_POS Inpatient.xlsx
Repricing - PPO_POS Outpatient.xlsx
Repricing - PPO_POS Professional.xlsx
Repricing - PPO_POS Other.xlsx
APPENDIX E

MONTHLY ENROLLMENT, MONTHLY CLAIMS EXPERIENCE

[See “Monthly Data” Tabs in SONH RFP Attachment.xlsx]

- Monthly enrollment counts from January 2014 to December 2016
- Monthly claims experience from January 2014 to December 2016

INFORMATION BELOW NEEDS TO BE REQUESTED

Please see Appendix J: Data Request form. Contact Danielle Bishop at Danielle.Bishop@nh.gov to request this information. Access to this data on the State’s FTP site shall be provided to prospective Bidders who manifest a reasonable likelihood of meeting the minimum qualifications of this RFP. Such likelihood shall be evidenced by the apparent provider network of the prospective Bidder.

PLAN PARTICIPANT CENSUS

Please contact Danielle Bishop at Danielle.Bishop@nh.gov to request this information.

- SONH Census as of December 2016.xlsx

LARGE CLAIMANT REPORTS

Please contact Danielle Bishop at Danielle.Bishop@nh.gov to request this information.

- SONH Large Claimants 2015 and 2016.xlsx
  - Active Non-Troopers
  - Active Troopers
  - Non-Medicare Retiree

UTILIZATION REPORTS

Please contact Danielle Bishop at Danielle.Bishop@nh.gov to request this information.

- SONH Utilization Report YE 8-2016.xlsx
  - Active (Including Troopers & COBRA)
  - Non-Medicare Retiree
- SONH Vitals-SmartShopper 11-2016 - Actives.pdf
- SONH Vitals-SmartShopper 11-2016 - Non-Medicare Retiree.pdf
APPENDIX F

PLAN DEVIATIONS FORM

This form needs to be completed and returned with your proposal in order to be considered in the carrier selection process.

Active HMO and POS Plan Designs

[ ] This is to certify that the submitted proposal includes no deviations to the Active Plan designs as outlined in “State of NH Active HMO Plan.pdf” and “State of NH Active POS Plan.pdf”.

Non-Medicare Retiree and Medicare Retiree Plan Designs

[ ] This is to certify that the submitted proposal includes no deviations to the Retiree Plan designs as outlined in “State of NH Ret U65 POS Plan.pdf”, “State of NH Ret U65 PPO Plan.pdf”, and the “State of NH Ret 65+ Plan.pdf”.

All Other Requirements outlined in the RFP

Important: Note that any deviations determined to be material may result in the rejection of the bid.

[ ] This is to certify that the submitted proposal adheres to all the requirements outlined in the RFP with the following exceptions:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

[ ] This is to certify that the submitted proposal adheres to all the requirements outlined in the RFP with no deviations.

____________________________________
Signature

____________________________________
Print Name

____________________________________
Title
APPENDIX G
STATE OF NEW HAMPSHIRE REQUEST FOR PROPOSAL TRANSMITTAL LETTER

Date: ___________________     Company Name: ________________________________________
Address:

To: Point of Contact: Danielle Bishop
Telephone: 603-271-3290

RE: Proposal Invitation Name: ADMINISTRATION OF MEDICAL BENEFITS
RFP Number: 2017-192
RFP Posted Date (on or by): March 9, 2017
RFP Opening Date and Time: April 19, 2017 @ 2:00 PM (ET)

[Insert name of signor]_____________________________, on behalf of _____________________________ [insert name of entity submitting RFP(collectively referred to as “Vendor”) hereby submits an offer as contained in the written RFPRFP submitted herewith (“RFP”) to the State of New Hampshire in response to RFP # 2017-192 for Administration of Medical Benefit services at the price(s) quoted herein in complete accordance with the RFP.

Vendor attests to the fact that:

1. The Vendor has reviewed and agreed to be bound by all RFP terms and conditions.
2. The Vendor has not altered any of the language or other provisions contained in the RFP document.
3. The RFP is effective for a minimum period of 6 months from the RFP Opening date as indicated above.
4. The prices Vendor has quoted in the proposal were established without collusion with other vendors.
5. The Vendor has read and fully understands this RFP.

Authorized Signor’s Signature ___________________________   Authorized Signor’s Title ___________________________

NOTARY PUBLIC/JUSTICE OF THE PEACE

COUNTY: ___________________ STATE: ___________ ZIP: _________________

On the _____ day of _______________, 2017, personally appeared before me, the above named ________________________, in his/her capacity as authorized representative of ________________________, known to me or satisfactorily proven, and took oath that the foregoing is true and accurate to the best of his/her knowledge and belief.

In witness thereof, I hereunto set my hand and official seal.

_________________________________________________________
(Notary Public/Justice of the Peace)

My commission expires: ___________________________ (Date)
APPENDIX H

Subject: SAMPLE FORM - TO BE COMPLETED UPON AWARD

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

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

GENERAL PROVISIONS

<table>
<thead>
<tr>
<th>1. IDENTIFICATION.</th>
<th>1.2 State Agency Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 State Agency Name</td>
<td>1.3 Contractor Name</td>
</tr>
<tr>
<td>1.4 Contractor Address</td>
<td></td>
</tr>
<tr>
<td>1.5 Contractor Phone Number</td>
<td>1.6 Account Number</td>
</tr>
<tr>
<td>1.7 Completion Date</td>
<td>1.8 Price Limitation</td>
</tr>
<tr>
<td>1.9 Contracting Officer for State Agency</td>
<td>1.10 State Agency Telephone Number</td>
</tr>
<tr>
<td>1.11 Contractor Signature</td>
<td>1.12 Name and Title of Contractor Signatory</td>
</tr>
<tr>
<td>1.13 Acknowledgement: State of , County of</td>
<td></td>
</tr>
</tbody>
</table>

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

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal]

1.13.2 Name and Title of Notary or Justice of the Peace

1.14 State Agency Signature

Date: 1.15 Name and Title of State Agency Signatory

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

By: Director, On:

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

By: On:

1.18 Approval by the Governor and Executive Council

By: On:
2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT. Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 if the event fund in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unforeseen circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor’s books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State’s representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer’s decision shall be final for the State.

8. EVENT OF DEFAULT REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"): 8.1.1 failure to perform the Services satisfactorily or on schedule; 8.1.2 failure to submit any report required hereunder; and/or 8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA ACCESS/CONFIDENTIALITY/PRESERVATION.

9.1 As used in this Agreement, the word “data” shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report (“Termination Report”) describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. CONTRACTOR’S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers’ compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS. The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, each certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

15. WORKERS’ COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A (“Workers’ Compensation”).

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers’ Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers’ Compensation in the manner described in N.H. RSA chapter 281-A and any
applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers’ Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers’ Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.
APPENDIX I

Note: Below is the State’s current BAA. The State is in the process of updating this BAA. The Selected Bidder will be required to sign the State’s updated BAA when executing the contract.

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates. As defined herein, “Business Associate” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean [name of Business Associate]. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this Agreement shall mean the State of New Hampshire Department of Administrative Services Employee and Retiree Health Benefit Program. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

BUSINESS ASSOCIATE AGREEMENT

1. Definitions
   a. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.
   b. All terms not otherwise defined herein shall have the same meaning as those set forth in the HIPAA Rules.

2. Use and Disclosure of Protected Health Information (PHI)
   a. Business Associate shall not use, disclose, maintain or transmit PHI except as reasonably necessary to provide the services set forth in this Agreement or as required by law.
   b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with Covered Entity’s minimum necessary policies and procedures.
   c. Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity, except for the specific uses and disclosures set forth below.
   d. Business Associate may use protected health information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. To the extent Business Associate discloses PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (a) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (b) an agreement from such third party to notify Business Associate of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
   e. Business Associate may provide data aggregation services relating to the health care operations of Covered Entity.
   f. Business Associate is authorized to use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c). Business Associate shall de-identify the PHI in a manner agreed upon by Business Associate and Covered Entity. Uses and disclosures of the de-identified information shall be limited to those consistent with the provisions of this Agreement.
   g. Business Associate shall not, unless such disclosure is reasonably necessary to provide services outlined in the Agreement, disclose any PHI in response to a request for disclosure on the basis it is required by law without first notifying Covered Entity. In the event Covered Entity objects to the disclosure it shall seek the appropriate relief and the Business Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.
h. Covered Entity may from time to time agree, pursuant to 45 CFR 164.522, to be bound by additional restrictions over and above those uses, disclosures and security safeguards of PHI outlined in the HIPAA Rules. Covered Entity shall notify Business Associate, in writing, of any such agreements. Business Associate agrees to be bound by any such additional restrictions.

3. Obligations and Activities of Business Associate
   a. Business Associate shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement.
   b. Business Associate shall report to the designated Privacy Officer of Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement, including any security incident involving PHI, ePHI, or Unsecured PHI as required by 45 CFR 164.410.
   c. Business Associate shall report a breach or a potential breach to Covered Entity upon discovery of any such incident. Business Associate will handle breach notifications to individuals, the United States Department of Health and Human Services Office for Civil Rights, and, where applicable, the media. Should it be necessary to notify the media of any such breach, Business Associate will ensure that Covered Entity will receive notice of the breach prior to such incident being reported to the media.
   d. Business Associate shall, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure, as evidenced in writing, that any subcontractors that create, receive, maintain or transmit PHI on behalf of Business Associate agree to the same restrictions, conditions and requirements that apply to Business Associate with respect to such information, including the duty to return or destroy PHI. Covered Entity shall be considered a direct third party beneficiary of Business Associate’s corresponding business associate agreements with any of its contracted business associates, who will be receiving PHI pursuant to this Agreement, with rights of enforcement and indemnification from such business associates.
   e. To the extent Business Associate is to carry out one or more of Covered Entity’s obligations under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).
   f. Business Associate shall make available all of its internal practices, policies and procedures, books and records to the Secretary for the purpose of determining Covered Entity’s compliance with the HIPAA Rules.
   g. Within five (5) business days of receiving a written request from Covered Entity, Business Associate shall make available to the Covered Entity during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI for the purpose of enabling Covered Entity to determine Business Associate’s compliance with the terms of the Agreement.

Individual Rights and PHI

h. Access
   i. Business Associate shall respond to an individual’s request for access to his or her PHI as part of Business Associate’s normal customer service function, if the request is communicated to Business Associate directly by the individual or the individual’s personal representative. Business Associate shall respond to the request with regard to PHI that Business Associate and/or its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
   ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity by individuals to invoke a right of access under the HIPAA Privacy Regulation by performing the following functions:
      1. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate shall make available to Covered Entity, or at Covered Entity’s direction to the individual (or the individual’s personal representative),
any PHI about the individual created or received for or from Covered Entity in Business Associate’s custody or control (and/or the custody or control of its subcontractors), for inspection and obtaining copies so that Covered Entity may meet its access obligations under 45 CFR 164.524, and, where applicable, the HITECH Act. Business Associate shall make such information available in an electronic format where required by the HITECH Act.

i. Amendment
   i. Business Associate shall respond to an individual’s request to amend his or her PHI as part of Business Associate’s normal customer service functions, if the request is communicated to Business Associate directly by the individual or the individual’s personal representative. Business Associate shall respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
   ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity to invoke a right to amend under the HIPAA Privacy Regulation by performing the following functions:
       1. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate shall amend any portion of the PHI created or received for or from Covered Entity in Business Associate’s custody or control (and/or the custody or control of its subcontractors), so that Covered Entity may meet its amendment obligations under 45 CFR 164.526.

j. Disclosure Accounting
   i. Business Associate shall respond to an individual’s request for an accounting of disclosures of his or her PHI as part of Business Associate’s normal customer service function, if the request is communicated to the Business Associate directly by the individual or the individual’s personal representative. Business Associate shall respond to a request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
   ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity by individuals or their personal representatives to invoke a right to an accounting of disclosures under the HIPAA Privacy Regulation by performing the following functions so that Covered Entity may meet its disclosure accounting obligation under 45 CFR 164.528:
   iii. Disclosure Tracking
      1. Business Associate shall record each disclosure that Business Associate makes of individuals’ PHI, which is not excepted from disclosure accounting under Section II.C.2.b.
      2. The information about each disclosure that Business Associate must record (“Disclosure Information”) is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512. Disclosure Information also includes any information required to be provided by the HITECH Act.
      3. For repetitive disclosures of individuals’ PHI that Business Associate makes for a single purpose to the same person or entity (including to Covered Entity or Employer), Business Associate may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.
   iv. Exceptions from Disclosure Tracking
1. Business Associate shall not be required to record Disclosure Information or otherwise account for disclosures of individuals’ PHI (a) for Treatment, Payment or Health Care Operations, (except where required by the HITECH Act, as of the effective dates of such requirements) (b) to the individual who is the subject of the PHI, to that Individual’s personal representative, or to another person or entity authorized by the individual (c) to persons involved in that individual’s health care or payment for health care as provided by 45 Code of Federal Regulations § 164.510, (d) for notification for disaster relief purposes as provided by 45 Code of Federal Regulations § 164.510, (e) for national security or intelligence purposes, (f) to law enforcement officials or correctional institutions regarding inmates, (g) that are incident to a use or disclosure that is permitted by this Agreement or the ASO Agreement, (h) as part of a limited data set in accordance with 45 CFR 164.514(e), or (i) that occurred prior to Covered Entity’s compliance date.

v. Disclosure Tracking Time Periods

1. Unless otherwise provided by the HITECH Act and/or any accompanying regulations, Business Associate shall have available for Covered Entity the Disclosure Information required by Section 3.j.iii.2 above for the six (6) years immediately preceding the date of Covered Entity’s request for the Disclosure Information.

vi. Provision of Disclosure Accounting

1. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate will make available to Covered Entity, or at Covered Entity’s direction to the individual (or the individual’s personal representative), the Disclosure Information regarding the Individual, so Covered Entity may meet its disclosure accounting obligations under 45 CFR 164.528 and the HITECH Act.

k. Confidential Communications

i. Business Associate shall respond to an individual’s request for a confidential communication as part of Business Associate’s normal customer service function, if the request is communicated to Business Associate directly by the individual or the individual’s personal representative. Business Associate shall respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation. If an individual’s request, made to Business Associate, extends beyond information held by Business Associate or Business Associate’s subcontractors, Business Associate shall refer individual to Covered Entity. Business Associate assumes no obligation to coordinate any request for a confidential communication of PHI maintained by other business associates of Covered Entity.

ii. In addition, Business Associate shall assist Covered Entity in responding to requests to it by individuals (or their personal representatives) to invoke a right of confidential communication under the HIPAA Privacy Regulation by performing the following functions:

1. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate will begin to send all communications of PHI directed to the individual to the identified alternate address so that Covered Entity may meet its access obligations under 45 CFR 164.524.

l. Restrictions

i. Business Associate shall respond to an individual’s request for a restriction as part of Business Associate’s normal customer service function, if the request is communicated to Business Associate directly by the individual (or the individual’s personal representative). Business Associate shall respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
ii. In addition, Business Associate shall promptly, upon receipt of notice from Covered Entity, restrict the use or disclosure of individuals’ PHI, provided the Business Associate has agreed to such a restriction. Covered Entity agrees that it will not commit Business Associate to any restriction on the use or disclosure of individuals’ PHI for treatment, payment or health care operations without Business Associate’s prior written approval.

4. **Obligations of Covered Entity**
   a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR § 164.520, to the extent that such change or limitation may affect Business Associate’s use or disclosure of PHI.
   b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals to use or disclose his or her PHI to the extent that such changes may affect Business Associate’s use or disclosure of PHI.
   c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.

5. **Term and Termination**
   a. The term of this Agreement shall be effective as of _______________________ and shall terminate __________________  or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.
   b. In addition to provision #10 of the standard contract P-37 of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity’s knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as _______________. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
   c. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained or received by Business Associate on behalf of Covered Entity, shall:
      i. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
      ii. Return to Covered Entity [or, if agreed to by Covered Entity, destroy] the remaining PHI that Business Associate still maintains in any form;
      iii. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
      iv. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in this Agreement which applied prior to termination; and
      v. Return to Covered Entity [or, if agreed to by Covered Entity, destroy] the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.
   d. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

6. **Miscellaneous**
   a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the HIPAA Rules as in effect or as amended.
   b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
   c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.
d. Interpretation. The parties agree that any ambiguity in the Agreement shall be interpreted to permit compliance with the HIPAA Rules.

e. Segregation. If any term or condition of this Attachment _____ or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Attachment _____ are declared severable.

f. Survival. Provisions in this Attachment _____ regarding the use and disclosure of PHI, return or destruction of PHI, the defense and indemnification provisions of provision #13 of the standard contract P-37, shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement.

The State of New Hampshire Employee and Retiree Health Benefit Program

Signature of Authorized Representative

Name of Authorized Representative

Title of Authorized Representative

Date

Contractor

Signature of Authorized Representative

Name of Authorized Representative

Title of Authorized Representative

Date
APPENDIX J

DATA REQUEST FORM

- Data
  - Census data
  - Claims Repricing data
  - Provider Network Match data
  - “Site-of-Service” Identification data
  - Large Claimant Reports
  - Utilization Reports

To obtain the RFP data, please complete this Data Request Form and send to Danielle Ruest at Danielle.Bishop@nh.gov or via fax at 603-271-7564.

Data Request Form

We confirm that we are requesting this information for the sole purpose of responding to the State of New Hampshire’s Administration of Medical Benefits RFP. As a recipient of this information, we will not use or disclose this information for any other purpose than to respond to the State's RFP. We will destroy this information upon the completion of the RFP process.

We confirm that our bid will meet the Minimum Qualifications identified in Section II.C of this RFP document.

We confirm:

- We are requesting this information for the sole purpose of responding to the State’s RFP;
- Our bid will meet the Minimum Qualifications and are prepared to provide documentation supporting this claim, if requested by the State, in order to receive the RFP data file; and
- Our bid will include complete response to all sections of this RFP.

Signed: __________________________________________

Print Name: _________________________________________

Title: ______________________________________________

Phone Number: _____________________________________