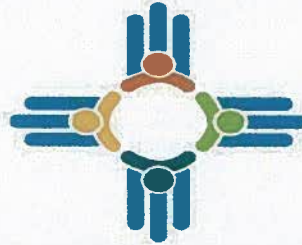


**STATE OF NEW MEXICO**



**HUMAN  
SERVICES**  
D E P A R T M E N T  
MEDICAL ASSISTANCE DIVISION

**Amended and Restated Medicaid Managed Care Agreement**

**among**

**New Mexico Human Services Department,**

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**HCBS Insurance Services Company, operating as**

**Blue Cross and Blue Shield of New Mexico**



**PSC: 13-630-8000-0021-A2**

**STATE OF NEW MEXICO  
HUMAN SERVICES DEPARTMENT  
MEDICAID MANAGED CARE SERVICES AGREEMENT  
FOR CENTENNIAL CARE**

**AMENDMENT NO. [2]**

This Amendment No. 2 to PSC: 13-630-8000-0021 is made and entered into by and between the New Mexico Human Services Department (“HSD”), the New Mexico Behavioral Health Purchasing Collaborative (the “Collaborative”) and HCSC Insurance Services Company, operating as Blue Cross and Blue Shield of New Mexico (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

**WHEREAS**, the Centers for Medicare & Medicaid Services have requested certain revisions to the Contract;

**WHEREAS**, there are certain clarifications and revisions to the Contract that are necessary;

**IT IS MUTUALLY AGREED BY THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE REFERENCED CONTRACT ARE AMENDED AND RESTATED AS FOLLOWS:**

- 1) **Section 2 of the Contract is amended by amending and adding the following definitions:**

**Major Subcontractor** means an entity with which the CONTRACTOR has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the Covered Services; provided that a Major Subcontractor does not include a provider or a Contract Provider.

**Overpayment** means any funds that a person or entity receives in excess of the Medicaid allowable amount of the CONTRACTOR’s allowed amount as negotiated with the provider. Overpayments shall not include funds that have been (i) subject to a payment suspension; (ii) identified as a third-party liability as set forth in Section 4.18.13; (iii) subject to the CONTRACTOR’s system-directed mass adjustments, such as due to fee schedule changes; or (iv) for purposes of filing an “Overpayment Report” as required in Section 4.17.4.2.1, less than fifty dollars (\$50.00) or those funds recoverable through existing routine and customary adjustments using HIPAA complaint formats;

**Psychotropic Drug** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Psychotropic Medication** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Retroactive Period** means the time between the notification date by HSD to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date. The Retroactive Period addresses those instances when the Member is enrolled with the CONTRACTOR but the eligibility date is effective before the CONTRACTOR is notified of enrollment.

**Waste** means the overutilization of services or other practices that result in unnecessary costs.

2) **Section 4.4.2.7 of the Contract is amended and restated to read as follows:**

4.4.2.7 The CONTRACTOR shall make reasonable efforts to contact Members to conduct an HRA and provide information about care coordination. The CONTRACTOR shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member (if a phone number is available). The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about care coordination and how to obtain an HRA. The process outlined in this section shall constitute sufficient effort by the CONTRACTOR to assist a Member.

3) **Section 4.4.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.1 The CONTRACTOR shall perform an in-person comprehensive needs assessment on all Members identified for care coordination level 2 or level 3—at the Member's primary residence. The visit may occur in another location only with HSD approval. For members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

4) **Section 4.5.12.1 of the Contract is amended and restated to read as follows:**

4.5.12.1 The CONTRACTOR shall impose the maximal nominal copayment established by HSD in accordance with federal regulations on any prescription filled for a Member with a brand name drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to brand name drugs that are classified as Psychotropic Drugs for the treatment of Behavioral Health conditions. The CONTRACTOR shall

develop a copayment exception process to be prior approved by HSD for other brand name drugs where such drugs are not tolerated by the Member.

5) **Section 4.8.6.1.4 of the Contract is amended and restated to read as follows:**

4.8.6.1.4 The Member must have fifteen (15) Calendar Days of enrollment to select a PCP. If a Member does not select a PCP within fifteen (15) Calendar Days of enrollment, the CONTRACTOR shall make the assignment and notify the Member in writing of his or her PCP's name, location, and office telephone number, while providing the Member with an opportunity to select a different PCP if the Member is dissatisfied with the assignment; and

6) **Section 4.8.7.4 of the Contract is amended and restated to read as follows:**

4.8.7.4.1 Distance Requirements

4.8.7.4.1 For (i) PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

4.8.7.4.1.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.1.2 Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.

4.8.7.4.1.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.7.4.2 For the providers described in Attachment 8 to the Contract:

4.8.7.4.2.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.2.2 Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

4.8.7.4.2.3 Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of provider is not physically



present in the prescribed radius or unless otherwise exempted as approved by HSD.

7) **Section 4.10.2.10.5 of the Contract is amended and restated to read as follows:**

4.10.2.10.5 The CONTRACTOR shall have an open formulary for all Psychotropic Medications. Open formulary for all Psychotropic Medications means that no prior authorization, fail first, or step therapy requirement shall apply to Psychotropic Medications when the prescriber indicates that a generic or alternative medication does not meet the therapeutic needs of the Member;

8) **Section 4.10.7.5.2 of the Contract is amended and restated to read as follows:**

4.10.7.5.2 The rate to be developed for these projects shall include the following services: (i) initial hospital admission; (ii) any subsequent hospital re-admissions, including emergency room visits, within a thirty (30) Calendar Day period clinically related to the initial discharge; (iii) office visits with the patient's PCMH; (iv) emergency room visits for the same diagnosis; (v) diagnostic tests; (vi) in-home services; and (vii) wellness and community health.

9) **Section 4.12.3.1 of the Contract is amended and restated to read as follows:**

4.12.3.1 HSD shall retain the services of an EQRO in accordance with 42 CFR 438.354. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR's compliance with HSD's managed care regulations and quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

10) **Section 4.12.4.10 of the Contract is amended and restated to read as follows:**

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Long Term Care Services, one (1) on services to children,

and PIPs as required by the Adult Medicaid Quality Grant. PIP work plans and activities must be consistent with PIPs as required by the Adult Medicaid Quality Grant, federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>;

11) **Section 4.17.1.1 of the Contract is amended and restated to read as follows:**

4.17.1.1 The CONTRACTOR, Major Subcontractors and Contract Providers shall have a comprehensive internal Fraud, Waste and Abuse program.

12) **Section 4.17.1.7 of the Contract is amended and restated to read as follows:**

4.17.1.7 The CONTRACTOR, Major Subcontractors and Contract Providers shall comply with all program integrity provisions of the PPACA including:

4.17.1.7.1 Enhanced provider screening and enrollment, section 6401;

4.17.1.7.2 Termination of provider participation, section 6501; and

4.17.1.7.3 Provider disclosure of current or previous affiliation with excluded provider(s), section 6401.

4.17.1.7.4 The requirements set forth in Section 4.17.1.7 shall be included in the CONTRACTOR's contracts with such Major Subcontractors and Contract Providers no later than the time of such contracts' respective renewals.

13) **Section 4.17.1.10 of the Contract is amended and restated to read as follows:**

4.17.1.10 The CONTRACTOR shall make every reasonable effort to detect, recoup and prevent Overpayments made to Contract Providers in accordance with federal and State law and regulations. The CONTRACTOR shall report Claims identified for Overpayment recoupment to HSD at a regularly scheduled interval and in a format agreed to by HSD and the CONTRACTOR and reflected on the CONTRACTOR's Encounter Data. HSD may require an HSD-contracted Recovery Audit Contractor to review paid Claims that are over three hundred sixty (360) Calendar Days old and pursue Overpayments for those Claims that do not indicate recovery amounts in the CONTRACTOR's Encounter Data.

14) **Section 4.17.2.3 of the Contract is amended and restated to read as follows:**

4.17.2.3 The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD as follows within the timeframes required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and/or Abuse in the administration of Centennial Care shall be reported to HSD. It shall be HSD's responsibility to report verified cases to MFEAD;

4.17.2.3.2 All confirmed, credible or suspected provider Fraud, Waste and/or Abuse shall be immediately reported to HSD and shall include the information provided in 42 CFR § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD; and

4.17.2.3.3 All confirmed or suspected Member Fraud, Waste and/or Abuse shall be reported to HSD.

15) **Section 4.17.2.4 of the Contract is amended and restated to read as follows:**

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) make an initial report to HSD of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HSD with monthly updates. HSD may, at its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter timeframe. In addition, unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud, Waste and/or Abuse or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

16) **Section 4.17.2.5 of the Contract is amended and restated to read as follows:**

4.17.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency for matters where the CONTRACTOR has determined that only an Overpayment exists.

17) **Section 4.17.3.2.3 of the Contract is amended and restated to read as follows:**

4.17.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and State statutes and regulations related to Medicaid program integrity and Fraud/Abuse/Waste and on identifying and educating targeted Contract Providers with patterns of incorrect billing practices and/or Overpayments;

18) **Section 4.17.4 of the Contract is amended and restated to read as follows:**

4.17.4 Recoveries of Overpayments and/or Fraud

4.17.4.1 Identification Process for Overpayments

4.17.4.1.1 The CONTRACTOR shall report to HSD all instances where the CONTRACTOR has notified a provider of a potential Overpayment, including the date of such notification, the stated reasons and the potential Overpayment amount. HSD may, at its sole discretion, require monthly updates as to the status of any reported potential Overpayment.

4.17.4.1.2 Providers are required to report identified Overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an Overpayment if the provider has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference that an Overpayment exists.

4.17.4.2 Self-Reporting

4.17.4.2.1 For all identified Overpayments and within the timeframes specified in 4.17.4.1.1, the provider shall send an "Overpayment Report" to the CONTRACTOR and HSD which shall include, at a minimum, (i) provider's name; (ii) provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid claim control number, as appropriate; (viii) description of a corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the Overpayment; (xi) if a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to

determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

#### 4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for Overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an Overpayment existed; or

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund, such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

#### 4.17.4.4 Failure To Self-Report And/Or Refund Overpayments

4.17.4.4.1 The CONTRACTOR shall inform all providers that all Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day timeframe may be considered false claims and may be subject to referrals as credible allegations of fraud and subject to Section 4.17.2.3.1 of this Contract.

19) **Section 4.18.1 of the Contract is amended and restated to read as follows:**

4.18.1 The CONTRACTOR shall at all times be in compliance with the net worth requirements under applicable insurance laws.

20) **Section 4.18.2.1 of the Contract is amended and restated to read as follows:**



- 4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in State of New Mexico in accordance with section 1903(m)(1) of the Social Security Act (amended by section 4706 of the Balanced Budget Act of 1997), and applicable state insurance laws. The CONTRACTOR shall deposit, in the form of cash or securities or investments consistent with applicable state insurance laws, an amount equal to ninety percent (90%) of the total capitation payment paid to the CONTRACTOR in the first month of the Contract Year as determined by HSD. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.
- 4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR's Centennial Care program.
  - 4.18.2.1.2. The CONTRACTOR must satisfy this requirement no later than sixty (60) Calendar Days after notification by HSD of the deposit amount required.
  - 4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.
  - 4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.
  - 4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.
  - 4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.
    - 4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to withdrawal of funds from this account as outlined in Section 4.18.2.1.6.

4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The CONTRACTOR shall deposit the assets with any organization or trustee acceptable through which a custodial or controlled account is utilized.

21) **Section 4.18.2.2 of the Contract is amended and restated to read as follows:**

4.18.2.2 In the event that a determination is made by HSD that the CONTRACTOR is insolvent under applicable state insurance law, HSD may draw upon the amount. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

22) **Section 4.18.2.4 of the Contract is amended and restated to read as follows:**

4.18.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, overpayments made to the CONTRACTOR, and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to health care providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other claims subject to applicable state insurance law.

23) **Section 4.18.2.5 of the Contract is amended and restated to read as follows:**

4.18.2.5 HSD shall adjust this reserve requirement quarterly, as needed. The reserve account may be accessed solely for payment for Covered Services to the CONTRACTOR's Members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with applicable state insurance regulations and guidelines.

24) **Section 4.18.4 of the Contract is amended and restated to read as follows:**

4.18.4 Surplus Requirement

The CONTRACTOR shall maintain at all times in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the CONTRACTOR's domiciliary state regulator, and restricted funds of deposits controlled by HSD (including the CONTRACTOR's insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars (\$1,500,000), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the CONTRACTOR's prepaid revenues. In the event that the CONTRACTOR's surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

25) **Section 4.18.7.1 of the Contract is amended and restated as follows:**

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond in the amount of at least one million dollars (\$1,000,000).

26) **Section 4.18.10.1.1 of the Contract is amended and restated as follows:**

4.18.10.1.1 Comply with and be subject to all applicable state and federal statutes and regulations including those regarding solvency and risk standards. In addition, the CONTRACTOR shall meet specific Medicaid financial requirements and to present to HSD any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time from the date of the request or as specified herein.

27) **Section 4.18.11.1.1 of the Contract is amended and restated to read as follows:**

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1.1 through 4.18.11.1.1.5 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1.1 Cash Deposits;

4.18.11.1.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit

Insurance Corporation (FDIC) or equivalent federally insured deposit;

4.18.11.1.1.3 Surety Bond issued by a surety or insurance company licensed to do business in New Mexico;

4.18.11.1.1.4 Certificate of Deposit; and

4.18.11.1.1.5 Investment account with financial institute licensed to do business in the State of New Mexico.

28) **Section 4.18.11.4 of the Contract is amended and restated to read as follows:**

4.18.11.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in a material default of or failing to materially perform the activities outlined in this Agreement or if HSD determines the CONTRACTOR insolvent as outlined under the applicable state insurance law.

29) **Section 4.18.11.6 of the Contract is amended and restated to read as follows:**

4.18.11.6 The CONTRACTOR shall purchase the performance bond within forty five (45) Calendar Days of receipt of the first month of capitation from HSD.

30) **Section 4.18.11.10 of the Contract is amended and restated to read as follows:**

4.18.11.10 The CONTRACTOR shall hold the performance bond with any organization or trustee acceptable through which a custodial or controlled account is utilized.

31) **Section 4.18.12.3 of the Contract is amended and restated to read as follows:**

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the applicable state insurance regulator for approval. The CONTRACTOR

must submit the pricing details of the reinsurance agreement including the covered period to HSD for approval.

32) **Section 4.18.13.1.4.4 of the Contract is amended and restated to read as follows:**

4.18.13.1.4.4 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR's provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the claim; and may permit payments to be made in accordance with state regulations;

33) **Section 4.18.13.10 of the Contract is amended and restated to read as follows:**

4.18.13.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.18.13, third-party resources shall not include subrogation resources; provided, however, the CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the Claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for purposes of reporting.

34) **Section 4.18.16.2 of the Contract is amended and restated to read as follows:**

4.18.16.2 The CONTRACTOR shall submit third party liability recoveries including Medicare payment information on a date of services basis in accordance with Section 4.21.12.1 of this Agreement.

35) **Section 4.21.1.6 of the Contract is amended and restated to read as follows:**

4.21.1.6 HSD's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the Agreement. A list of required reports is provided in Attachment 4.

4.21.1.6.1 The CONTRACTOR shall comply with all changes specified in writing by HSD, after HSD has discussed such changes with the CONTRACTOR.



HSD shall notify the CONTRACTOR, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. The CONTRACTOR shall be held harmless on the first submission of the revised report if HSD fails to meet this requirement for any changes for existing reports. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report revised by HSD to include a change in data requirements or definition will not be subject to penalty for accuracy.

4.21.1.6.2 HSD shall notify the CONTRACTOR, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.

36) **Section 6 of the Contract is amended to add the following new section 6.12 to read as follows:**

6.12 Retroactive Period Reconciliation

6.12.1 The CONTRACTOR is required to reimburse providers for the medical expenses incurred by the Member in the Retroactive Period. The duration and expenditures associated with the Retroactive Period may fluctuate for each Member and are not considered in the prospective capitation payment rate development.

6.12.2 HSD shall reconcile the difference between the medical expenses incurred by the CONTRACTOR during the Retroactive Period and the payment made by HSD to the CONTRACTOR for the Retroactive Period that may occur due to the enrollment process outlined in Section 4.2.8.2.

6.12.3 The reconciliation process for the Retroactive Period is outlined in Attachment 9.

37) **Section 7.2.9 of the Contract is amended and restated to read as follows:**

7.2.9 Care Coordination Expenses

7.2.9.1 The CONTRACTOR shall provide care coordination services in accordance with Section 4.4 of this Agreement.

7.2.9.2 For purposes of this Agreement, the following care coordination functions will be deemed medical services:

7.2.9.2.1 Comprehensive needs assessment;

7.2.9.2.2 Face-to-face meetings between the care coordinator and the Member;

- 7.2.9.2.3 Telephonic meetings between the care coordinator and the Member;
- 7.2.9.2.4 Case management;
- 7.2.9.2.5 Discharge consultation;
- 7.2.9.2.6 CCP development and updates;
- 7.2.9.2.7 Health education provided to the Member;
- 7.2.9.2.8 Disease management provided to the Member; and
- 7.2.9.2.9 Costs associated with Community Health Workers.

7.2.9.3 The CONTRACTOR shall submit Member care coordination activities through Encounter Data.

7.2.9.4 For purposes of this Agreement, the following care coordination functions will be deemed administrative services:

- 7.2.9.4.1 Health risk assessments (HRAs);
- 7.2.9.4.2 Data runs;
- 7.2.9.4.3 Referrals; and
- 7.2.9.4.4 Case assignment and scheduling.

38) **Section 7.3 of the Contract is amended and restated to read as follows:**

**7.3 Failure to Meet Agreement Requirements**

**7.3.1 General**

7.3.1.1 In the event that the CONTRACTOR or any person with an ownership interest in the CONTRACTOR, affiliate, parent or subcontractor, fails to comply with this Agreement, HSD may impose, at HSD's discretion sanctions (inclusive of the specific monetary penalties and other penalties described in this Section 7.3.

7.3.1.2 Sanctions paid by the CONTRACTOR pursuant to this Section 7.3 shall be included as administrative expenses subject to Section 7.2.8 of this Agreement.

7.3.1.3 HSD retains the right to apply progressively strict sanctions CONTRACTOR against the CONTRACTOR, for failure to perform in any of the Agreement areas.

- 7.3.1.4 Any sanction, including the withholding of capitation payments, does not constitute just cause for the CONTRACTOR to interrupt providing Covered Services to Members.
- 7.3.1.5 HSD may impose any other administrative, contractual or legal remedies available under federal or State law for the CONTRACTOR's noncompliance under this Agreement.
- 7.3.1.6 HSD will give the Collaborative written notice whenever it imposes or lifts a sanction for one of the violations listed herein that relates to Behavioral Health.
- 7.3.1.7 HSD will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed herein. The notice will be given no later than thirty (30) Calendar Days after HSD imposes or lifts a sanction and must specify the affected CONTRACTOR, the kind of sanction and the reason for HSD's decision to impose or lift the sanction.

### 7.3.2 Corrective Action Plans

- 7.3.2.1 If HSD determines that the CONTRACTOR is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that sanctions are also necessary.
- 7.3.2.2 The CONTRACTOR may dispute a notice of noncompliance in accordance with Section 7.11 of this Agreement.
- 7.3.2.3 The CONTRACTOR shall be required to provide CAPs to HSD within fourteen (14) Calendar Days of receipt of a noncompliance notice from HSD. CAPs are subject to review and approval by HSD.
- 7.3.2.4 If HSD imposes a DCAP on the CONTRACTOR, the CONTRACTOR will have fourteen (14) Calendar Days to respond to HSD.
- 7.3.2.5 If the CONTRACTOR does not effectively implement the CAP/DCAP within the timeframe specified in the CAP/DCAP, HSD may impose additional sanctions.
- 7.3.2.6 If HSD staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party either designated by HSD or approved by HSD to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

### 7.3.3 Sanctions

7.3.3.1 HSD may impose any or all of the non-monetary sanctions and monetary penalties as described in this Section to the extent authorized by federal and State law.

7.3.3.2 Non-monetary intermediate sanctions may include:

7.3.3.2.1 Suspension of auto-assignment of Members who have not selected an MCO;

7.3.3.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

7.3.3.2.3 Notification to Members of their right to terminate enrollment with the CONTRACTOR's MCO without cause as described in 42 C.F.R. § 438.702(a)(3);

7.3.3.2.4 Disenrollment of Members by HSD;

7.3.3.2.5 Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

7.3.3.2.6 Rescission of Marketing consent and suspension of the CONTRACTOR's Marketing efforts;

7.3.3.2.7 Appointment of temporary management or any portion thereof for an MCO as provided in 42 C.F.R. § 438.706 and the CONTRACTOR shall pay for any costs associated with the imposition of temporary management; and

7.3.3.2.8 Additional sanctions permitted under federal or State statute or regulations that address areas of noncompliance.

7.3.3.3 Monetary penalties may include:

7.3.3.3.1 Actual damages incurred by HSD and/or Members resulting from the CONTRACTOR's non-performance of obligations under this Agreement;

7.3.3.3.2 Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the CONTRACTOR's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the CONTRACTOR and the rates paid to the replacement health plan. HSD may withhold payment to the CONTRACTOR for damages until such damages are paid in full;

7.3.3.3.3 Civil monetary penalties as described in 42 C.F.R. § 438.704;

7.3.3.3.4 Monetary penalties up to five percent (5%) of the CONTRACTOR's Medicaid capitation payment for each month in which the penalty is assessed;

7.3.3.3.5 Other monetary penalties for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below.

7.3.3.4 HSD reserves the right to assess a general monetary penalty of five hundred dollars (\$500) per occurrence with any notice of deficiency.

7.3.4 Other Monetary Penalties

	<b>PROGRAM ISSUES</b>	<b>PENALTY</b>
<b>1.</b>	Failure to comply with Claims processing as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement
<b>2.</b>	Failure to comply with Encounter submission as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement.
<b>3.</b>	Failure to comply with the timeframes for a comprehensive care assessment and developing and approving a CCP for care coordination level 2 and level 3	<p>\$10,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 75-94% of members for the reporting period.</p> <p>\$25,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% of less of Members for the reporting period.</p>



4.	Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
5.	Failure to obtain approval of Member Materials as required by Section 4.14.1 of this Agreement	\$5,000 per day for each Calendar Day that HSD determines the CONTRACTOR has provided Member Material that has not been approved by HSD. The \$5,000 per day damage amounts will double every ten (10) days.
6.	Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of this Agreement	<p>\$10,000 per occurrence where the CONTRACTOR fails to comply with the timeframes but is in compliance with the timeframes for 75-94% of Grievances and Appeals for the reporting period.</p> <p>\$25,000 per occurrence where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% or less of Grievances and Appeals for the reporting period.</p>
7.	Failure to submit timely reports in accordance with Section 4.21 of this Agreement	\$1,000 per report, per Calendar Day. The \$1,000 per day damage amounts will double every ten (10) Calendar days.
8.	Failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with Section 4.21 of this Agreement	\$5,000 per report, per occurrence.
9.	Failure to submit timely Summary of Evidence in accordance with Section 4.16 of this Agreement	\$1,000 per occurrence.
10.	Failure to have legal counsel	\$10,000 per occurrence.

	appear in accordance with Section 4.16 of this Agreement	
<b>11.</b>	Failure to meet HEDIS targets for the performance measures described in Section 4.12.8 of this Agreement	A monetary penalty based on 2% of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year.

\*HSD can modify any monetary penalty if the CONTRACTOR engages in a pattern of behavior which constitutes a violation of this Agreement and involves a significant risk of harm to Members or to the integrity of Centennial Care.

**7.3.5 Payment of Monetary Penalties**

7.3.5.1 HSD shall provide the CONTRACTOR with notice of any monetary penalties assessed at least thirty (30) Calendar Days before deducting such amounts from the monthly capitation payment. The collection of monetary penalties by HSD shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by HSD will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the monetary penalties described in this Section.

7.3.5.2 Monetary penalties as described in Section 7.3.5 of this Agreement shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

**7.3.6 Waiver of Sanctions**

HSD may waive the application of sanctions (including monetary penalties) at its discretion if HSD determines that such waiver is in the best interests of the Centennial Care program and its Members.

**7.3.7 Federal Sanctions**

Payments provided for under this Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

39) **Section 7.27.11 of the Contract is amended and restated to read as follows:**

7.27.11 Referrals for Credible Allegations of Fraud

7.27.11.1 The CONTRACTOR shall report to HSD suspected cases of Fraud whenever there are credible allegations of Fraud. The CONTRACTOR shall follow HSD's direction in identifying and reporting cases of credible allegations of Fraud. HSD shall make the final determination of whether to refer such cases to MFEAD, and other law enforcement agencies, for further investigation. HSD's directions to the CONTRACTOR may include, but is not limited to:

7.27.11.1.1 At HSD's direction, the CONTRACTOR shall suspend all Medicaid payments, in whole or in part as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD's notice, the CONTRACTOR (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pending Claims, or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD's notice.

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law.

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD.

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider;

7.27.11.1.4.2 The dismissal of all charges and/or claims against the provider related to the provider's alleged fraud by a court of competent jurisdiction; or

7.27.11.1.4.3 For other good cause as determined solely by HSD.

7.27.11.1.5 HSD shall document in writing the termination of a payment suspension and shall provide such documentation to the CONTRACTOR.

7.27.11.2 Should HSD require the CONTRACTOR's assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review, and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

40) **Section 7.46.2 of the Contract is amended and restated as follows:**

7.46.2 All notices required to be given to the State under this Agreement shall be sent to the following, or his or her designee:

Julie Weinberg, Director  
Medical Assistance Division  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348

Or

Christopher Collins, General Counsel  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, NM 87504-2348

41) **Attachment 6 to the Contract is amended and restated to read as follows:**

**Attachment 6: Alternative Benefit Plan Covered Services**

<b>Alternative Benefit Plan Services Included Under Centennial Care</b>
Allergy testing and injections
Annual physical exam and consultation
Assertive Community Treatment (ACT)
Autism spectrum disorder <sup>1</sup>
Bariatric surgery <sup>2</sup>
Behavioral health professional services: outpatient behavioral health <sup>3</sup> and substance abuse services <sup>4</sup>
Cancer clinical trials <sup>5</sup>
Cardiovascular rehabilitation <sup>6</sup>
Chemotherapy and radiation therapy
Dental services <sup>7</sup>
Diabetes treatment, including diabetic shoes and related medical supplies
Dialysis
Disease management
Durable medical equipment
Educational materials and counseling for a healthy lifestyle
Electroconvulsive Therapy (ECT)
Emergency services (including emergency room visits and psychiatric ER)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals age 19 and 20
Eye exams and treatment related to treatment and testing of eye diseases only <sup>8</sup>
Family planning, sterilization, pregnancy termination, contraceptives <sup>9</sup>
Glasses and contact lenses: covered only for aphakia (following removal of the lens) <sup>10</sup>
Hearing testing or screening as part of a routine health exam <sup>11</sup>

<sup>1</sup> Covers speech, occupational and physical therapy, and applied behavioral analysis for Members age 19-20; and Members age 21-22 who are enrolled in high school.

<sup>2</sup> Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

<sup>3</sup> Includes evaluation, testing, assessment, medication management, therapy and Intensive Outpatient Program (IOP) services.

<sup>4</sup> Includes outpatient detoxification, therapy, partial hospitalization and IOP services.

<sup>5</sup> Covers routine patient costs associated with Phase I, II, III and IV cancer clinical trials.

<sup>6</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per cardiac event. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>7</sup> ABP dental services are equivalent to the adult dental benefit package for traditional Medicaid categories.

Increased periodicity schedule and medically necessary orthodontia covered for Members age 19-20.

<sup>8</sup> Refraction is not covered. Routine vision care is not covered.

<sup>9</sup> Sterilization reversal is not covered.

<sup>10</sup> Coverage of materials is limited to \$300 per surgery. Contact lenses or eyeglasses obtained more than 90 days following surgery are not covered.

<sup>11</sup> Hearing aids not covered. Hearing testing by an audiologist or hearing aid dealer is not covered.



Home health services <sup>12</sup>
Hospice services, including hospice at home or in a nursing facility
Hospital inpatient <sup>13</sup>
Hospital outpatient
Immunizations
Inhalation therapy
Inpatient rehabilitation <sup>14</sup>
IV infusions
Laboratory genetic testing to specific molecular lab tests such as BRCA1 and BRCA2 and similar tests used to determine appropriate treatment <sup>15</sup>
Laboratory services, including diagnostic testing and other age appropriate tests
Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests
Medical supplies: diabetic and contraceptive supplies only <sup>16</sup>
Medication assisted therapy for opioid dependence
Nutritional counseling
Obstetric/gynecological care, prenatal care, deliveries, midwives
Orthotics <sup>17</sup>
Physician visits
Podiatry services <sup>18</sup>
Prescription drug items <sup>19</sup>
Preventive care <sup>20</sup>
Primary care to treat illness/injury
Prosthetics
Psychosocial Rehabilitation (PSR)

<sup>12</sup> Limited to 100 visits per year. A visit cannot exceed four hours.

<sup>13</sup> Free-standing psychiatric hospitals are only covered for Members age 19-20 and are not a covered service for ABP or ABP-exempt, except for Members under age 21 except as an "in lieu of service." Psychiatric units within an acute care hospital are covered under the ABP. Inpatient drug rehabilitation services are not covered. Acute inpatient services for detoxification are covered.

<sup>14</sup> Covers inpatient services at a skilled nursing or acute rehabilitation facility when provided as a step-down level of care following discharge from the hospital prior to discharge to home. Extended care or long-term care hospitals are not covered.

<sup>15</sup> Not including random genetic screening.

<sup>16</sup> Medical supplies used on an inpatient basis, applied as part of treatment in a practitioner's office, outpatient hospital, residential facility, or home health service, are covered when separate payment is allowed in these settings.

<sup>17</sup> Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace or diabetic shoes.

<sup>18</sup> Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

<sup>19</sup> Over-the-counter drug items are not covered, except for prenatal drug items, low-dose aspirin as preventive for cardiac conditions, contraceptive drugs and devices, and items for treating diabetes. The contractor may choose to cover any over-the-counter product when it is less expensive than the therapeutically equivalent drug that would require a prescription (a 'legend' drug).

<sup>20</sup> ABP preventive services include the A&B recommendations of the United States Preventive Services Task Force (USPSTF)

Pulmonary rehabilitation <sup>21</sup>
Radiology, including diagnostic imaging and radiation therapy, mammography and other age appropriate imaging
Reconstructive surgery <sup>22</sup>
Rehabilitation and habilitation: physical therapy, occupational therapy and speech and language pathology <sup>23</sup>
Rehabilitation inpatient hospitalization: step-down lower level of care from an acute care hospital for not more than 14 days
Reproductive health services (not including fertility treatment)
Skilled nursing
Specialist visits
Telemedicine
Tobacco cessation counseling
Transplant services <sup>24</sup>
Transportation services (emergency and non-emergency medical), including air and ground ambulance, taxi and handivan <sup>25</sup>
Urgent care services

42) **Attachment 8 is added to the Contract to read as follows:**

**Attachment 8: Providers with Distance Requirements**

**A. Behavioral Health**

1. Freestanding Psychiatric Hospitals
2. General Hospitals with psychiatric units
3. Partial Hospital Programs
4. Accredited Residential Treatment Centers (ARTC)
5. Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)

<sup>21</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered..

<sup>22</sup> Covers reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders that result from accidental injury, congenital defects or disease.

<sup>23</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>24</sup> Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants. Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs. Limited to two organ/tissue transplants per lifetime. Outpatient immunosuppressive drugs do not apply toward the transplant benefit limit.

<sup>25</sup> Covers expenses for transportation, meals and lodging that are determined necessary to secure medical or Behavioral Health services for an ABP Member.

6. Treatment Foster Care I & II (TFC I & II)
7. Core Service Agencies (CSA)
8. Community Mental Health Centers (CMHC)
9. Indian Health Service and Tribal 638s providing Behavioral Health services
10. Outpatient Provider Agencies
11. Agencies providing Behavioral Management Services (BMS)
12. Agencies providing Day Treatment Services
13. Agencies providing Assertive Community Treatment (ACT)
14. Agencies providing Multi-Systematic Therapy (MST)
15. Agencies providing intensive Outpatient Services
16. Methadone Clinics
17. FQHCs providing Behavioral Health services
18. Rural Health Clinics providing Behavioral Health services
19. Psychiatrists
20. Psychologists (including prescribing psychologists)
21. Suboxone certified MDs
22. All other licensed Independent Behavioral Health practitioners (LISW, LPCC, LMFT, CNS & CNP with psychiatric certification, independent practices or groups)

## **B. Physical Health**

1. Cardiology
2. Certified Nurse Practitioner
3. Certified Midwives
4. Dermatology
5. Dental
6. Endocrinology
7. ENT
8. FQHC
9. RHC
10. Hem/Oncology
11. IT/U
12. Neurology
13. Neurosurgeon
14. OB-GYN
15. Orthopedics
16. Pediatrics
17. Physician Assistant
18. Podiatry
19. Rheumatology
20. Surgeons
21. Urology

## **C. Long Term Care**

1. Assisted Living Facilities

2. Personal Care Service Agencies (PCS) – delegated
3. Personal Care Service Agencies (PCS) – directed
4. Nursing Facilities

**D. Hospitals**

1. General Hospitals
2. Inpatient Psychiatric Hospitals

**E. Transportation**

- 43) **Attachment 9 is added to the Contract to read as follows:**

**Attachment 9: Retroactive Period Reconciliation**

1. HSD shall reconcile the medical expenditures related to the Retroactive Period for each Contract year period (January 1 to December 31 of each Contract year). The Retroactive Period may exist for some Members whose effective date of Medicaid eligibility is determined prior to HSDs notification date to the CONTRACTOR outlined in Section 4.2.8.
2. The reconciliation for the Retroactive Period is limited to the medical expenses only.
3. For purposes of this Attachment, “medical expense” is defined as the expenditures for Covered Services in Attachment 2. Value added services and administrative expenditures will not be countable expenses in the calculation of the reconciliation.
4. HSD will permit the CONTRACTOR to retain 5.263 percent of the total medical expense for administrative costs.
5. HSD shall adjust the final reconciliation for applicable premium tax depending on the outcome of the reconciliation.
6. HSD will utilize encounter data received and accepted by HSD as the source for the measurement of the reconciliation on a cohort basis limited to Members who are in the Retroactive Period and eligible according to HSD’s eligibility system in the month they incurred medical expenses.
7. HSD shall conduct the final reconciliation for the contract year period no sooner than eight (8) months after the end of the calendar year or contract period.
  - a. During the calendar year or contract period, HSD at its discretion, may perform interim reconciliations and may recoup from or make payment to the CONTRACTOR. HSD shall determine the pro-rated percentage to recoup or pay.

- b. Interim recoupment or payment will be factored into the final reconciliation.
- 8. Actual medical cost plus the administrative allowance and premium tax will be compared to the payment made by HSD to the CONTRACTOR for the Retroactive Period to determine the value of recoupment from or payment to the CONTRACTOR.
- 9. HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.
- 44) **Attachment 10 is added to the Contract to read as follows:**

**Attachment 10: List of Psychotropic Drugs and Medications**



**GENERAL DESCRIPTION**      **THERAPEUTIC CLASS**  
(MCOs must use their **PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY**  
comparable therapeutic classes)  
(brand names begin with a capital letter)

**Anti-Anxiety Medications and Antidepressants (non-benzodiazepines)** H2F, H2G, H2J, H2S, H2U, H7B, H7C, H7D, H7E, H7F, H2O, H7P, H7R, H7S, H7T, H7U, H7X, H7O, H7Z

Abilify	desvenlafaxine	Latuda	Pamelor	Symbyax
amitriptyline	Desyrel	Lexapro	paroxetine	thiothixene
amoxapine	doxepin	loxapine	Paxil	Tofranil
Anafranil	duloxetine	Loxitane	Pexeva	trazodone
Aripiprazole	Effexor	Ludiomil	pimozide	trimipramine
Asendin	Elavil	lurasidone	Pristiq	venlafaxine
Aventyl	escitalopram	Luvox	protriptyline	Vivactil
bupropion	Fanapt	maprotiline	Prozac	Wellbutrin
BuSpar	fluoxetine	mirtazapine	quetiapine	ziprasidone
buspirone	fluoxetine & olanzapine	Moban	Remeron	Zoloft
Celexa (SSRI)	fluvoxamine	molindone	resperidone	Zyprexa

citalopram	Geodon	Navane	Risperdal
clomipramine	Haldol	Norpramin	Sarafem
clozapine	Haloperidol	nortriptyline	Seroquel
Clozaril	iloperidone	olanzapione	sertraline
Cymbalta	imipramine	Orap	Sinequan
desipramine	Invega	Paliperidone	Surmontil

**Anti-Mania Medications H2M  
(Mood Stabilizers)**

Eskalith	lithium carbonate	lithium citrate	Lithobid
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**Mood Stabilizing H4B  
Anticonvulsants**

clonazepam	divalproex sodium	lomotrigine	oxcarbazepine	topiramate
carbamazepine	Klonopin	gabapentin	Tegretol	Trileptal
Depakote	Lamictal	Neurontin	Topamax	valproic acid

**Monoamine Oxidase Inhibitors  
H2H, H2J, H7J**

Emsam	Marplan	Parnate	selegiline
isocarboxazid	Nardil	phenelzine	tranylcypromine

**Phenothiazines and other H2G  
major tranquilizers and  
antipsychotics**


chlorpromazine	perphenazine	thioridazine	trifluoperazine
fluphenazine	Stelazine	Thorazine	Trilafon

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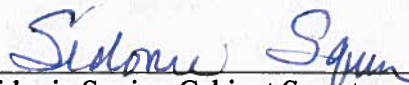
**All other sections of PSC [13-630-8000-0021], as amended, remain the same.**

IN WITNESS WHEREOF, the parties have executed this amended and restated contract as of the date of signature by the Human Services Department.

**CONTRACTOR**

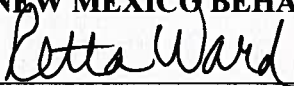
By:  Date: 6/25/14  
Title: Kurt Shipley, Senior Vice President, New Mexico Government Contracts  
HCSC Insurance Services Company, operating as Blue Cross Blue Shield of New Mexico  
5701 Balloon Fiesta Parkway NE  
Albuquerque, NM 87113

**STATE OF NEW MEXICO**

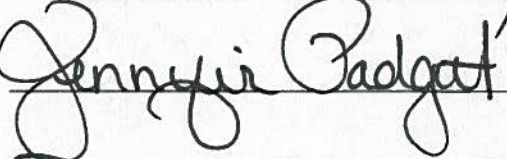
By:  Date: 10/9/14  
Sidonie Squier, Cabinet Secretary  
Human Services Department

By:  Date: 10/16/14  
Danny Sandoval, CFO  
Human Services Department


**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

By:  Date: 10/7/14

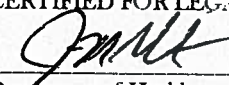
Title: Cabinet Secretary

By: 

Title: Deputy Cabinet Secretary, CYFD


By:  Date: 10/23/14

Title: Secy, HSD

CERTIFIED FOR LEGAL SUFFICIENCY:  
 10/7/14  
Department of Health  
Assistant General Counsel

Date: 10-20-14

**Approved as to Form and Legal Sufficiency:**

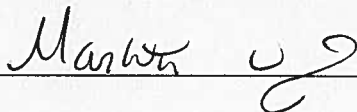
By:   
\_\_\_\_\_  
Christopher P. Collins, Chief Legal Counsel  
Human Services Department

Date: 9/30/14

The records of the Taxation and Revenue Department reflect that the CONTRACTOR is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

**TAXATION AND REVENUE DEPARTMENT**

**ID Number: 02-445429-000**

By:   
\_\_\_\_\_

Date: 10/28/14

Title: \_\_\_\_\_



**STATE OF NEW MEXICO**



**HUMAN  
SERVICES**  
DEPARTMENT  
MEDICAL ASSISTANCE DIVISION

**Amended and Restated Medicaid Managed Care Agreement**

**among**

**New Mexico Human Services Department,**

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**United Healthcare of New Mexico, Inc.**



**PSC: 13-630-8000-0024-A2**

**STATE OF NEW MEXICO  
HUMAN SERVICES DEPARTMENT  
MEDICAID MANAGED CARE SERVICES AGREEMENT  
FOR CENTENNIAL CARE**

**AMENDMENT NO. [2]**

This Amendment No. 2 to PSC: 13-630-8000-0024 is made and entered into by and between the New Mexico Human Services Department (“HSD”), the New Mexico Behavioral Health Purchasing Collaborative (the “Collaborative”) and UnitedHealthcare of New Mexico, Inc. (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

**WHEREAS**, the Centers for Medicare & Medicaid Services have requested certain revisions to the Contract;

**WHEREAS**, there are certain clarifications and revisions to the Contract that are necessary;

**IT IS MUTUALLY AGREED BY THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE REFERENCED CONTRACT ARE AMENDED AND RESTATED AS FOLLOWS:**

- 1) **Section 2 of the Contract is amended by amending and adding the following definitions:**

**Major Subcontractor** means an entity with which the CONTRACTOR has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the Covered Services; provided that a Major Subcontractor does not include a provider or a Contract Provider.

**Overpayment** means any funds that a person or entity receives in excess of the Medicaid allowable amount of the CONTRACTOR’s allowed amount as negotiated with the provider. Overpayments shall not include funds that have been (i) subject to a payment suspension; (ii) identified as a third-party liability as set forth in Section 4.18.13; (iii) subject to the CONTRACTOR’s system-directed mass adjustments, such as due to fee schedule changes; or (iv) for purposes of filing an “Overpayment Report” as required in Section 4.17.4.2.1, less than fifty dollars (\$50.00) or those funds recoverable through existing routine and customary adjustments using HIPAA complaint formats;

**Psychotropic Drug** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Psychotropic Medication** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Retroactive Period** means the time between the notification date by HSD to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date. The Retroactive Period addresses those instances when the Member is enrolled with the CONTRACTOR but the eligibility date is effective before the CONTRACTOR is notified of enrollment.

**Waste** means the overutilization of services or other practices that result in unnecessary costs.

2) **Section 4.4.2.7 of the Contract is amended and restated to read as follows:**

4.4.2.7 The CONTRACTOR shall make reasonable efforts to contact Members to conduct an HRA and provide information about care coordination. The CONTRACTOR shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member (if a phone number is available). The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about care coordination and how to obtain an HRA. The process outlined in this section shall constitute sufficient effort by the CONTRACTOR to assist a Member.

3) **Section 4.4.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.1 The CONTRACTOR shall perform an in-person comprehensive needs assessment on all Members identified for care coordination level 2 or level 3—at the Member's primary residence. The visit may occur in another location only with HSD approval. For members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

4) **Section 4.5.12.1 of the Contract is amended and restated to read as follows:**

4.5.12.1 The CONTRACTOR shall impose the maximal nominal copayment established by HSD in accordance with federal regulations on any prescription filled for a Member with a brand name drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to brand name drugs that are classified as Psychotropic Drugs for the treatment of Behavioral Health conditions. The CONTRACTOR shall

develop a copayment exception process to be prior approved by HSD for other brand name drugs where such drugs are not tolerated by the Member.

5) **Section 4.8.6.1.4 of the Contract is amended and restated to read as follows:**

4.8.6.1.4 The Member must have fifteen (15) Calendar Days of enrollment to select a PCP. If a Member does not select a PCP within fifteen (15) Calendar Days of enrollment, the CONTRACTOR shall make the assignment and notify the Member in writing of his or her PCP's name, location, and office telephone number, while providing the Member with an opportunity to select a different PCP if the Member is dissatisfied with the assignment; and

6) **Section 4.8.7.4 of the Contract is amended and restated to read as follows:**

4.8.7.4.1 Distance Requirements

4.8.7.4.1 For (i) PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

4.8.7.4.1.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.1.2 Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.

4.8.7.4.1.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.7.4.2 For the providers described in Attachment 8 to the Contract:

4.8.7.4.2.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.2.2 Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

4.8.7.4.2.3 Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of provider is not physically

present in the prescribed radius or unless otherwise exempted as approved by HSD.

7) **Section 4.10.2.10.5 of the Contract is amended and restated to read as follows:**

4.10.2.10.5 The CONTRACTOR shall have an open formulary for all Psychotropic Medications. Open formulary for all Psychotropic Medications means that no prior authorization, fail first, or step therapy requirement shall apply to Psychotropic Medications when the prescriber indicates that a generic or alternative medication does not meet the therapeutic needs of the Member;

8) **Section 4.10.7.5.2 of the Contract is amended and restated to read as follows:**

4.10.7.5.2 The rate to be developed for these projects shall include the following services: (i) initial hospital admission; (ii) any subsequent hospital re-admissions, including emergency room visits, within a thirty (30) Calendar Day period clinically related to the initial discharge; (iii) office visits with the patient's PCMH; (iv) emergency room visits for the same diagnosis; (v) diagnostic tests; (vi) in-home services; and (vii) wellness and community health.

9) **Section 4.12.3.1 of the Contract is amended and restated to read as follows:**

4.12.3.1 HSD shall retain the services of an EQRO in accordance with 42 CFR 438.354. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR's compliance with HSD's managed care regulations and quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

10) **Section 4.12.4.10 of the Contract is amended and restated to read as follows:**

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Long Term Care Services, one (1) on services to children,



and PIPs as required by the Adult Medicaid Quality Grant. PIP work plans and activities must be consistent with PIPs as required by the Adult Medicaid Quality Grant, federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>;

11) **Section 4.17.1.1 of the Contract is amended and restated to read as follows:**

4.17.1.1 The CONTRACTOR, Major Subcontractors and Contract Providers shall have a comprehensive internal Fraud, Waste and Abuse program.

12) **Section 4.17.1.7 of the Contract is amended and restated to read as follows:**

4.17.1.7 The CONTRACTOR, Major Subcontractors and Contract Providers shall comply with all program integrity provisions of the PPACA including:

4.17.1.7.1 Enhanced provider screening and enrollment, section 6401;

4.17.1.7.2 Termination of provider participation, section 6501; and

4.17.1.7.3 Provider disclosure of current or previous affiliation with excluded provider(s), section 6401.

4.17.1.7.4 The requirements set forth in Section 4.17.1.7 shall be included in the CONTRACTOR's contracts with such Major Subcontractors and Contract Providers no later than the time of such contracts' respective renewals.

13) **Section 4.17.1.10 of the Contract is amended and restated to read as follows:**

4.17.1.10 The CONTRACTOR shall make every reasonable effort to detect, recoup and prevent Overpayments made to Contract Providers in accordance with federal and State law and regulations. The CONTRACTOR shall report Claims identified for Overpayment recoupment to HSD at a regularly scheduled interval and in a format agreed to by HSD and the CONTRACTOR and reflected on the CONTRACTOR's Encounter Data. HSD may require an HSD-contracted Recovery Audit Contractor to review paid Claims that are over three hundred sixty (360) Calendar Days old and pursue Overpayments for those Claims that do not indicate recovery amounts in the CONTRACTOR's Encounter Data.

14) **Section 4.17.2.3 of the Contract is amended and restated to read as follows:**

4.17.2.3 The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD as follows within the timeframes required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and/or Abuse in the administration of Centennial Care shall be reported to HSD. It shall be HSD's responsibility to report verified cases to MFEAD;

4.17.2.3.2 All confirmed, credible or suspected provider Fraud, Waste and/or Abuse shall be immediately reported to HSD and shall include the information provided in 42 CFR § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD; and

4.17.2.3.3 All confirmed or suspected Member Fraud, Waste and/or Abuse shall be reported to HSD.

15) **Section 4.17.2.4 of the Contract is amended and restated to read as follows:**

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) make an initial report to HSD of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HSD with monthly updates. HSD may, at its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter timeframe. In addition, unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud, Waste and/or Abuse or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

16) **Section 4.17.2.5 of the Contract is amended and restated to read as follows:**

4.17.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency for matters where the CONTRACTOR has determined that only an Overpayment exists.

17) **Section 4.17.3.2.3 of the Contract is amended and restated to read as follows:**

4.17.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and State statutes and regulations related to Medicaid program integrity and Fraud/Abuse/Waste and on identifying and educating targeted Contract Providers with patterns of incorrect billing practices and/or Overpayments;

18) **Section 4.17.4 of the Contract is amended and restated to read as follows:**

4.17.4 Recoveries of Overpayments and/or Fraud

4.17.4.1 Identification Process for Overpayments

4.17.4.1.1 The CONTRACTOR shall report to HSD all instances where the CONTRACTOR has notified a provider of a potential Overpayment, including the date of such notification, the stated reasons and the potential Overpayment amount. HSD may, at its sole discretion, require monthly updates as to the status of any reported potential Overpayment.

4.17.4.1.2 Providers are required to report identified Overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an Overpayment if the provider has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference that an Overpayment exists.

4.17.4.2 Self-Reporting

4.17.4.2.1 For all identified Overpayments and within the timeframes specified in 4.17.4.1.1, the provider shall send an "Overpayment Report" to the CONTRACTOR and HSD which shall include, at a minimum, (i) provider's name; (ii) provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid claim control number, as appropriate; (viii) description of a corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the Overpayment; (xi) if a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to

determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

#### 4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for Overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an Overpayment existed; or

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund, such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

#### 4.17.4.4 Failure To Self-Report And/Or Refund Overpayments

4.17.4.4.1 The CONTRACTOR shall inform all providers that all Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day timeframe may be considered false claims and may be subject to referrals as credible allegations of fraud and subject to Section 4.17.2.3.1 of this Contract.

19) **Section 4.18.1 of the Contract is amended and restated to read as follows:**

4.18.1 The CONTRACTOR shall at all times be in compliance with the net worth requirements under applicable insurance laws.

20) **Section 4.18.2.1 of the Contract is amended and restated to read as follows:**

- 4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in State of New Mexico in accordance with section 1903(m)(1) of the Social Security Act (amended by section 4706 of the Balanced Budget Act of 1997), and applicable state insurance laws. The CONTRACTOR shall deposit, in the form of cash or securities or investments consistent with applicable state insurance laws, an amount equal to ninety percent (90%) of the total capitation payment paid to the CONTRACTOR in the first month of the Contract Year as determined by HSD. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.
- 4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR's Centennial Care program.
  - 4.18.2.1.2. The CONTRACTOR must satisfy this requirement no later than sixty (60) Calendar Days after notification by HSD of the deposit amount required.
  - 4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.
  - 4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.
  - 4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.
  - 4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.
    - 4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to withdrawal of funds from this account as outlined in Section 4.18.2.1.6.



4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The CONTRACTOR shall deposit the assets with any organization or trustee acceptable through which a custodial or controlled account is utilized.

21) **Section 4.18.2.2 of the Contract is amended and restated to read as follows:**

4.18.2.2 In the event that a determination is made by HSD that the CONTRACTOR is insolvent under applicable state insurance law, HSD may draw upon the amount. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

22) **Section 4.18.2.4 of the Contract is amended and restated to read as follows:**

4.18.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, overpayments made to the CONTRACTOR, and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to health care providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other claims subject to applicable state insurance law.

23) **Section 4.18.2.5 of the Contract is amended and restated to read as follows:**

4.18.2.5 HSD shall adjust this reserve requirement quarterly, as needed. The reserve account may be accessed solely for payment for Covered Services to the CONTRACTOR's Members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with applicable state insurance regulations and guidelines.

24) **Section 4.18.4 of the Contract is amended and restated to read as follows:**

4.18.4 Surplus Requirement

The CONTRACTOR shall maintain at all times in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the CONTRACTOR's domiciliary state regulator, and restricted funds of deposits controlled by HSD (including the CONTRACTOR's insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars (\$1,500,000), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the CONTRACTOR's prepaid revenues. In the event that the CONTRACTOR's surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

25) **Section 4.18.7.1 of the Contract is amended and restated as follows:**

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond in the amount of at least one million dollars (\$1,000,000).

26) **Section 4.18.10.1.1 of the Contract is amended and restated as follows:**

4.18.10.1.1 Comply with and be subject to all applicable state and federal statutes and regulations including those regarding solvency and risk standards. In addition, the CONTRACTOR shall meet specific Medicaid financial requirements and to present to HSD any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time from the date of the request or as specified herein.

27) **Section 4.18.11.1.1 of the Contract is amended and restated to read as follows:**

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1.1 through 4.18.11.1.1.5 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1.1 Cash Deposits;

4.18.11.1.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit

Insurance Corporation (FDIC) or equivalent  
federally insured deposit;

4.18.11.1.1.3 Surety Bond issued by a surety or  
insurance company licensed to do business in  
New Mexico;

4.18.11.1.1.4 Certificate of Deposit; and

4.18.11.1.1.5 Investment account with financial  
institute licensed to do business in the State  
of New Mexico.

28) **Section 4.18.11.4 of the Contract is amended and restated to read as follows:**

4.18.11.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in a material default of or failing to materially perform the activities outlined in this Agreement or if HSD determines the CONTRACTOR insolvent as outlined under the applicable state insurance law.

29) **Section 4.18.11.6 of the Contract is amended and restated to read as follows:**

4.18.11.6 The CONTRACTOR shall purchase the performance bond within forty five (45) Calendar Days of receipt of the first month of capitation from HSD.

30) **Section 4.18.11.10 of the Contract is amended and restated to read as follows:**

4.18.11.10 The CONTRACTOR shall hold the performance bond with any organization or trustee acceptable through which a custodial or controlled account is utilized.

31) **Section 4.18.12.3 of the Contract is amended and restated to read as follows:**

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the applicable state insurance regulator for approval. The CONTRACTOR

must submit the pricing details of the reinsurance agreement including the covered period to HSD for approval.

32) **Section 4.18.13.1.4.4 of the Contract is amended and restated to read as follows:**

4.18.13.1.4.4 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR's provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the claim; and may permit payments to be made in accordance with state regulations;

33) **Section 4.18.13.10 of the Contract is amended and restated to read as follows:**

4.18.13.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.18.13, third-party resources shall not include subrogation resources; provided, however, the CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the Claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for purposes of reporting.

34) **Section 4.18.16.2 of the Contract is amended and restated to read as follows:**

4.18.16.2 The CONTRACTOR shall submit third party liability recoveries including Medicare payment information on a date of services basis in accordance with Section 4.21.12.1 of this Agreement.

35) **Section 4.21.1.6 of the Contract is amended and restated to read as follows:**

4.21.1.6 HSD's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the Agreement. A list of required reports is provided in Attachment 4.

4.21.1.6.1 The CONTRACTOR shall comply with all changes specified in writing by HSD, after HSD has discussed such changes with the CONTRACTOR.

HSD shall notify the CONTRACTOR, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. The CONTRACTOR shall be held harmless on the first submission of the revised report if HSD fails to meet this requirement for any changes for existing reports. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report revised by HSD to include a change in data requirements or definition will not be subject to penalty for accuracy.

4.21.1.6.2 HSD shall notify the CONTRACTOR, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.

36) **Section 6 of the Contract is amended to add the following new section 6.12 to read as follows:**

6.12 Retroactive Period Reconciliation

6.12.1 The CONTRACTOR is required to reimburse providers for the medical expenses incurred by the Member in the Retroactive Period. The duration and expenditures associated with the Retroactive Period may fluctuate for each Member and are not considered in the prospective capitation payment rate development.

6.12.2 HSD shall reconcile the difference between the medical expenses incurred by the CONTRACTOR during the Retroactive Period and the payment made by HSD to the CONTRACTOR for the Retroactive Period that may occur due to the enrollment process outlined in Section 4.2.8.2.

6.12.3 The reconciliation process for the Retroactive Period is outlined in Attachment 9.

37) **Section 7.2.9 of the Contract is amended and restated to read as follows:**

7.2.9 Care Coordination Expenses

7.2.9.1 The CONTRACTOR shall provide care coordination services in accordance with Section 4.4 of this Agreement.

7.2.9.2 For purposes of this Agreement, the following care coordination functions will be deemed medical services:

7.2.9.2.1 Comprehensive needs assessment;

7.2.9.2.2 Face-to-face meetings between the care coordinator and the Member;

- 7.2.9.2.3 Telephonic meetings between the care coordinator and the Member;
- 7.2.9.2.4 Case management;
- 7.2.9.2.5 Discharge consultation;
- 7.2.9.2.6 CCP development and updates;
- 7.2.9.2.7 Health education provided to the Member;
- 7.2.9.2.8 Disease management provided to the Member; and
- 7.2.9.2.9 Costs associated with Community Health Workers.

7.2.9.3 The CONTRACTOR shall submit Member care coordination activities through Encounter Data.

7.2.9.4 For purposes of this Agreement, the following care coordination functions will be deemed administrative services:

- 7.2.9.4.1 Health risk assessments (HRAs);
- 7.2.9.4.2 Data runs;
- 7.2.9.4.3 Referrals; and
- 7.2.9.4.4 Case assignment and scheduling.

38) **Section 7.3 of the Contract is amended and restated to read as follows:**

**7.3 Failure to Meet Agreement Requirements**

**7.3.1 General**

7.3.1.1 In the event that the CONTRACTOR or any person with an ownership interest in the CONTRACTOR, affiliate, parent or subcontractor, fails to comply with this Agreement, HSD may impose, at HSD's discretion sanctions (inclusive of the specific monetary penalties and other penalties described in this Section 7.3.

7.3.1.2 Sanctions paid by the CONTRACTOR pursuant to this Section 7.3 shall be included as administrative expenses subject to Section 7.2.8 of this Agreement.

7.3.1.3 HSD retains the right to apply progressively strict sanctions CONTRACTOR against the CONTRACTOR, for failure to perform in any of the Agreement areas.



7.3.1.4 Any sanction, including the withholding of capitation payments, does not constitute just cause for the CONTRACTOR to interrupt providing Covered Services to Members.

7.3.1.5 HSD may impose any other administrative, contractual or legal remedies available under federal or State law for the CONTRACTOR's noncompliance under this Agreement.

7.3.1.6 HSD will give the Collaborative written notice whenever it imposes or lifts a sanction for one of the violations listed herein that relates to Behavioral Health.

7.3.1.7 HSD will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed herein. The notice will be given no later than thirty (30) Calendar Days after HSD imposes or lifts a sanction and must specify the affected CONTRACTOR, the kind of sanction and the reason for HSD's decision to impose or lift the sanction.

### 7.3.2 Corrective Action Plans

7.3.2.1 If HSD determines that the CONTRACTOR is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that sanctions are also necessary.

7.3.2.2 The CONTRACTOR may dispute a notice of noncompliance in accordance with Section 7.11 of this Agreement.

7.3.2.3 The CONTRACTOR shall be required to provide CAPs to HSD within fourteen (14) Calendar Days of receipt of a noncompliance notice from HSD. CAPs are subject to review and approval by HSD.

7.3.2.4 If HSD imposes a DCAP on the CONTRACTOR, the CONTRACTOR will have fourteen (14) Calendar Days to respond to HSD.

7.3.2.5 If the CONTRACTOR does not effectively implement the CAP/DCAP within the timeframe specified in the CAP/DCAP, HSD may impose additional sanctions.

7.3.2.6 If HSD staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party either designated by HSD or approved by HSD to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

### 7.3.3 Sanctions

7.3.3.1 HSD may impose any or all of the non-monetary sanctions and monetary penalties as described in this Section to the extent authorized by federal and State law.

7.3.3.2 Non-monetary intermediate sanctions may include:

7.3.3.2.1 Suspension of auto-assignment of Members who have not selected an MCO;

7.3.3.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

7.3.3.2.3 Notification to Members of their right to terminate enrollment with the CONTRACTOR's MCO without cause as described in 42 C.F.R. § 438.702(a)(3);

7.3.3.2.4 Disenrollment of Members by HSD;

7.3.3.2.5 Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

7.3.3.2.6 Rescission of Marketing consent and suspension of the CONTRACTOR's Marketing efforts;

7.3.3.2.7 Appointment of temporary management or any portion thereof for an MCO as provided in 42 C.F.R. § 438.706 and the CONTRACTOR shall pay for any costs associated with the imposition of temporary management; and

7.3.3.2.8 Additional sanctions permitted under federal or State statute or regulations that address areas of noncompliance.

7.3.3.3 Monetary penalties may include:

7.3.3.3.1 Actual damages incurred by HSD and/or Members resulting from the CONTRACTOR's non-performance of obligations under this Agreement;

7.3.3.3.2 Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the CONTRACTOR's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the CONTRACTOR and the rates paid to the replacement health plan. HSD may withhold payment to the CONTRACTOR for damages until such damages are paid in full;

7.3.3.3.3 Civil monetary penalties as described in 42 C.F.R. § 438.704;

7.3.3.3.4 Monetary penalties up to five percent (5%) of the CONTRACTOR's Medicaid capitation payment for each month in which the penalty is assessed;

7.3.3.3.5 Other monetary penalties for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below.

7.3.3.4 HSD reserves the right to assess a general monetary penalty of five hundred dollars (\$500) per occurrence with any notice of deficiency.

7.3.4 Other Monetary Penalties

	<b>PROGRAM ISSUES</b>	<b>PENALTY</b>
<b>1.</b>	Failure to comply with Claims processing as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement
<b>2.</b>	Failure to comply with Encounter submission as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement.
<b>3.</b>	Failure to comply with the timeframes for a comprehensive care assessment and developing and approving a CCP for care coordination level 2 and level 3	<p>\$10,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 75-94% of members for the reporting period.</p> <p>\$25,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% of less of Members for the reporting period.</p>

4.	Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
5.	Failure to obtain approval of Member Materials as required by Section 4.14.1 of this Agreement	\$5,000 per day for each Calendar Day that HSD determines the CONTRACTOR has provided Member Material that has not been approved by HSD. The \$5,000 per day damage amounts will double every ten (10) days.
6.	Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of this Agreement	<p>\$10,000 per occurrence where the CONTRACTOR fails to comply with the timeframes but is in compliance with the timeframes for 75-94% of Grievances and Appeals for the reporting period.</p> <p>\$25,000 per occurrence where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% or less of Grievances and Appeals for the reporting period.</p>
7.	Failure to submit timely reports in accordance with Section 4.21 of this Agreement	\$1,000 per report, per Calendar Day. The \$1,000 per day damage amounts will double every ten (10) Calendar days.
8.	Failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with Section 4.21 of this Agreement	\$5,000 per report, per occurrence.
9.	Failure to submit timely Summary of Evidence in accordance with Section 4.16 of this Agreement	\$1,000 per occurrence.
10.	Failure to have legal counsel	\$10,000 per occurrence.

	appear in accordance with Section 4.16 of this Agreement	
<b>11.</b>	Failure to meet HEDIS targets for the performance measures described in Section 4.12.8 of this Agreement	A monetary penalty based on 2% of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year.

\*HSD can modify any monetary penalty if the CONTRACTOR engages in a pattern of behavior which constitutes a violation of this Agreement and involves a significant risk of harm to Members or to the integrity of Centennial Care.

### 7.3.5 Payment of Monetary Penalties

7.3.5.1 HSD shall provide the CONTRACTOR with notice of any monetary penalties assessed at least thirty (30) Calendar Days before deducting such amounts from the monthly capitation payment. The collection of monetary penalties by HSD shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by HSD will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the monetary penalties described in this Section.

7.3.5.2 Monetary penalties as described in Section 7.3.5 of this Agreement shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

### 7.3.6 Waiver of Sanctions

HSD may waive the application of sanctions (including monetary penalties) at its discretion if HSD determines that such waiver is in the best interests of the Centennial Care program and its Members.

### 7.3.7 Federal Sanctions

Payments provided for under this Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

39) **Section 7.27.11 of the Contract is amended and restated to read as follows:**

7.27.11 Referrals for Credible Allegations of Fraud

7.27.11.1 The CONTRACTOR shall report to HSD suspected cases of Fraud whenever there are credible allegations of Fraud. The CONTRACTOR shall follow HSD's direction in identifying and reporting cases of credible allegations of Fraud. HSD shall make the final determination of whether to refer such cases to MFEAD, and other law enforcement agencies, for further investigation. HSD's directions to the CONTRACTOR may include, but is not limited to:

7.27.11.1.1 At HSD's direction, the CONTRACTOR shall suspend all Medicaid payments, in whole or in part as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD's notice, the CONTRACTOR (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pending Claims, or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD's notice.

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law.

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD.

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:



7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider;

7.27.11.1.4.2 The dismissal of all charges and/or claims against the provider related to the provider's alleged fraud by a court of competent jurisdiction; or

7.27.11.1.4.3 For other good cause as determined solely by HSD.

7.27.11.1.5 HSD shall document in writing the termination of a payment suspension and shall provide such documentation to the CONTRACTOR.

7.27.11.2 Should HSD require the CONTRACTOR's assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review, and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

40) **Section 7.46.2 of the Contract is amended and restated as follows:**

7.46.2 All notices required to be given to the State under this Agreement shall be sent to the following, or his or her designee:

Julie Weinberg, Director  
Medical Assistance Division  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348

Or

Christopher Collins, General Counsel  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, NM 87504-2348

41) **Attachment 6 to the Contract is amended and restated to read as follows:**

**Attachment 6: Alternative Benefit Plan Covered Services**

<b>Alternative Benefit Plan Services Included Under Centennial Care</b>
Allergy testing and injections
Annual physical exam and consultation
Assertive Community Treatment (ACT)
Autism spectrum disorder <sup>1</sup>
Bariatric surgery <sup>2</sup>
Behavioral health professional services: outpatient behavioral health <sup>3</sup> and substance abuse services <sup>4</sup>
Cancer clinical trials <sup>5</sup>
Cardiovascular rehabilitation <sup>6</sup>
Chemotherapy and radiation therapy
Dental services <sup>7</sup>
Diabetes treatment, including diabetic shoes and related medical supplies
Dialysis
Disease management
Durable medical equipment
Educational materials and counseling for a healthy lifestyle
Electroconvulsive Therapy (ECT)
Emergency services (including emergency room visits and psychiatric ER)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals age 19 and 20
Eye exams and treatment related to treatment and testing of eye diseases only <sup>8</sup>
Family planning, sterilization, pregnancy termination, contraceptives <sup>9</sup>
Glasses and contact lenses: covered only for aphakia (following removal of the lens) <sup>10</sup>
Hearing testing or screening as part of a routine health exam <sup>11</sup>

<sup>1</sup> Covers speech, occupational and physical therapy, and applied behavioral analysis for Members age 19-20; and Members age 21-22 who are enrolled in high school.

<sup>2</sup> Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

<sup>3</sup> Includes evaluation, testing, assessment, medication management, therapy and Intensive Outpatient Program (IOP) services.

<sup>4</sup> Includes outpatient detoxification, therapy, partial hospitalization and IOP services.

<sup>5</sup> Covers routine patient costs associated with Phase I, II, III and IV cancer clinical trials.

<sup>6</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per cardiac event. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>7</sup> ABP dental services are equivalent to the adult dental benefit package for traditional Medicaid categories.

Increased periodicity schedule and medically necessary orthodontia covered for Members age 19-20.

<sup>8</sup> Refraction is not covered. Routine vision care is not covered.

<sup>9</sup> Sterilization reversal is not covered.

<sup>10</sup> Coverage of materials is limited to \$300 per surgery. Contact lenses or eyeglasses obtained more than 90 days following surgery are not covered.

<sup>11</sup> Hearing aids not covered. Hearing testing by an audiologist or hearing aid dealer is not covered.

Home health services <sup>12</sup>
Hospice services, including hospice at home or in a nursing facility
Hospital inpatient <sup>13</sup>
Hospital outpatient
Immunizations
Inhalation therapy
Inpatient rehabilitation <sup>14</sup>
IV infusions
Laboratory genetic testing to specific molecular lab tests such as BRCA1 and BRCA2 and similar tests used to determine appropriate treatment <sup>15</sup>
Laboratory services, including diagnostic testing and other age appropriate tests
Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests
Medical supplies: diabetic and contraceptive supplies only <sup>16</sup>
Medication assisted therapy for opioid dependence
Nutritional counseling
Obstetric/gynecological care, prenatal care, deliveries, midwives
Orthotics <sup>17</sup>
Physician visits
Podiatry services <sup>18</sup>
Prescription drug items <sup>19</sup>
Preventive care <sup>20</sup>
Primary care to treat illness/injury
Prosthetics
Psychosocial Rehabilitation (PSR)

<sup>12</sup> Limited to 100 visits per year. A visit cannot exceed four hours.

<sup>13</sup> Free-standing psychiatric hospitals are only covered for Members age 19-20 and are not a covered service for ABP or ABP-exempt, except for Members under age 21 except as an "in lieu of service." Psychiatric units within an acute care hospital are covered under the ABP. Inpatient drug rehabilitation services are not covered. Acute inpatient services for detoxification are covered.

<sup>14</sup> Covers inpatient services at a skilled nursing or acute rehabilitation facility when provided as a step-down level of care following discharge from the hospital prior to discharge to home. Extended care or long-term care hospitals are not covered.

<sup>15</sup> Not including random genetic screening.

<sup>16</sup> Medical supplies used on an inpatient basis, applied as part of treatment in a practitioner's office, outpatient hospital, residential facility, or home health service, are covered when separate payment is allowed in these settings.

<sup>17</sup> Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace or diabetic shoes.

<sup>18</sup> Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

<sup>19</sup> Over-the-counter drug items are not covered, except for prenatal drug items, low-dose aspirin as preventive for cardiac conditions, contraceptive drugs and devices, and items for treating diabetes. The contractor may choose to cover any over-the-counter product when it is less expensive than the therapeutically equivalent drug that would require a prescription (a 'legend' drug).

<sup>20</sup> ABP preventive services include the A&B recommendations of the United States Preventive Services Task Force (USPSTF)

Pulmonary rehabilitation <sup>21</sup>
Radiology, including diagnostic imaging and radiation therapy, mammography and other age appropriate imaging
Reconstructive surgery <sup>22</sup>
Rehabilitation and habilitation: physical therapy, occupational therapy and speech and language pathology <sup>23</sup>
Rehabilitation inpatient hospitalization: step-down lower level of care from an acute care hospital for not more than 14 days
Reproductive health services (not including fertility treatment)
Skilled nursing
Specialist visits
Telemedicine
Tobacco cessation counseling
Transplant services <sup>24</sup>
Transportation services (emergency and non-emergency medical), including air and ground ambulance, taxi and handivan <sup>25</sup>
Urgent care services

42) **Attachment 8 is added to the Contract to read as follows:**

**Attachment 8: Providers with Distance Requirements**

**A. Behavioral Health**

1. Freestanding Psychiatric Hospitals
2. General Hospitals with psychiatric units
3. Partial Hospital Programs
4. Accredited Residential Treatment Centers (ARTC)
5. Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)

<sup>21</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered..

<sup>22</sup> Covers reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders that result from accidental injury, congenital defects or disease.

<sup>23</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>24</sup> Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants. Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs. Limited to two organ/tissue transplants per lifetime. Outpatient immunosuppressive drugs do not apply toward the transplant benefit limit.

<sup>25</sup> Covers expenses for transportation, meals and lodging that are determined necessary to secure medical or Behavioral Health services for an ABP Member.

6. Treatment Foster Care I & II (TFC I & II)
7. Core Service Agencies (CSA)
8. Community Mental Health Centers (CMHC)
9. Indian Health Service and Tribal 638s providing Behavioral Health services
10. Outpatient Provider Agencies
11. Agencies providing Behavioral Management Services (BMS)
12. Agencies providing Day Treatment Services
13. Agencies providing Assertive Community Treatment (ACT)
14. Agencies providing Multi-Systematic Therapy (MST)
15. Agencies providing intensive Outpatient Services
16. Methadone Clinics
17. FQHCs providing Behavioral Health services
18. Rural Health Clinics providing Behavioral Health services
19. Psychiatrists
20. Psychologists (including prescribing psychologists)
21. Suboxone certified MDs
22. All other licensed Independent Behavioral Health practitioners (LISW, LPCC, LMFT, CNS & CNP with psychiatric certification, independent practices or groups)

#### **B. Physical Health**

1. Cardiology
2. Certified Nurse Practitioner
3. Certified Midwives
4. Dermatology
5. Dental
6. Endocrinology
7. ENT
8. FQHC
9. RHC
10. Hem/Oncology
11. I/T/U
12. Neurology
13. Neurosurgeon
14. OB-GYN
15. Orthopedics
16. Pediatrics
17. Physician Assistant
18. Podiatry
19. Rheumatology
20. Surgeons
21. Urology

#### **C. Long Term Care**

1. Assisted Living Facilities

2. Personal Care Service Agencies (PCS) – delegated
3. Personal Care Service Agencies (PCS) – directed
4. Nursing Facilities

**D. Hospitals**

1. General Hospitals
2. Inpatient Psychiatric Hospitals

**E. Transportation**

- 43) **Attachment 9 is added to the Contract to read as follows:**

**Attachment 9: Retroactive Period Reconciliation**

1. HSD shall reconcile the medical expenditures related to the Retroactive Period for each Contract year period (January 1 to December 31 of each Contract year). The Retroactive Period may exist for some Members whose effective date of Medicaid eligibility is determined prior to HSDs notification date to the CONTRACTOR outlined in Section 4.2.8.
2. The reconciliation for the Retroactive Period is limited to the medical expenses only.
3. For purposes of this Attachment, “medical expense” is defined as the expenditures for Covered Services in Attachment 2. Value added services and administrative expenditures will not be countable expenses in the calculation of the reconciliation.
4. HSD will permit the CONTRACTOR to retain 5.263 percent of the total medical expense for administrative costs.
5. HSD shall adjust the final reconciliation for applicable premium tax depending on the outcome of the reconciliation.
6. HSD will utilize encounter data received and accepted by HSD as the source for the measurement of the reconciliation on a cohort basis limited to Members who are in the Retroactive Period and eligible according to HSD’s eligibility system in the month they incurred medical expenses.
7. HSD shall conduct the final reconciliation for the contract year period no sooner than eight (8) months after the end of the calendar year or contract period.
  - a. During the calendar year or contract period, HSD at its discretion, may perform interim reconciliations and may recoup from or make payment to the CONTRACTOR. HSD shall determine the pro-rated percentage to recoup or pay.



- b. Interim recoupment or payment will be factored into the final reconciliation.
- 8. Actual medical cost plus the administrative allowance and premium tax will be compared to the payment made by HSD to the CONTRACTOR for the Retroactive Period to determine the value of recoupment from or payment to the CONTRACTOR.
- 9. HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.
- 44) **Attachment 10 is added to the Contract to read as follows:**

**Attachment 10: List of Psychotropic Drugs and Medications**

GENERAL DESCRIPTION	THERAPEUTIC CLASS (MCOs must use their primary examples of medications in the category comparable therapeutic classes)	(brand names begin with a capital letter)																																																							
<b>Anti-Anxiety Medications and Antidepressants (non-benzodiazepines)</b>	H2F, H2G, H2J, H2S, H2U, H7B, H7C, H7D, H7E, H7F, H2O, H7P, H7R, H7S, H7T, H7U, H7X, H7O, H7Z	<table border="0"> <tr> <td>Abilify</td> <td>desvenlafaxine</td> <td>Latuda</td> <td>Pamelor</td> <td>Symbyax</td> </tr> <tr> <td>amitriptyline</td> <td>Desyrel</td> <td>Lexapro</td> <td>paroxetine</td> <td>thiothixene</td> </tr> <tr> <td>amoxapine</td> <td>doxepin</td> <td>loxapine</td> <td>Paxil</td> <td>Tofranil</td> </tr> <tr> <td>Anafranil</td> <td>duloxetine</td> <td>Loxitane</td> <td>Pexeva</td> <td>trazodone</td> </tr> <tr> <td>Aripiprazole</td> <td>Effexor</td> <td>Ludiomil</td> <td>pimozide</td> <td>trimipramine</td> </tr> <tr> <td>Asendin</td> <td>Elavil</td> <td>lurasidone</td> <td>Pristiq</td> <td>venlafaxine</td> </tr> <tr> <td>Aventyl</td> <td>escitalopram</td> <td>Luvox</td> <td>protriptyline</td> <td>Vivactil</td> </tr> <tr> <td>bupropion</td> <td>Fanapt</td> <td>maprotiline</td> <td>Prozac</td> <td>Wellbutrin</td> </tr> <tr> <td>BuSpar</td> <td>fluoxetine</td> <td>mirtazapine</td> <td>quetiapine</td> <td>ziprasidone</td> </tr> <tr> <td>bupirone</td> <td>fluoxetine &amp; olanzapine</td> <td>Moban</td> <td>Remeron</td> <td>Zoloft</td> </tr> <tr> <td>Celexa (SSRI)</td> <td>fluvoxamine</td> <td>molindone</td> <td>resperidone</td> <td>Zyprexa</td> </tr> </table>	Abilify	desvenlafaxine	Latuda	Pamelor	Symbyax	amitriptyline	Desyrel	Lexapro	paroxetine	thiothixene	amoxapine	doxepin	loxapine	Paxil	Tofranil	Anafranil	duloxetine	Loxitane	Pexeva	trazodone	Aripiprazole	Effexor	Ludiomil	pimozide	trimipramine	Asendin	Elavil	lurasidone	Pristiq	venlafaxine	Aventyl	escitalopram	Luvox	protriptyline	Vivactil	bupropion	Fanapt	maprotiline	Prozac	Wellbutrin	BuSpar	fluoxetine	mirtazapine	quetiapine	ziprasidone	bupirone	fluoxetine & olanzapine	Moban	Remeron	Zoloft	Celexa (SSRI)	fluvoxamine	molindone	resperidone	Zyprexa
Abilify	desvenlafaxine	Latuda	Pamelor	Symbyax																																																					
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Asendin	Elavil	lurasidone	Pristiq	venlafaxine																																																					
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Celexa (SSRI)	fluvoxamine	molindone	resperidone	Zyprexa																																																					

citalopram	Geodon	Navane	Risperdal
clomipramine	Haldol	Norpramin	Sarafem
clozapine	Haloperidol	nortriptyline	Seroquel
Clozaril	iloperidone	olanzapione	sertraline
Cymbalta	imipramine	Orap	Sinequan
desipramine	Invega	Paliperidone	Surmontil

**Anti-Mania Medications H2M  
(Mood Stabilizers)**

Eskalith	lithium carbonate	lithium citrate	Lithobid
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**Mood Stabilizing Anticonvulsants H4B**

clonazepam	divalproex sodium	lomotrigine	oxcarbazepine	topiramate
carbamazepine	Klonopin	gabapentin	Tegretol	Trileptal
Depakote	Lamictal	Neurontin	Topamax	valproic acid

**Monoamine Oxidase Inhibitors H2H, H2J, H7J**

Emsam	Marplan	Parnate	selegiline
isocarboxazid	Nardil	phenelzine	tranylcypromine

**Phenothiazines and other H2G  
major tranquilizers and  
antipsychotics**

chlorpromazine	perphenazine	thioridazine	trifluoperazine
fluphenazine	Stelazine	Thorazine	Trilafon

**The remainder of this page is intentionally left blank.**

**All other sections of PSC 13-630-8000-0024, as amended, remain the same.**

IN WITNESS WHEREOF, the parties have executed this amended and restated contract as of the date of signature by the Human Services Department.

**CONTRACTOR**

By: Y.P. 9-1-14  
Title: CEO

Date: July 10, 2014

**STATE OF NEW MEXICO**

By: Sidonie Squier  
Sidonie Squier, Cabinet Secretary  
Human Services Department

Date: 10/9/14

By: Danny Sandoval  
Danny Sandoval, CFO  
Human Services Department

Date: 10/14/14

**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

By: Retta Ward

Date: 10/7/14

Title: Cabinet Secretary

By: Jennyji Padgett

Title: Deputy Cabinet Secretary, CyFD

CERTIFIED FOR LEGAL SUFFICIENCY:  
[Signature] 10/7/14  
Department of Health  
Assistant General Counsel


Date: 10-20-14

By: Sidonie Squier

Date: 10/23/14

Title: Secy, HSD

**Approved as to Form and Legal Sufficiency:**

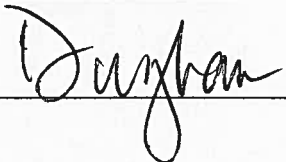
By:   
\_\_\_\_\_  
Christopher P. Collins, Chief Legal Counsel  
Human Services Department

Date: 9/30/14

The records of the Taxation and Revenue Department reflect that the CONTRACTOR is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

**TAXATION AND REVENUE DEPARTMENT**

**ID Number: 03-145330-00 .9**

By:   
\_\_\_\_\_

Date: 10.28.14

Title: \_\_\_\_\_



**STATE OF NEW MEXICO**



**HUMAN  
SERVICES**  
DEPARTMENT  
MEDICAL ASSISTANCE DIVISION

**Amended and Restated Medicaid Managed Care Agreement**

**among**

**New Mexico Human Services Department,**

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**Molina Healthcare of New Mexico, Inc.**



**PSC: 13-630-8000-0022-A2**

**STATE OF NEW MEXICO  
HUMAN SERVICES DEPARTMENT  
MEDICAID MANAGED CARE SERVICES AGREEMENT  
FOR CENTENNIAL CARE**

**AMENDMENT NO. [2]**

This Amendment No. 2 to PSC: 13-630-8000-0022 is made and entered into by and between the New Mexico Human Services Department (“HSD”), the New Mexico Behavioral Health Purchasing Collaborative (the “Collaborative”) and Molina Healthcare of New Mexico (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

**WHEREAS**, the Centers for Medicare & Medicaid Services have requested certain revisions to the Contract;

**WHEREAS**, there are certain clarifications and revisions to the Contract that are necessary;

**IT IS MUTUALLY AGREED BY THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE REFERENCED CONTRACT ARE AMENDED AND RESTATED AS FOLLOWS:**

- 1) **Section 2 of the Contract is amended by amending and adding the following definitions:**

**Major Subcontractor** means an entity with which the CONTRACTOR has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the Covered Services; provided that a Major Subcontractor does not include a provider or a Contract Provider.

**Overpayment** means any funds that a person or entity receives in excess of the Medicaid allowable amount of the CONTRACTOR’s allowed amount as negotiated with the provider. Overpayments shall not include funds that have been (i) subject to a payment suspension; (ii) identified as a third-party liability as set forth in Section 4.18.13; (iii) subject to the CONTRACTOR’s system-directed mass adjustments, such as due to fee schedule changes; or (iv) for purposes of filing an “Overpayment Report” as required in Section 4.17.4.2.1, less than fifty dollars (\$50.00) or those funds recoverable through existing routine and customary adjustments using HIPAA complaint formats;

**Psychotropic Drug** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Psychotropic Medication** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Retroactive Period** means the time between the notification date by HSD to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date. The Retroactive Period addresses those instances when the Member is enrolled with the CONTRACTOR but the eligibility date is effective before the CONTRACTOR is notified of enrollment.

**Waste** means the overutilization of services or other practices that result in unnecessary costs.

2) **Section 4.4.2.7 of the Contract is amended and restated to read as follows:**

4.4.2.7 The CONTRACTOR shall make reasonable efforts to contact Members to conduct an HRA and provide information about care coordination. The CONTRACTOR shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member (if a phone number is available). The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about care coordination and how to obtain an HRA. The process outlined in this section shall constitute sufficient effort by the CONTRACTOR to assist a Member.

3) **Section 4.4.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.1 The CONTRACTOR shall perform an in-person comprehensive needs assessment on all Members identified for care coordination level 2 or level 3—at the Member's primary residence. The visit may occur in another location only with HSD approval. For members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

4) **Section 4.5.12.1 of the Contract is amended and restated to read as follows:**

4.5.12.1 The CONTRACTOR shall impose the maximal nominal copayment established by HSD in accordance with federal regulations on any prescription filled for a Member with a brand name drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to brand name drugs that are classified as Psychotropic Drugs for the treatment of Behavioral Health conditions. The CONTRACTOR shall

develop a copayment exception process to be prior approved by HSD for other brand name drugs where such drugs are not tolerated by the Member.

5) **Section 4.8.6.1.4 of the Contract is amended and restated to read as follows:**

4.8.6.1.4 The Member must have fifteen (15) Calendar Days of enrollment to select a PCP. If a Member does not select a PCP within fifteen (15) Calendar Days of enrollment, the CONTRACTOR shall make the assignment and notify the Member in writing of his or her PCP's name, location, and office telephone number, while providing the Member with an opportunity to select a different PCP if the Member is dissatisfied with the assignment; and

6) **Section 4.8.7.4 of the Contract is amended and restated to read as follows:**

4.8.7.4.1 Distance Requirements

4.8.7.4.1 For (i) PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

4.8.7.4.1.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.1.2 Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.

4.8.7.4.1.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.7.4.2 For the providers described in Attachment 8 to the Contract:

4.8.7.4.2.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.2.2 Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

4.8.7.4.2.3 Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of provider is not physically

present in the prescribed radius or unless otherwise exempted as approved by HSD.

7) **Section 4.10.2.10.5 of the Contract is amended and restated to read as follows:**

4.10.2.10.5 The CONTRACTOR shall have an open formulary for all Psychotropic Medications. Open formulary for all Psychotropic Medications means that no prior authorization, fail first, or step therapy requirement shall apply to Psychotropic Medications when the prescriber indicates that a generic or alternative medication does not meet the therapeutic needs of the Member;

8) **Section 4.10.7.5.2 of the Contract is amended and restated to read as follows:**

4.10.7.5.2 The rate to be developed for these projects shall include the following services: (i) initial hospital admission; (ii) any subsequent hospital re-admissions, including emergency room visits, within a thirty (30) Calendar Day period clinically related to the initial discharge; (iii) office visits with the patient's PCMH; (iv) emergency room visits for the same diagnosis; (v) diagnostic tests; (vi) in-home services; and (vii) wellness and community health.

9) **Section 4.12.3.1 of the Contract is amended and restated to read as follows:**

4.12.3.1 HSD shall retain the services of an EQRO in accordance with 42 CFR 438.354. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR's compliance with HSD's managed care regulations and quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

10) **Section 4.12.4.10 of the Contract is amended and restated to read as follows:**

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Long Term Care Services, one (1) on services to children,



and PIPs as required by the Adult Medicaid Quality Grant. PIP work plans and activities must be consistent with PIPs as required by the Adult Medicaid Quality Grant, federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>;

11) **Section 4.17.1.1 of the Contract is amended and restated to read as follows:**

4.17.1.1 The CONTRACTOR, Major Subcontractors and Contract Providers shall have a comprehensive internal Fraud, Waste and Abuse program.

12) **Section 4.17.1.7 of the Contract is amended and restated to read as follows:**

4.17.1.7 The CONTRACTOR, Major Subcontractors and Contract Providers shall comply with all program integrity provisions of the PPACA including:

4.17.1.7.1 Enhanced provider screening and enrollment, section 6401;

4.17.1.7.2 Termination of provider participation, section 6501; and

4.17.1.7.3 Provider disclosure of current or previous affiliation with excluded provider(s), section 6401.

4.17.1.7.4 The requirements set forth in Section 4.17.1.7 shall be included in the CONTRACTOR's contracts with such Major Subcontractors and Contract Providers no later than the time of such contracts' respective renewals.

13) **Section 4.17.1.10 of the Contract is amended and restated to read as follows:**

4.17.1.10 The CONTRACTOR shall make every reasonable effort to detect, recoup and prevent Overpayments made to Contract Providers in accordance with federal and State law and regulations. The CONTRACTOR shall report Claims identified for Overpayment recoupment to HSD at a regularly scheduled interval and in a format agreed to by HSD and the CONTRACTOR and reflected on the CONTRACTOR's Encounter Data. HSD may require an HSD-contracted Recovery Audit Contractor to review paid Claims that are over three hundred sixty (360) Calendar Days old and pursue Overpayments for those Claims that do not indicate recovery amounts in the CONTRACTOR's Encounter Data.



14) **Section 4.17.2.3 of the Contract is amended and restated to read as follows:**

4.17.2.3 The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD as follows within the timeframes required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and/or Abuse in the administration of Centennial Care shall be reported to HSD. It shall be HSD's responsibility to report verified cases to MFEAD;

4.17.2.3.2 All confirmed, credible or suspected provider Fraud, Waste and/or Abuse shall be immediately reported to HSD and shall include the information provided in 42 CFR § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD; and

4.17.2.3.3 All confirmed or suspected Member Fraud, Waste and/or Abuse shall be reported to HSD.

15) **Section 4.17.2.4 of the Contract is amended and restated to read as follows:**

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) make an initial report to HSD of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HSD with monthly updates. HSD may, at its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter timeframe. In addition, unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud, Waste and/or Abuse or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

16) **Section 4.17.2.5 of the Contract is amended and restated to read as follows:**

4.17.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency for matters where the CONTRACTOR has determined that only an Overpayment exists.

17) **Section 4.17.3.2.3 of the Contract is amended and restated to read as follows:**

4.17.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and State statutes and regulations related to Medicaid program integrity and Fraud/Abuse/Waste and on identifying and educating targeted Contract Providers with patterns of incorrect billing practices and/or Overpayments;

18) **Section 4.17.4 of the Contract is amended and restated to read as follows:**

4.17.4 Recoveries of Overpayments and/or Fraud

4.17.4.1 Identification Process for Overpayments

4.17.4.1.1 The CONTRACTOR shall report to HSD all instances where the CONTRACTOR has notified a provider of a potential Overpayment, including the date of such notification, the stated reasons and the potential Overpayment amount. HSD may, at its sole discretion, require monthly updates as to the status of any reported potential Overpayment.

4.17.4.1.2 Providers are required to report identified Overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an Overpayment if the provider has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference that an Overpayment exists.

4.17.4.2 Self-Reporting

4.17.4.2.1 For all identified Overpayments and within the timeframes specified in 4.17.4.1.1, the provider shall send an "Overpayment Report" to the CONTRACTOR and HSD which shall include, at a minimum, (i) provider's name; (ii) provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid claim control number, as appropriate; (viii) description of a corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the Overpayment; (xi) if a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to

determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

#### 4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for Overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an Overpayment existed; or

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund, such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

#### 4.17.4.4 Failure To Self-Report And/Or Refund Overpayments

4.17.4.4.1 The CONTRACTOR shall inform all providers that all Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day timeframe may be considered false claims and may be subject to referrals as credible allegations of fraud and subject to Section 4.17.2.3.1 of this Contract.

19) **Section 4.18.1 of the Contract is amended and restated to read as follows:**

4.18.1 The CONTRACTOR shall at all times be in compliance with the net worth requirements under applicable insurance laws.

20) **Section 4.18.2.1 of the Contract is amended and restated to read as follows:**

- 4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in State of New Mexico in accordance with section 1903(m)(1) of the Social Security Act (amended by section 4706 of the Balanced Budget Act of 1997), and applicable state insurance laws. The CONTRACTOR shall deposit, in the form of cash or securities or investments consistent with applicable state insurance laws, an amount equal to ninety percent (90%) of the total capitation payment paid to the CONTRACTOR in the first month of the Contract Year as determined by HSD. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.
- 4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR's Centennial Care program.
  - 4.18.2.1.2. The CONTRACTOR must satisfy this requirement no later than sixty (60) Calendar Days after notification by HSD of the deposit amount required.
  - 4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.
  - 4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.
  - 4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.
  - 4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.
    - 4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to withdrawal of funds from this account as outlined in Section 4.18.2.1.6.

4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The CONTRACTOR shall deposit the assets with any organization or trustee acceptable through which a custodial or controlled account is utilized.

21) **Section 4.18.2.2 of the Contract is amended and restated to read as follows:**

4.18.2.2 In the event that a determination is made by HSD that the CONTRACTOR is insolvent under applicable state insurance law, HSD may draw upon the amount. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

22) **Section 4.18.2.4 of the Contract is amended and restated to read as follows:**

4.18.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, overpayments made to the CONTRACTOR, and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to health care providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other claims subject to applicable state insurance law.

23) **Section 4.18.2.5 of the Contract is amended and restated to read as follows:**

4.18.2.5 HSD shall adjust this reserve requirement quarterly, as needed. The reserve account may be accessed solely for payment for Covered Services to the CONTRACTOR's Members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with applicable state insurance regulations and guidelines.



24) **Section 4.18.4 of the Contract is amended and restated to read as follows:**

4.18.4 Surplus Requirement

The CONTRACTOR shall maintain at all times in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the CONTRACTOR's domiciliary state regulator, and restricted funds of deposits controlled by HSD (including the CONTRACTOR's insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars (\$1,500,000), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the CONTRACTOR's prepaid revenues. In the event that the CONTRACTOR's surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

25) **Section 4.18.7.1 of the Contract is amended and restated as follows:**

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond in the amount of at least one million dollars (\$1,000,000).

26) **Section 4.18.10.1.1 of the Contract is amended and restated as follows:**

4.18.10.1.1 Comply with and be subject to all applicable state and federal statutes and regulations including those regarding solvency and risk standards. In addition, the CONTRACTOR shall meet specific Medicaid financial requirements and to present to HSD any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time from the date of the request or as specified herein.

27) **Section 4.18.11.1.1 of the Contract is amended and restated to read as follows:**

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1.1 through 4.18.11.1.1.5 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1.1 Cash Deposits;

4.18.11.1.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit



Insurance Corporation (FDIC) or equivalent  
federally insured deposit;

4.18.11.1.1.3 Surety Bond issued by a surety or  
insurance company licensed to do business in  
New Mexico;

4.18.11.1.1.4 Certificate of Deposit; and

4.18.11.1.1.5 Investment account with financial  
institute licensed to do business in the State  
of New Mexico.

28) **Section 4.18.11.4 of the Contract is amended and restated to read as follows:**

4.18.11.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in a material default of or failing to materially perform the activities outlined in this Agreement or if HSD determines the CONTRACTOR insolvent as outlined under the applicable state insurance law.

29) **Section 4.18.11.6 of the Contract is amended and restated to read as follows:**

4.18.11.6 The CONTRACTOR shall purchase the performance bond within forty five (45) Calendar Days of receipt of the first month of capitation from HSD.

30) **Section 4.18.11.10 of the Contract is amended and restated to read as follows:**

4.18.11.10 The CONTRACTOR shall hold the performance bond with any organization or trustee acceptable through which a custodial or controlled account is utilized.

31) **Section 4.18.12.3 of the Contract is amended and restated to read as follows:**

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the applicable state insurance regulator for approval. The CONTRACTOR

must submit the pricing details of the reinsurance agreement including the covered period to HSD for approval.

32) **Section 4.18.13.1.4.4 of the Contract is amended and restated to read as follows:**

4.18.13.1.4.4 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR's provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the claim; and may permit payments to be made in accordance with state regulations;

33) **Section 4.18.13.10 of the Contract is amended and restated to read as follows:**

4.18.13.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.18.13, third-party resources shall not include subrogation resources; provided, however, the CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the Claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for purposes of reporting.

34) **Section 4.18.16.2 of the Contract is amended and restated to read as follows:**

4.18.16.2 The CONTRACTOR shall submit third party liability recoveries including Medicare payment information on a date of services basis in accordance with Section 4.21.12.1 of this Agreement.

35) **Section 4.21.1.6 of the Contract is amended and restated to read as follows:**

4.21.1.6 HSD's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the Agreement. A list of required reports is provided in Attachment 4.

4.21.1.6.1 The CONTRACTOR shall comply with all changes specified in writing by HSD, after HSD has discussed such changes with the CONTRACTOR.

HSD shall notify the CONTRACTOR, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. The CONTRACTOR shall be held harmless on the first submission of the revised report if HSD fails to meet this requirement for any changes for existing reports. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report revised by HSD to include a change in data requirements or definition will not be subject to penalty for accuracy.

4.21.1.6.2 HSD shall notify the CONTRACTOR, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.

36) **Section 6 of the Contract is amended to add the following new section 6.12 to read as follows:**

6.12 Retroactive Period Reconciliation

6.12.1 The CONTRACTOR is required to reimburse providers for the medical expenses incurred by the Member in the Retroactive Period. The duration and expenditures associated with the Retroactive Period may fluctuate for each Member and are not considered in the prospective capitation payment rate development.

6.12.2 HSD shall reconcile the difference between the medical expenses incurred by the CONTRACTOR during the Retroactive Period and the payment made by HSD to the CONTRACTOR for the Retroactive Period that may occur due to the enrollment process outlined in Section 4.2.8.2.

6.12.3 The reconciliation process for the Retroactive Period is outlined in Attachment 9.

37) **Section 7.2.9 of the Contract is amended and restated to read as follows:**

7.2.9 Care Coordination Expenses

7.2.9.1 The CONTRACTOR shall provide care coordination services in accordance with Section 4.4 of this Agreement.

7.2.9.2 For purposes of this Agreement, the following care coordination functions will be deemed medical services:

7.2.9.2.1 Comprehensive needs assessment;

7.2.9.2.2 Face-to-face meetings between the care coordinator and the Member;

- 7.2.9.2.3 Telephonic meetings between the care coordinator and the Member;
- 7.2.9.2.4 Case management;
- 7.2.9.2.5 Discharge consultation;
- 7.2.9.2.6 CCP development and updates;
- 7.2.9.2.7 Health education provided to the Member;
- 7.2.9.2.8 Disease management provided to the Member; and
- 7.2.9.2.9 Costs associated with Community Health Workers.

7.2.9.3 The CONTRACTOR shall submit Member care coordination activities through Encounter Data.

7.2.9.4 For purposes of this Agreement, the following care coordination functions will be deemed administrative services:

- 7.2.9.4.1 Health risk assessments (HRAs);
- 7.2.9.4.2 Data runs;
- 7.2.9.4.3 Referrals; and
- 7.2.9.4.4 Case assignment and scheduling.

38) **Section 7.3 of the Contract is amended and restated to read as follows:**

**7.3 Failure to Meet Agreement Requirements**

**7.3.1 General**

7.3.1.1 In the event that the CONTRACTOR or any person with an ownership interest in the CONTRACTOR, affiliate, parent or subcontractor, fails to comply with this Agreement, HSD may impose, at HSD's discretion sanctions (inclusive of the specific monetary penalties and other penalties described in this Section 7.3.

7.3.1.2 Sanctions paid by the CONTRACTOR pursuant to this Section 7.3 shall be included as administrative expenses subject to Section 7.2.8 of this Agreement.

7.3.1.3 HSD retains the right to apply progressively strict sanctions CONTRACTOR against the CONTRACTOR, for failure to perform in any of the Agreement areas.

- 7.3.1.4 Any sanction, including the withholding of capitation payments, does not constitute just cause for the CONTRACTOR to interrupt providing Covered Services to Members.
- 7.3.1.5 HSD may impose any other administrative, contractual or legal remedies available under federal or State law for the CONTRACTOR's noncompliance under this Agreement.
- 7.3.1.6 HSD will give the Collaborative written notice whenever it imposes or lifts a sanction for one of the violations listed herein that relates to Behavioral Health.
- 7.3.1.7 HSD will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed herein. The notice will be given no later than thirty (30) Calendar Days after HSD imposes or lifts a sanction and must specify the affected CONTRACTOR, the kind of sanction and the reason for HSD's decision to impose or lift the sanction.
- 7.3.2 Corrective Action Plans
- 7.3.2.1 If HSD determines that the CONTRACTOR is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that sanctions are also necessary.
- 7.3.2.2 The CONTRACTOR may dispute a notice of noncompliance in accordance with Section 7.11 of this Agreement.
- 7.3.2.3 The CONTRACTOR shall be required to provide CAPs to HSD within fourteen (14) Calendar Days of receipt of a noncompliance notice from HSD. CAPs are subject to review and approval by HSD.
- 7.3.2.4 If HSD imposes a DCAP on the CONTRACTOR, the CONTRACTOR will have fourteen (14) Calendar Days to respond to HSD.
- 7.3.2.5 If the CONTRACTOR does not effectively implement the CAP/DCAP within the timeframe specified in the CAP/DCAP, HSD may impose additional sanctions.
- 7.3.2.6 If HSD staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party either designated by HSD or approved by HSD to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

7.3.3 Sanctions



7.3.3.1 HSD may impose any or all of the non-monetary sanctions and monetary penalties as described in this Section to the extent authorized by federal and State law.

7.3.3.2 Non-monetary intermediate sanctions may include:

7.3.3.2.1 Suspension of auto-assignment of Members who have not selected an MCO;

7.3.3.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

7.3.3.2.3 Notification to Members of their right to terminate enrollment with the CONTRACTOR's MCO without cause as described in 42 C.F.R. § 438.702(a)(3);

7.3.3.2.4 Disenrollment of Members by HSD;

7.3.3.2.5 Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

7.3.3.2.6 Rescission of Marketing consent and suspension of the CONTRACTOR's Marketing efforts;

7.3.3.2.7 Appointment of temporary management or any portion thereof for an MCO as provided in 42 C.F.R. § 438.706 and the CONTRACTOR shall pay for any costs associated with the imposition of temporary management; and

7.3.3.2.8 Additional sanctions permitted under federal or State statute or regulations that address areas of noncompliance.

7.3.3.3 Monetary penalties may include:

7.3.3.3.1 Actual damages incurred by HSD and/or Members resulting from the CONTRACTOR's non-performance of obligations under this Agreement;

7.3.3.3.2 Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the CONTRACTOR's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the CONTRACTOR and the rates paid to the replacement health plan. HSD may withhold payment to the CONTRACTOR for damages until such damages are paid in full;

7.3.3.3.3 Civil monetary penalties as described in 42 C.F.R. § 438.704;

7.3.3.3.4 Monetary penalties up to five percent (5%) of the CONTRACTOR's Medicaid capitation payment for each month in which the penalty is assessed;



7.3.3.3.5 Other monetary penalties for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below.

7.3.3.4 HSD reserves the right to assess a general monetary penalty of five hundred dollars (\$500) per occurrence with any notice of deficiency.

7.3.4 Other Monetary Penalties

	<b>PROGRAM ISSUES</b>	<b>PENALTY</b>
1.	Failure to comply with Claims processing as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement
2.	Failure to comply with Encounter submission as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement.
3.	Failure to comply with the timeframes for a comprehensive care assessment and developing and approving a CCP for care coordination level 2 and level 3	<p>\$10,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 75-94% of members for the reporting period.</p> <p>\$25,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% of less of Members for the reporting period.</p>

4.	Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
5.	Failure to obtain approval of Member Materials as required by Section 4.14.1 of this Agreement	\$5,000 per day for each Calendar Day that HSD determines the CONTRACTOR has provided Member Material that has not been approved by HSD. The \$5,000 per day damage amounts will double every ten (10) days.
6.	Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of this Agreement	<p>\$10,000 per occurrence where the CONTRACTOR fails to comply with the timeframes but is in compliance with the timeframes for 75-94% of Grievances and Appeals for the reporting period.</p> <p>\$25,000 per occurrence where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% or less of Grievances and Appeals for the reporting period.</p>
7.	Failure to submit timely reports in accordance with Section 4.21 of this Agreement	\$1,000 per report, per Calendar Day. The \$1,000 per day damage amounts will double every ten (10) Calendar days.
8.	Failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with Section 4.21 of this Agreement	\$5,000 per report, per occurrence.
9.	Failure to submit timely Summary of Evidence in accordance with Section 4.16 of this Agreement	\$1,000 per occurrence.
10.	Failure to have legal counsel	\$10,000 per occurrence.

	appear in accordance with Section 4.16 of this Agreement	
<b>11.</b>	Failure to meet HEDIS targets for the performance measures described in Section 4.12.8 of this Agreement	A monetary penalty based on 2% of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year.

\*HSD can modify any monetary penalty if the CONTRACTOR engages in a pattern of behavior which constitutes a violation of this Agreement and involves a significant risk of harm to Members or to the integrity of Centennial Care.

**7.3.5 Payment of Monetary Penalties**

7.3.5.1 HSD shall provide the CONTRACTOR with notice of any monetary penalties assessed at least thirty (30) Calendar Days before deducting such amounts from the monthly capitation payment. The collection of monetary penalties by HSD shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by HSD will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the monetary penalties described in this Section.

7.3.5.2 Monetary penalties as described in Section 7.3.5 of this Agreement shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

**7.3.6 Waiver of Sanctions**

HSD may waive the application of sanctions (including monetary penalties) at its discretion if HSD determines that such waiver is in the best interests of the Centennial Care program and its Members.

**7.3.7 Federal Sanctions**

Payments provided for under this Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

39) **Section 7.27.11 of the Contract is amended and restated to read as follows:**

7.27.11 Referrals for Credible Allegations of Fraud

7.27.11.1 The CONTRACTOR shall report to HSD suspected cases of Fraud whenever there are credible allegations of Fraud. The CONTRACTOR shall follow HSD's direction in identifying and reporting cases of credible allegations of Fraud. HSD shall make the final determination of whether to refer such cases to MFEAD, and other law enforcement agencies, for further investigation. HSD's directions to the CONTRACTOR may include, but is not limited to:

7.27.11.1.1 At HSD's direction, the CONTRACTOR shall suspend all Medicaid payments, in whole or in part as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD's notice, the CONTRACTOR (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pending Claims, or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD's notice.

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law.

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD.

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider;

7.27.11.1.4.2 The dismissal of all charges and/or claims against the provider related to the provider's alleged fraud by a court of competent jurisdiction; or

7.27.11.1.4.3 For other good cause as determined solely by HSD.

7.27.11.1.5 HSD shall document in writing the termination of a payment suspension and shall provide such documentation to the CONTRACTOR.

7.27.11.2 Should HSD require the CONTRACTOR's assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review, and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

40) **Section 7.46.2 of the Contract is amended and restated as follows:**

7.46.2 All notices required to be given to the State under this Agreement shall be sent to the following, or his or her designee:

Julie Weinberg, Director  
Medical Assistance Division  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348

Or

Christopher Collins, General Counsel  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, NM 87504-2348

41) **Attachment 6 to the Contract is amended and restated to read as follows:**



**Attachment 6: Alternative Benefit Plan Covered Services**

<b>Alternative Benefit Plan Services Included Under Centennial Care</b>
Allergy testing and injections
Annual physical exam and consultation
Assertive Community Treatment (ACT)
Autism spectrum disorder <sup>1</sup>
Bariatric surgery <sup>2</sup>
Behavioral health professional services: outpatient behavioral health <sup>3</sup> and substance abuse services <sup>4</sup>
Cancer clinical trials <sup>5</sup>
Cardiovascular rehabilitation <sup>6</sup>
Chemotherapy and radiation therapy
Dental services <sup>7</sup>
Diabetes treatment, including diabetic shoes and related medical supplies
Dialysis
Disease management
Durable medical equipment
Educational materials and counseling for a healthy lifestyle
Electroconvulsive Therapy (ECT)
Emergency services (including emergency room visits and psychiatric ER)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals age 19 and 20
Eye exams and treatment related to treatment and testing of eye diseases only <sup>8</sup>
Family planning, sterilization, pregnancy termination, contraceptives <sup>9</sup>
Glasses and contact lenses: covered only for aphakia (following removal of the lens) <sup>10</sup>
Hearing testing or screening as part of a routine health exam <sup>11</sup>

<sup>1</sup> Covers speech, occupational and physical therapy, and applied behavioral analysis for Members age 19-20; and Members age 21-22 who are enrolled in high school.

<sup>2</sup> Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

<sup>3</sup> Includes evaluation, testing, assessment, medication management, therapy and Intensive Outpatient Program (IOP) services.

<sup>4</sup> Includes outpatient detoxification, therapy, partial hospitalization and IOP services.

<sup>5</sup> Covers routine patient costs associated with Phase I, II, III and IV cancer clinical trials.

<sup>6</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per cardiac event. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>7</sup> ABP dental services are equivalent to the adult dental benefit package for traditional Medicaid categories.

Increased periodicity schedule and medically necessary orthodontia covered for Members age 19-20.

<sup>8</sup> Refraction is not covered. Routine vision care is not covered.

<sup>9</sup> Sterilization reversal is not covered.

<sup>10</sup> Coverage of materials is limited to \$300 per surgery. Contact lenses or eyeglasses obtained more than 90 days following surgery are not covered.

<sup>11</sup> Hearing aids not covered. Hearing testing by an audiologist or hearing aid dealer is not covered.



Home health services <sup>12</sup>
Hospice services, including hospice at home or in a nursing facility
Hospital inpatient <sup>13</sup>
Hospital outpatient
Immunizations
Inhalation therapy
Inpatient rehabilitation <sup>14</sup>
IV infusions
Laboratory genetic testing to specific molecular lab tests such as BRCA1 and BRCA2 and similar tests used to determine appropriate treatment <sup>15</sup>
Laboratory services, including diagnostic testing and other age appropriate tests
Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests
Medical supplies: diabetic and contraceptive supplies only <sup>16</sup>
Medication assisted therapy for opioid dependence
Nutritional counseling
Obstetric/gynecological care, prenatal care, deliveries, midwives
Orthotics <sup>17</sup>
Physician visits
Podiatry services <sup>18</sup>
Prescription drug items <sup>19</sup>
Preventive care <sup>20</sup>
Primary care to treat illness/injury
Prosthetics
Psychosocial Rehabilitation (PSR)

<sup>12</sup> Limited to 100 visits per year. A visit cannot exceed four hours.

<sup>13</sup> Free-standing psychiatric hospitals are only covered for Members age 19-20 and are not a covered service for ABP or ABP-exempt, except for Members under age 21 except as an "in lieu of service." Psychiatric units within an acute care hospital are covered under the ABP. Inpatient drug rehabilitation services are not covered. Acute inpatient services for detoxification are covered.

<sup>14</sup> Covers inpatient services at a skilled nursing or acute rehabilitation facility when provided as a step-down level of care following discharge from the hospital prior to discharge to home. Extended care or long-term care hospitals are not covered.

<sup>15</sup> Not including random genetic screening.

<sup>16</sup> Medical supplies used on an inpatient basis, applied as part of treatment in a practitioner's office, outpatient hospital, residential facility, or home health service, are covered when separate payment is allowed in these settings.

<sup>17</sup> Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace or diabetic shoes.

<sup>18</sup> Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

<sup>19</sup> Over-the-counter drug items are not covered, except for prenatal drug items, low-dose aspirin as preventive for cardiac conditions, contraceptive drugs and devices, and items for treating diabetes. The contractor may choose to cover any over-the-counter product when it is less expensive than the therapeutically equivalent drug that would require a prescription (a 'legend' drug).

<sup>20</sup> ABP preventive services include the A&B recommendations of the United States Preventive Services Task Force (USPSTF)

Pulmonary rehabilitation <sup>21</sup>
Radiology, including diagnostic imaging and radiation therapy, mammography and other age appropriate imaging
Reconstructive surgery <sup>22</sup>
Rehabilitation and habilitation: physical therapy, occupational therapy and speech and language pathology <sup>23</sup>
Rehabilitation inpatient hospitalization: step-down lower level of care from an acute care hospital for not more than 14 days
Reproductive health services (not including fertility treatment)
Skilled nursing
Specialist visits
Telemedicine
Tobacco cessation counseling
Transplant services <sup>24</sup>
Transportation services (emergency and non-emergency medical), including air and ground ambulance, taxi and handivan <sup>25</sup>
Urgent care services

42) **Attachment 8 is added to the Contract to read as follows:**

**Attachment 8: Providers with Distance Requirements**

**A. Behavioral Health**

1. Freestanding Psychiatric Hospitals
2. General Hospitals with psychiatric units
3. Partial Hospital Programs
4. Accredited Residential Treatment Centers (ARTC)
5. Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)

<sup>21</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered..

<sup>22</sup> Covers reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders that result from accidental injury, congenital defects or disease.

<sup>23</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>24</sup> Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants. Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs. Limited to two organ/tissue transplants per lifetime. Outpatient immunosuppressive drugs do not apply toward the transplant benefit limit.

<sup>25</sup> Covers expenses for transportation, meals and lodging that are determined necessary to secure medical or Behavioral Health services for an ABP Member.

6. Treatment Foster Care I & II (TFC I & II)
7. Core Service Agencies (CSA)
8. Community Mental Health Centers (CMHC)
9. Indian Health Service and Tribal 638s providing Behavioral Health services
10. Outpatient Provider Agencies
11. Agencies providing Behavioral Management Services (BMS)
12. Agencies providing Day Treatment Services
13. Agencies providing Assertive Community Treatment (ACT)
14. Agencies providing Multi-Systematic Therapy (MST)
15. Agencies providing intensive Outpatient Services
16. Methadone Clinics
17. FQHCs providing Behavioral Health services
18. Rural Health Clinics providing Behavioral Health services
19. Psychiatrists
20. Psychologists (including prescribing psychologists)
21. Suboxone certified MDs
22. All other licensed Independent Behavioral Health practitioners (LISW, LPCC, LMFT, CNS & CNP with psychiatric certification, independent practices or groups)

#### **B. Physical Health**

1. Cardiology
2. Certified Nurse Practitioner
3. Certified Midwives
4. Dermatology
5. Dental
6. Endocrinology
7. ENT
8. FQHC
9. RHC
10. Hem/Oncology
11. I/T/U
12. Neurology
13. Neurosurgeon
14. OB-GYN
15. Orthopedics
16. Pediatrics
17. Physician Assistant
18. Podiatry
19. Rheumatology
20. Surgeons
21. Urology

#### **C. Long Term Care**

1. Assisted Living Facilities

2. Personal Care Service Agencies (PCS) – delegated
3. Personal Care Service Agencies (PCS) – directed
4. Nursing Facilities

**D. Hospitals**

1. General Hospitals
2. Inpatient Psychiatric Hospitals

**E. Transportation**

- 43) **Attachment 9 is added to the Contract to read as follows:**

**Attachment 9: Retroactive Period Reconciliation**

1. HSD shall reconcile the medical expenditures related to the Retroactive Period for each Contract year period (January 1 to December 31 of each Contract year). The Retroactive Period may exist for some Members whose effective date of Medicaid eligibility is determined prior to HSDs notification date to the CONTRACTOR outlined in Section 4.2.8.
2. The reconciliation for the Retroactive Period is limited to the medical expenses only.
3. For purposes of this Attachment, “medical expense” is defined as the expenditures for Covered Services in Attachment 2. Value added services and administrative expenditures will not be countable expenses in the calculation of the reconciliation.
4. HSD will permit the CONTRACTOR to retain 5.263 percent of the total medical expense for administrative costs.
5. HSD shall adjust the final reconciliation for applicable premium tax depending on the outcome of the reconciliation.
6. HSD will utilize encounter data received and accepted by HSD as the source for the measurement of the reconciliation on a cohort basis limited to Members who are in the Retroactive Period and eligible according to HSD’s eligibility system in the month they incurred medical expenses.
7. HSD shall conduct the final reconciliation for the contract year period no sooner than eight (8) months after the end of the calendar year or contract period.
  - a. During the calendar year or contract period, HSD at its discretion, may perform interim reconciliations and may recoup from or make payment to the CONTRACTOR. HSD shall determine the pro-rated percentage to recoup or pay.

- b. Interim recoupment or payment will be factored into the final reconciliation.
- 8. Actual medical cost plus the administrative allowance and premium tax will be compared to the payment made by HSD to the CONTRACTOR for the Retroactive Period to determine the value of recoupment from or payment to the CONTRACTOR.
- 9. HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.
- 44) **Attachment 10 is added to the Contract to read as follows:**

**Attachment 10: List of Psychotropic Drugs and Medications**



**GENERAL DESCRIPTION**  
**THERAPEUTIC CLASS**  
 (MCOs must use their PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY comparable therapeutic classes)  
 (brand names begin with a capital letter)

**Anti-Anxiety Medications and Antidepressants (non-benzodiazepines)**  
 H2F, H2G, H2J, H2S, H2U, H7B, H7C, H7D, H7E, H7F, H2O, H7P, H7R, H7S, H7T, H7U, H7X, H7O, H7Z

Abilify	desvenlafaxine	Latuda	Pamelor	Symbyax
amitriptyline	Desyrel	Lexapro	paroxetine	thiothixene
amoxapine	doxepin	loxapine	Paxil	Tofranil
Anafranil	duloxetine	Loxitane	Pexeva	trazodone
Aripiprazole	Effexor	Ludiomil	pimozide	trimipramine
Asendin	Elavil	lurasidone	Pristiq	venlafaxine
Aventyl	escitalopram	Luvox	protriptyline	Vivactil
bupropion	Fanapt	maprotiline	Prozac	Wellbutrin
BuSpar	fluoxetine	mirtazapine	quetiapine	ziprasidone
buspirone	fluoxetine & olanzapine	Moban	Remeron	Zoloft
Celexa (SSRI)	fluvoxamine	molindone	resperidone	Zyprexa



citalopram	Geodon	Navane	Risperdal
clomipramine	Haldol	Norpramin	Sarafem
clozapine	Haloperidol	nortriptyline	Seroquel
Clozaril	iloperidone	olanzapione	sertraline
Cymbalta	imipramine	Orap	Sinequan
desipramine	Invega	Paliperidone	Surmontil

**Anti-Mania Medications (Mood Stabilizers) H2M**

Eskalith	lithium carbonate	lithium citrate	Lithobid
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**Mood Anticonvulsants Stabilizing H4B**

clonazepam	divalproex sodium	lomotrigine	oxcarbazepine	topiramate
carbamazepine	Klonopin	gabapentin	Tegretol	Trileptal
Depakote	Lamictal	Neurontin	Topamax	valproic acid

**Monoamine Oxidase Inhibitors H2H, H2J, H7J**

Emsam	Marplan	Parnate	selegiline
isocarboxazid	Nardil	phenelzine	tranylcypromine

**Phenothiazines and other H2G  
major tranquilizers and  
antipsychotics**

chlorpromazine	perphenazine	thioridazine	trifluoperazine
fluphenazine	Stelazine	Thorazine	Trilafon

**The remainder of this page is intentionally left blank.**

**All other sections of PSC [13-630-8000-0022], as amended, remain the same.**

**IN WITNESS WHEREOF**, the parties have executed this amended and restated contract as of the date of signature by the Human Services Department.

**CONTRACTOR**

By: [Signature] Date: 6/27/14  
Title: CFO - Making Healthcare of NM

**STATE OF NEW MEXICO**

By: [Signature] Date: 10/9/14  
Sidonie Squier, Cabinet Secretary  
Human Services Department

By: [Signature] Date: 10/1/14  
Danny Sandoval, CFO  
Human Services Department

**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

By: [Signature] Date: 10/7/14

Title: Cabinet Secretary

CERTIFIED FOR LEGAL SUFFICIENCY:  
[Signature] 10/7/14  
Department of Health  
Assistant General Counsel

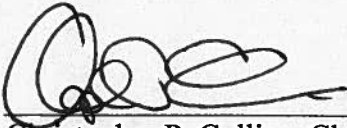
By: [Signature] Date: 10-20-14

Title: Deputy Cabinet Secretary, CYFD

By: [Signature] Date: 10/23/14

Title: Secy, HSD

**Approved as to Form and Legal Sufficiency:**

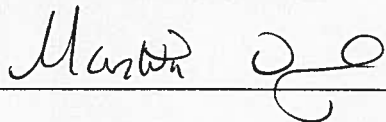
By:   
\_\_\_\_\_  
Christopher P. Collins, Chief Legal Counsel  
Human Services Department

Date: 9/30/14

The records of the Taxation and Revenue Department reflect that the CONTRACTOR is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

**TAXATION AND REVENUE DEPARTMENT**

**ID Number: 02-215219-00-9**

By:   
\_\_\_\_\_

Date: 10/28/14

Title: \_\_\_\_\_

**STATE OF NEW MEXICO**



**HUMAN  
SERVICES**  
DEPARTMENT  
MEDICAL ASSISTANCE DIVISION

**Amended and Restated Medicaid Managed Care Agreement**

**among**

**New Mexico Human Services Department,**

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**Presbyterian Health Plan, Inc.**



**PSC: 13-630-8000-0023-A2**



**STATE OF NEW MEXICO  
HUMAN SERVICES DEPARTMENT  
MEDICAID MANAGED CARE SERVICES AGREEMENT  
FOR CENTENNIAL CARE**

**AMENDMENT NO. [2]**

This Amendment No. 2 to PSC: 13-630-8000-0023 is made and entered into by and between the New Mexico Human Services Department (“HSD”), the New Mexico Behavioral Health Purchasing Collaborative (the “Collaborative”) and Presbyterian Health Plan, Inc. (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

**WHEREAS**, the Centers for Medicare & Medicaid Services have requested certain revisions to the Contract;

**WHEREAS**, there are certain clarifications and revisions to the Contract that are necessary;

**IT IS MUTUALLY AGREED BY THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE REFERENCED CONTRACT ARE AMENDED AND RESTATED AS FOLLOWS:**

- 1) **Section 2 of the Contract is amended by amending and adding the following definitions:**

**Major Subcontractor** means an entity with which the CONTRACTOR has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the Covered Services; provided that a Major Subcontractor does not include a provider or a Contract Provider.

**Overpayment** means any funds that a person or entity receives in excess of the Medicaid allowable amount of the CONTRACTOR’s allowed amount as negotiated with the provider. Overpayments shall not include funds that have been (i) subject to a payment suspension; (ii) identified as a third-party liability as set forth in Section 4.18.13; (iii) subject to the CONTRACTOR’s system-directed mass adjustments, such as due to fee schedule changes; or (iv) for purposes of filing an “Overpayment Report” as required in Section 4.17.4.2.1, less than fifty dollars (\$50.00) or those funds recoverable through existing routine and customary adjustments using HIPAA complaint formats;

**Psychotropic Drug** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.



**Psychotropic Medication** means the therapeutic classes of drugs and the medications listed in Attachment 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

**Retroactive Period** means the time between the notification date by HSD to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date. The Retroactive Period addresses those instances when the Member is enrolled with the CONTRACTOR but the eligibility date is effective before the CONTRACTOR is notified of enrollment.

**Waste** means the overutilization of services or other practices that result in unnecessary costs.

2) **Section 4.4.2.7 of the Contract is amended and restated to read as follows:**

4.4.2.7 The CONTRACTOR shall make reasonable efforts to contact Members to conduct an HRA and provide information about care coordination. The CONTRACTOR shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member (if a phone number is available). The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about care coordination and how to obtain an HRA. The process outlined in this section shall constitute sufficient effort by the CONTRACTOR to assist a Member.

3) **Section 4.4.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.1 The CONTRACTOR shall perform an in-person comprehensive needs assessment on all Members identified for care coordination level 2 or level 3—at the Member's primary residence. The visit may occur in another location only with HSD approval. For members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

4) **Section 4.5.12.1 of the Contract is amended and restated to read as follows:**

4.5.12.1 The CONTRACTOR shall impose the maximal nominal copayment established by HSD in accordance with federal regulations on any prescription filled for a Member with a brand name drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to brand name drugs that are classified as Psychotropic Drugs for the treatment of Behavioral Health conditions. The CONTRACTOR shall

develop a copayment exception process to be prior approved by HSD for other brand name drugs where such drugs are not tolerated by the Member.

5) **Section 4.8.6.1.4 of the Contract is amended and restated to read as follows:**

4.8.6.1.4 The Member must have fifteen (15) Calendar Days of enrollment to select a PCP. If a Member does not select a PCP within fifteen (15) Calendar Days of enrollment, the CONTRACTOR shall make the assignment and notify the Member in writing of his or her PCP's name, location, and office telephone number, while providing the Member with an opportunity to select a different PCP if the Member is dissatisfied with the assignment; and

6) **Section 4.8.7.4 of the Contract is amended and restated to read as follows:**

4.8.7.4.1 Distance Requirements

4.8.7.4.1 For (i) PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

4.8.7.4.1.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.1.2 Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.

4.8.7.4.1.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.7.4.2 For the providers described in Attachment 8 to the Contract:

4.8.7.4.2.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.

4.8.7.4.2.2 Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

4.8.7.4.2.3 Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of provider is not physically

present in the prescribed radius or unless otherwise exempted as approved by HSD.

7) **Section 4.10.2.10.5 of the Contract is amended and restated to read as follows:**

4.10.2.10.5 The CONTRACTOR shall have an open formulary for all Psychotropic Medications. Open formulary for all Psychotropic Medications means that no prior authorization, fail first, or step therapy requirement shall apply to Psychotropic Medications when the prescriber indicates that a generic or alternative medication does not meet the therapeutic needs of the Member;

8) **Section 4.10.7.5.2 of the Contract is amended and restated to read as follows:**

4.10.7.5.2 The rate to be developed for these projects shall include the following services: (i) initial hospital admission; (ii) any subsequent hospital re-admissions, including emergency room visits, within a thirty (30) Calendar Day period clinically related to the initial discharge; (iii) office visits with the patient's PCMH; (iv) emergency room visits for the same diagnosis; (v) diagnostic tests; (vi) in-home services; and (vii) wellness and community health.

9) **Section 4.12.3.1 of the Contract is amended and restated to read as follows:**

4.12.3.1 HSD shall retain the services of an EQRO in accordance with 42 CFR 438.354. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR's compliance with HSD's managed care regulations and quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

10) **Section 4.12.4.10 of the Contract is amended and restated to read as follows:**

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Long Term Care Services, one (1) on services to children,

and PIPs as required by the Adult Medicaid Quality Grant. PIP work plans and activities must be consistent with PIPs as required by the Adult Medicaid Quality Grant, federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>;

11) **Section 4.17.1.1 of the Contract is amended and restated to read as follows:**

4.17.1.1 The CONTRACTOR, Major Subcontractors and Contract Providers shall have a comprehensive internal Fraud, Waste and Abuse program.

12) **Section 4.17.1.7 of the Contract is amended and restated to read as follows:**

4.17.1.7 The CONTRACTOR, Major Subcontractors and Contract Providers shall comply with all program integrity provisions of the PPACA including:

4.17.1.7.1 Enhanced provider screening and enrollment, section 6401;

4.17.1.7.2 Termination of provider participation, section 6501; and

4.17.1.7.3 Provider disclosure of current or previous affiliation with excluded provider(s), section 6401.

4.17.1.7.4 The requirements set forth in Section 4.17.1.7 shall be included in the CONTRACTOR's contracts with such Major Subcontractors and Contract Providers no later than the time of such contracts' respective renewals.

13) **Section 4.17.1.10 of the Contract is amended and restated to read as follows:**

4.17.1.10 The CONTRACTOR shall make every reasonable effort to detect, recoup and prevent Overpayments made to Contract Providers in accordance with federal and State law and regulations. The CONTRACTOR shall report Claims identified for Overpayment recoupment to HSD at a regularly scheduled interval and in a format agreed to by HSD and the CONTRACTOR and reflected on the CONTRACTOR's Encounter Data. HSD may require an HSD-contracted Recovery Audit Contractor to review paid Claims that are over three hundred sixty (360) Calendar Days old and pursue Overpayments for those Claims that do not indicate recovery amounts in the CONTRACTOR's Encounter Data.

14) **Section 4.17.2.3 of the Contract is amended and restated to read as follows:**

4.17.2.3 The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD as follows within the timeframes required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and/or Abuse in the administration of Centennial Care shall be reported to HSD. It shall be HSD's responsibility to report verified cases to MFEAD;

4.17.2.3.2 All confirmed, credible or suspected provider Fraud, Waste and/or Abuse shall be immediately reported to HSD and shall include the information provided in 42 CFR § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD; and

4.17.2.3.3 All confirmed or suspected Member Fraud, Waste and/or Abuse shall be reported to HSD.

15) **Section 4.17.2.4 of the Contract is amended and restated to read as follows:**

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) make an initial report to HSD of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HSD with monthly updates. HSD may, at its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter timeframe. In addition, unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud, Waste and/or Abuse or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

16) **Section 4.17.2.5 of the Contract is amended and restated to read as follows:**

4.17.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency for matters where the CONTRACTOR has determined that only an Overpayment exists.

17) **Section 4.17.3.2.3 of the Contract is amended and restated to read as follows:**



4.17.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and State statutes and regulations related to Medicaid program integrity and Fraud/Abuse/Waste and on identifying and educating targeted Contract Providers with patterns of incorrect billing practices and/or Overpayments;

18) **Section 4.17.4 of the Contract is amended and restated to read as follows:**

4.17.4 Recoveries of Overpayments and/or Fraud

4.17.4.1 Identification Process for Overpayments

4.17.4.1.1 The CONTRACTOR shall report to HSD all instances where the CONTRACTOR has notified a provider of a potential Overpayment, including the date of such notification, the stated reasons and the potential Overpayment amount. HSD may, at its sole discretion, require monthly updates as to the status of any reported potential Overpayment.

4.17.4.1.2 Providers are required to report identified Overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an Overpayment if the provider has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference that an Overpayment exists.

4.17.4.2 Self-Reporting

4.17.4.2.1 For all identified Overpayments and within the timeframes specified in 4.17.4.1.1, the provider shall send an "Overpayment Report" to the CONTRACTOR and HSD which shall include, at a minimum, (i) provider's name; (ii) provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid claim control number, as appropriate; (viii) description of a corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the Overpayment; (xi) if a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to



determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

#### 4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for Overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an Overpayment existed; or

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund, such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

#### 4.17.4.4 Failure To Self-Report And/Or Refund Overpayments

4.17.4.4.1 The CONTRACTOR shall inform all providers that all Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day timeframe may be considered false claims and may be subject to referrals as credible allegations of fraud and subject to Section 4.17.2.3.1 of this Contract.

19) **Section 4.18.1 of the Contract is amended and restated to read as follows:**

4.18.1 The CONTRACTOR shall at all times be in compliance with the net worth requirements under applicable insurance laws.

20) **Section 4.18.2.1 of the Contract is amended and restated to read as follows:**

- 4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in State of New Mexico in accordance with section 1903(m)(1) of the Social Security Act (amended by section 4706 of the Balanced Budget Act of 1997), and applicable state insurance laws. The CONTRACTOR shall deposit, in the form of cash or securities or investments consistent with applicable state insurance laws, an amount equal to ninety percent (90%) of the total capitation payment paid to the CONTRACTOR in the first month of the Contract Year as determined by HSD. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.
- 4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR's Centennial Care program.
  - 4.18.2.1.2. The CONTRACTOR must satisfy this requirement no later than sixty (60) Calendar Days after notification by HSD of the deposit amount required.
  - 4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.
  - 4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.
  - 4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.
  - 4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.
    - 4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to withdrawal of funds from this account as outlined in Section 4.18.2.1.6.

4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The CONTRACTOR shall deposit the assets with any organization or trustee acceptable through which a custodial or controlled account is utilized.

21) **Section 4.18.2.2 of the Contract is amended and restated to read as follows:**

4.18.2.2 In the event that a determination is made by HSD that the CONTRACTOR is insolvent under applicable state insurance law, HSD may draw upon the amount. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

22) **Section 4.18.2.4 of the Contract is amended and restated to read as follows:**

4.18.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, overpayments made to the CONTRACTOR, and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to health care providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other claims subject to applicable state insurance law.

23) **Section 4.18.2.5 of the Contract is amended and restated to read as follows:**

4.18.2.5 HSD shall adjust this reserve requirement quarterly, as needed. The reserve account may be accessed solely for payment for Covered Services to the CONTRACTOR's Members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with applicable state insurance regulations and guidelines.

24) **Section 4.18.4 of the Contract is amended and restated to read as follows:**

4.18.4 Surplus Requirement

The CONTRACTOR shall maintain at all times in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the CONTRACTOR's domiciliary state regulator, and restricted funds of deposits controlled by HSD (including the CONTRACTOR's insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars (\$1,500,000), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the CONTRACTOR's prepaid revenues. In the event that the CONTRACTOR's surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

25) **Section 4.18.7.1 of the Contract is amended and restated as follows:**

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond in the amount of at least one million dollars (\$1,000,000).

26) **Section 4.18.10.1.1 of the Contract is amended and restated as follows:**

4.18.10.1.1 Comply with and be subject to all applicable state and federal statutes and regulations including those regarding solvency and risk standards. In addition, the CONTRACTOR shall meet specific Medicaid financial requirements and to present to HSD any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time from the date of the request or as specified herein.

27) **Section 4.18.11.1.1 of the Contract is amended and restated to read as follows:**

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1.1 through 4.18.11.1.1.5 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1.1 Cash Deposits;

4.18.11.1.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit

Insurance Corporation (FDIC) or equivalent federally insured deposit;

4.18.11.1.1.3 Surety Bond issued by a surety or insurance company licensed to do business in New Mexico;

4.18.11.1.1.4 Certificate of Deposit; and

4.18.11.1.1.5 Investment account with financial institute licensed to do business in the State of New Mexico.

28) **Section 4.18.11.4 of the Contract is amended and restated to read as follows:**

4.18.11.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in a material default of or failing to materially perform the activities outlined in this Agreement or if HSD determines the CONTRACTOR insolvent as outlined under the applicable state insurance law.

29) **Section 4.18.11.6 of the Contract is amended and restated to read as follows:**

4.18.11.6 The CONTRACTOR shall purchase the performance bond within forty five (45) Calendar Days of receipt of the first month of capitation from HSD.

30) **Section 4.18.11.10 of the Contract is amended and restated to read as follows:**

4.18.11.10 The CONTRACTOR shall hold the performance bond with any organization or trustee acceptable through which a custodial or controlled account is utilized.

31) **Section 4.18.12.3 of the Contract is amended and restated to read as follows:**

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the applicable state insurance regulator for approval. The CONTRACTOR



must submit the pricing details of the reinsurance agreement including the covered period to HSD for approval.

32) **Section 4.18.13.1.4.4 of the Contract is amended and restated to read as follows:**

4.18.13.1.4.4 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR's provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the claim; and may permit payments to be made in accordance with state regulations;

33) **Section 4.18.13.10 of the Contract is amended and restated to read as follows:**

4.18.13.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.18.13, third-party resources shall not include subrogation resources; provided, however, the CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the Claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for purposes of reporting.

34) **Section 4.18.16.2 of the Contract is amended and restated to read as follows:**

4.18.16.2 The CONTRACTOR shall submit third party liability recoveries including Medicare payment information on a date of services basis in accordance with Section 4.21.12.1 of this Agreement.

35) **Section 4.21.1.6 of the Contract is amended and restated to read as follows:**

4.21.1.6 HSD's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the Agreement. A list of required reports is provided in Attachment 4.

4.21.1.6.1 The CONTRACTOR shall comply with all changes specified in writing by HSD, after HSD has discussed such changes with the CONTRACTOR.



HSD shall notify the CONTRACTOR, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. The CONTRACTOR shall be held harmless on the first submission of the revised report if HSD fails to meet this requirement for any changes for existing reports. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report revised by HSD to include a change in data requirements or definition will not be subject to penalty for accuracy.

4.21.1.6.2 HSD shall notify the CONTRACTOR, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.

36) **Section 6 of the Contract is amended to add the following new section 6.12 to read as follows:**

6.12 Retroactive Period Reconciliation

6.12.1 The CONTRACTOR is required to reimburse providers for the medical expenses incurred by the Member in the Retroactive Period. The duration and expenditures associated with the Retroactive Period may fluctuate for each Member and are not considered in the prospective capitation payment rate development.

6.12.2 HSD shall reconcile the difference between the medical expenses incurred by the CONTRACTOR during the Retroactive Period and the payment made by HSD to the CONTRACTOR for the Retroactive Period that may occur due to the enrollment process outlined in Section 4.2.8.2.

6.12.3 The reconciliation process for the Retroactive Period is outlined in Attachment 9.

37) **Section 7.2.9 of the Contract is amended and restated to read as follows:**

7.2.9 Care Coordination Expenses

7.2.9.1 The CONTRACTOR shall provide care coordination services in accordance with Section 4.4 of this Agreement.

7.2.9.2 For purposes of this Agreement, the following care coordination functions will be deemed medical services:

7.2.9.2.1 Comprehensive needs assessment;

7.2.9.2.2 Face-to-face meetings between the care coordinator and the Member;

- 7.2.9.2.3 Telephonic meetings between the care coordinator and the Member;
- 7.2.9.2.4 Case management;
- 7.2.9.2.5 Discharge consultation;
- 7.2.9.2.6 CCP development and updates;
- 7.2.9.2.7 Health education provided to the Member;
- 7.2.9.2.8 Disease management provided to the Member; and
- 7.2.9.2.9 Costs associated with Community Health Workers.

7.2.9.3 The CONTRACTOR shall submit Member care coordination activities through Encounter Data.

7.2.9.4 For purposes of this Agreement, the following care coordination functions will be deemed administrative services:

- 7.2.9.4.1 Health risk assessments (HRAs);
- 7.2.9.4.2 Data runs;
- 7.2.9.4.3 Referrals; and
- 7.2.9.4.4 Case assignment and scheduling.

38) **Section 7.3 of the Contract is amended and restated to read as follows:**

**7.3 Failure to Meet Agreement Requirements**

**7.3.1 General**

7.3.1.1 In the event that the CONTRACTOR or any person with an ownership interest in the CONTRACTOR, affiliate, parent or subcontractor, fails to comply with this Agreement, HSD may impose, at HSD's discretion sanctions (inclusive of the specific monetary penalties and other penalties described in this Section 7.3.

7.3.1.2 Sanctions paid by the CONTRACTOR pursuant to this Section 7.3 shall be included as administrative expenses subject to Section 7.2.8 of this Agreement.

7.3.1.3 HSD retains the right to apply progressively strict sanctions CONTRACTOR against the CONTRACTOR, for failure to perform in any of the Agreement areas.

- 7.3.1.4 Any sanction, including the withholding of capitation payments, does not constitute just cause for the CONTRACTOR to interrupt providing Covered Services to Members.
- 7.3.1.5 HSD may impose any other administrative, contractual or legal remedies available under federal or State law for the CONTRACTOR's noncompliance under this Agreement.
- 7.3.1.6 HSD will give the Collaborative written notice whenever it imposes or lifts a sanction for one of the violations listed herein that relates to Behavioral Health.
- 7.3.1.7 HSD will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed herein. The notice will be given no later than thirty (30) Calendar Days after HSD imposes or lifts a sanction and must specify the affected CONTRACTOR, the kind of sanction and the reason for HSD's decision to impose or lift the sanction.

### 7.3.2 Corrective Action Plans

- 7.3.2.1 If HSD determines that the CONTRACTOR is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that sanctions are also necessary.
- 7.3.2.2 The CONTRACTOR may dispute a notice of noncompliance in accordance with Section 7.11 of this Agreement.
- 7.3.2.3 The CONTRACTOR shall be required to provide CAPs to HSD within fourteen (14) Calendar Days of receipt of a noncompliance notice from HSD. CAPs are subject to review and approval by HSD.
- 7.3.2.4 If HSD imposes a DCAP on the CONTRACTOR, the CONTRACTOR will have fourteen (14) Calendar Days to respond to HSD.
- 7.3.2.5 If the CONTRACTOR does not effectively implement the CAP/DCAP within the timeframe specified in the CAP/DCAP, HSD may impose additional sanctions.
- 7.3.2.6 If HSD staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party either designated by HSD or approved by HSD to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

### 7.3.3 Sanctions

7.3.3.1 HSD may impose any or all of the non-monetary sanctions and monetary penalties as described in this Section to the extent authorized by federal and State law.

7.3.3.2 Non-monetary intermediate sanctions may include:

7.3.3.2.1 Suspension of auto-assignment of Members who have not selected an MCO;

7.3.3.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

7.3.3.2.3 Notification to Members of their right to terminate enrollment with the CONTRACTOR's MCO without cause as described in 42 C.F.R. § 438.702(a)(3);

7.3.3.2.4 Disenrollment of Members by HSD;

7.3.3.2.5 Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

7.3.3.2.6 Rescission of Marketing consent and suspension of the CONTRACTOR's Marketing efforts;

7.3.3.2.7 Appointment of temporary management or any portion thereof for an MCO as provided in 42 C.F.R. § 438.706 and the CONTRACTOR shall pay for any costs associated with the imposition of temporary management; and

7.3.3.2.8 Additional sanctions permitted under federal or State statute or regulations that address areas of noncompliance.

7.3.3.3 Monetary penalties may include:

7.3.3.3.1 Actual damages incurred by HSD and/or Members resulting from the CONTRACTOR's non-performance of obligations under this Agreement;

7.3.3.3.2 Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the CONTRACTOR's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the CONTRACTOR and the rates paid to the replacement health plan. HSD may withhold payment to the CONTRACTOR for damages until such damages are paid in full;

7.3.3.3.3 Civil monetary penalties as described in 42 C.F.R. § 438.704;

7.3.3.3.4 Monetary penalties up to five percent (5%) of the CONTRACTOR's Medicaid capitation payment for each month in which the penalty is assessed;

7.3.3.3.5 Other monetary penalties for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below.

7.3.3.4 HSD reserves the right to assess a general monetary penalty of five hundred dollars (\$500) per occurrence with any notice of deficiency.

7.3.4 Other Monetary Penalties

	<b>PROGRAM ISSUES</b>	<b>PENALTY</b>
1.	Failure to comply with Claims processing as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement
2.	Failure to comply with Encounter submission as described in Section 4.19 of this Agreement	2% of the monthly capitation payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement.
3.	Failure to comply with the timeframes for a comprehensive care assessment and developing and approving a CCP for care coordination level 2 and level 3	<p>\$10,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 75-94% of members for the reporting period.</p> <p>\$25,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% of less of Members for the reporting period.</p>



4.	Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
5.	Failure to obtain approval of Member Materials as required by Section 4.14.1 of this Agreement	\$5,000 per day for each Calendar Day that HSD determines the CONTRACTOR has provided Member Material that has not been approved by HSD. The \$5,000 per day damage amounts will double every ten (10) days.
6.	Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of this Agreement	<p>\$10,000 per occurrence where the CONTRACTOR fails to comply with the timeframes but is in compliance with the timeframes for 75-94% of Grievances and Appeals for the reporting period.</p> <p>\$25,000 per occurrence where the CONTRACTOR fails to comply with the timeframes for that Member but is in compliance with the timeframes for 74% or less of Grievances and Appeals for the reporting period.</p>
7.	Failure to submit timely reports in accordance with Section 4.21 of this Agreement	\$1,000 per report, per Calendar Day. The \$1,000 per day damage amounts will double every ten (10) Calendar days.
8.	Failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with Section 4.21 of this Agreement	\$5,000 per report, per occurrence.
9.	Failure to submit timely Summary of Evidence in accordance with Section 4.16 of this Agreement	\$1,000 per occurrence.
10.	Failure to have legal counsel	\$10,000 per occurrence.



	appear in accordance with Section 4.16 of this Agreement	
11.	Failure to meet HEDIS targets for the performance measures described in Section 4.12.8 of this Agreement	A monetary penalty based on 2% of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year.

\*HSD can modify any monetary penalty if the CONTRACTOR engages in a pattern of behavior which constitutes a violation of this Agreement and involves a significant risk of harm to Members or to the integrity of Centennial Care.

**7.3.5 Payment of Monetary Penalties**

7.3.5.1 HSD shall provide the CONTRACTOR with notice of any monetary penalties assessed at least thirty (30) Calendar Days before deducting such amounts from the monthly capitation payment. The collection of monetary penalties by HSD shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by HSD will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the monetary penalties described in this Section.

7.3.5.2 Monetary penalties as described in Section 7.3.5 of this Agreement shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

**7.3.6 Waiver of Sanctions**

HSD may waive the application of sanctions (including monetary penalties) at its discretion if HSD determines that such waiver is in the best interests of the Centennial Care program and its Members.

**7.3.7 Federal Sanctions**

Payments provided for under this Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

39) **Section 7.27.11 of the Contract is amended and restated to read as follows:**

**7.27.11 Referrals for Credible Allegations of Fraud**

7.27.11.1 The CONTRACTOR shall report to HSD suspected cases of Fraud whenever there are credible allegations of Fraud. The CONTRACTOR shall follow HSD's direction in identifying and reporting cases of credible allegations of Fraud. HSD shall make the final determination of whether to refer such cases to MFEAD, and other law enforcement agencies, for further investigation. HSD's directions to the CONTRACTOR may include, but is not limited to:

7.27.11.1.1 At HSD's direction, the CONTRACTOR shall suspend all Medicaid payments, in whole or in part as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD's notice, the CONTRACTOR (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pending Claims, or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD's notice.

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law.

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD.

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider;

7.27.11.1.4.2 The dismissal of all charges and/or claims against the provider related to the provider's alleged fraud by a court of competent jurisdiction; or

7.27.11.1.4.3 For other good cause as determined solely by HSD.

7.27.11.1.5 HSD shall document in writing the termination of a payment suspension and shall provide such documentation to the CONTRACTOR.

7.27.11.2 Should HSD require the CONTRACTOR's assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review, and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

40) **Section 7.46.2 of the Contract is amended and restated as follows:**

7.46.2 All notices required to be given to the State under this Agreement shall be sent to the following, or his or her designee:

Julie Weinberg, Director  
Medical Assistance Division  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348

Or

Christopher Collins, General Counsel  
New Mexico Human Services Department  
P.O. Box 2348  
Santa Fe, NM 87504-2348

41) **Attachment 6 to the Contract is amended and restated to read as follows:**

**Attachment 6: Alternative Benefit Plan Covered Services**

<b>Alternative Benefit Plan Services Included Under Centennial Care</b>
Allergy testing and injections
Annual physical exam and consultation
Assertive Community Treatment (ACT)
Autism spectrum disorder <sup>1</sup>
Bariatric surgery <sup>2</sup>
Behavioral health professional services: outpatient behavioral health <sup>3</sup> and substance abuse services <sup>4</sup>
Cancer clinical trials <sup>5</sup>
Cardiovascular rehabilitation <sup>6</sup>
Chemotherapy and radiation therapy
Dental services <sup>7</sup>
Diabetes treatment, including diabetic shoes and related medical supplies
Dialysis
Disease management
Durable medical equipment
Educational materials and counseling for a healthy lifestyle
Electroconvulsive Therapy (ECT)
Emergency services (including emergency room visits and psychiatric ER)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals age 19 and 20
Eye exams and treatment related to treatment and testing of eye diseases only <sup>8</sup>
Family planning, sterilization, pregnancy termination, contraceptives <sup>9</sup>
Glasses and contact lenses: covered only for aphakia (following removal of the lens) <sup>10</sup>
Hearing testing or screening as part of a routine health exam <sup>11</sup>

<sup>1</sup> Covers speech, occupational and physical therapy, and applied behavioral analysis for Members age 19-20; and Members age 21-22 who are enrolled in high school.

<sup>2</sup> Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

<sup>3</sup> Includes evaluation, testing, assessment, medication management, therapy and Intensive Outpatient Program (IOP) services.

<sup>4</sup> Includes outpatient detoxification, therapy, partial hospitalization and IOP services.

<sup>5</sup> Covers routine patient costs associated with Phase I, II, III and IV cancer clinical trials.

<sup>6</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per cardiac event. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>7</sup> ABP dental services are equivalent to the adult dental benefit package for traditional Medicaid categories. Increased periodicity schedule and medically necessary orthodontia covered for Members age 19-20.

<sup>8</sup> Refraction is not covered. Routine vision care is not covered.

<sup>9</sup> Sterilization reversal is not covered.

<sup>10</sup> Coverage of materials is limited to \$300 per surgery. Contact lenses or eyeglasses obtained more than 90 days following surgery are not covered.

<sup>11</sup> Hearing aids not covered. Hearing testing by an audiologist or hearing aid dealer is not covered.



Home health services <sup>12</sup>
Hospice services, including hospice at home or in a nursing facility
Hospital inpatient <sup>13</sup>
Hospital outpatient
Immunizations
Inhalation therapy
Inpatient rehabilitation <sup>14</sup>
IV infusions
Laboratory genetic testing to specific molecular lab tests such as BRCA1 and BRCA2 and similar tests used to determine appropriate treatment <sup>15</sup>
Laboratory services, including diagnostic testing and other age appropriate tests
Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests
Medical supplies: diabetic and contraceptive supplies only <sup>16</sup>
Medication assisted therapy for opioid dependence
Nutritional counseling
Obstetric/gynecological care, prenatal care, deliveries, midwives
Orthotics <sup>17</sup>
Physician visits
Podiatry services <sup>18</sup>
Prescription drug items <sup>19</sup>
Preventive care <sup>20</sup>
Primary care to treat illness/injury
Prosthetics
Psychosocial Rehabilitation (PSR)

<sup>12</sup> Limited to 100 visits per year. A visit cannot exceed four hours.

<sup>13</sup> Free-standing psychiatric hospitals are only covered for Members age 19-20 and are not a covered service for ABP or ABP-exempt, except for Members under age 21 except as an "in lieu of service." Psychiatric units within an acute care hospital are covered under the ABP. Inpatient drug rehabilitation services are not covered. Acute inpatient services for detoxification are covered.

<sup>14</sup> Covers inpatient services at a skilled nursing or acute rehabilitation facility when provided as a step-down level of care following discharge from the hospital prior to discharge to home. Extended care or long-term care hospitals are not covered.

<sup>15</sup> Not including random genetic screening.

<sup>16</sup> Medical supplies used on an inpatient basis, applied as part of treatment in a practitioner's office, outpatient hospital, residential facility, or home health service, are covered when separate payment is allowed in these settings.

<sup>17</sup> Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace or diabetic shoes.

<sup>18</sup> Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

<sup>19</sup> Over-the-counter drug items are not covered, except for prenatal drug items, low-dose aspirin as preventive for cardiac conditions, contraceptive drugs and devices, and items for treating diabetes. The contractor may choose to cover any over-the-counter product when it is less expensive than the therapeutically equivalent drug that would require a prescription (a 'legend' drug).

<sup>20</sup> ABP preventive services include the A&B recommendations of the United States Preventive Services Task Force (USPSTF)

Pulmonary rehabilitation <sup>21</sup>
Radiology, including diagnostic imaging and radiation therapy, mammography and other age appropriate imaging
Reconstructive surgery <sup>22</sup>
Rehabilitation and habilitation: physical therapy, occupational therapy and speech and language pathology <sup>23</sup>
Rehabilitation inpatient hospitalization: step-down lower level of care from an acute care hospital for not more than 14 days
Reproductive health services (not including fertility treatment)
Skilled nursing
Specialist visits
Telemedicine
Tobacco cessation counseling
Transplant services <sup>24</sup>
Transportation services (emergency and non-emergency medical), including air and ground ambulance, taxi and handivan <sup>25</sup>
Urgent care services

42) **Attachment 8 is added to the Contract to read as follows:**

**Attachment 8: Providers with Distance Requirements**

**A. Behavioral Health**

1. Freestanding Psychiatric Hospitals
2. General Hospitals with psychiatric units
3. Partial Hospital Programs
4. Accredited Residential Treatment Centers (ARTC)
5. Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)

<sup>21</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered..

<sup>22</sup> Covers reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders that result from accidental injury, congenital defects or disease.

<sup>23</sup> Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment). Duration limit is per condition. Extension of short-term therapy may be extended for one period of up to two months. Long-term therapy not covered.

<sup>24</sup> Limited to heart, heart/lung, lung, liver, cornea, kidney, skin, bone marrow and pancreas transplants. Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs. Limited to two organ/tissue transplants per lifetime. Outpatient immunosuppressive drugs do not apply toward the transplant benefit limit.

<sup>25</sup> Covers expenses for transportation, meals and lodging that are determined necessary to secure medical or Behavioral Health services for an ABP Member.



6. Treatment Foster Care I & II (TFC I & II)
7. Core Service Agencies (CSA)
8. Community Mental Health Centers (CMHC)
9. Indian Health Service and Tribal 638s providing Behavioral Health services
10. Outpatient Provider Agencies
11. Agencies providing Behavioral Management Services (BMS)
12. Agencies providing Day Treatment Services
13. Agencies providing Assertive Community Treatment (ACT)
14. Agencies providing Multi-Systematic Therapy (MST)
15. Agencies providing intensive Outpatient Services
16. Methadone Clinics
17. FQHCs providing Behavioral Health services
18. Rural Health Clinics providing Behavioral Health services
19. Psychiatrists
20. Psychologists (including prescribing psychologists)
21. Suboxone certified MDs
22. All other licensed Independent Behavioral Health practitioners (LISW, LPCC, LMFT, CNS & CNP with psychiatric certification, independent practices or groups)

#### **B. Physical Health**

1. Cardiology
2. Certified Nurse Practitioner
3. Certified Midwives
4. Dermatology
5. Dental
6. Endocrinology
7. ENT
8. FQHC
9. RHC
10. Hem/Oncology
11. I/T/U
12. Neurology
13. Neurosurgeon
14. OB-GYN
15. Orthopedics
16. Pediatrics
17. Physician Assistant
18. Podiatry
19. Rheumatology
20. Surgeons
21. Urology

#### **C. Long Term Care**

1. Assisted Living Facilities

2. Personal Care Service Agencies (PCS) – delegated
3. Personal Care Service Agencies (PCS) – directed
4. Nursing Facilities

**D. Hospitals**

1. General Hospitals
2. Inpatient Psychiatric Hospitals

**E. Transportation**

43) **Attachment 9 is added to the Contract to read as follows:**

**Attachment 9: Retroactive Period Reconciliation**

1. HSD shall reconcile the medical expenditures related to the Retroactive Period for each Contract year period (January 1 to December 31 of each Contract year). The Retroactive Period may exist for some Members whose effective date of Medicaid eligibility is determined prior to HSDs notification date to the CONTRACTOR outlined in Section 4.2.8.
2. The reconciliation for the Retroactive Period is limited to the medical expenses only.
3. For purposes of this Attachment, “medical expense” is defined as the expenditures for Covered Services in Attachment 2. Value added services and administrative expenditures will not be countable expenses in the calculation of the reconciliation.
4. HSD will permit the CONTRACTOR to retain 5.263 percent of the total medical expense for administrative costs.
5. HSD shall adjust the final reconciliation for applicable premium tax depending on the outcome of the reconciliation.
6. HSD will utilize encounter data received and accepted by HSD as the source for the measurement of the reconciliation on a cohort basis limited to Members who are in the Retroactive Period and eligible according to HSD’s eligibility system in the month they incurred medical expenses.
7. HSD shall conduct the final reconciliation for the contract year period no sooner than eight (8) months after the end of the calendar year or contract period.
  - a. During the calendar year or contract period, HSD at its discretion, may perform interim reconciliations and may recoup from or make payment to the CONTRACTOR. HSD shall determine the pro-rated percentage to recoup or pay.

- b. Interim recoupment or payment will be factored into the final reconciliation.
- 8. Actual medical cost plus the administrative allowance and premium tax will be compared to the payment made by HSD to the CONTRACTOR for the Retroactive Period to determine the value of recoupment from or payment to the CONTRACTOR.
- 9. HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.
- 44) **Attachment 10 is added to the Contract to read as follows:**

**Attachment 10: List of Psychotropic Drugs and Medications**

GENERAL DESCRIPTION	THERAPEUTIC CLASS (MCOs must use their PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY comparable therapeutic classes)	PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names begin with a capital letter)	
Anti-Anxiety Medications and Antidepressants (non-benzodiazepines)	H2F, H2G, H2J, H2S, H2U, H7B, H7C, H7D, H7E, H7F, H2O, H7P, H7R, H7S, H7T, H7U, H7X, H7O, H7Z	Abilify	Symbyax
		amitriptyline	thiothixene
		amoxapine	Tofranil
		Anafranil	trazodone
		Aripiprazole	trimipramine
		Asendin	venlafaxine
		Aventyl	Vivactil
		bupropion	Wellbutrin
		BuSpar	ziprasidone
		buspirone	Zoloft
		Celexa (SSRI)	Zyprexa

citalopram	Geodon	Navane	Risperdal
clomipramine	Haldol	Norpramin	Sarafem
clozapine	Haloperidol	nortriptyline	Seroquel
Clozaril	iloperidone	olanzapione	sertraline
Cymbalta	imipramine	Orap	Sinequan
desipramine	Invega	Paliperidone	Surmontil

**Anti-Mania Medications H2M  
 (Mood Stabilizers)**

Eskalith	lithium carbonate	lithium citrate	Lithobid
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**Mood Stabilizing H4B  
 Anticonvulsants**

clonazepam	divalproex sodium	lomotrigine	oxcarbazepine	topiramate
carbamazepine	Klonopin	gabapentin	Tegretol	Trileptal
Depakote	Lamictal	Neurontin	Topamax	valproic acid

**Monoamine Oxidase Inhibitors  
 H2H, H2J, H7J**



Emsam	Marplan	Parnate	selegiline
isocarboxazid	Nardil	phenelzine	tranylcypromine

**Phenothiazines and other H2G  
major tranquilizers and  
antipsychotics**

chlorpromazine	perphenazine	thioridazine	trifluoperazine
fluphenazine	Stelazine	Thorazine	Trilafon

**The remainder of this page is intentionally left blank.**

**All other sections of PSC [13-630-8000-0023], as amended, remain the same.**

IN WITNESS WHEREOF, the parties have executed this amended and restated contract as of the date of signature by the Human Services Department.

**CONTRACTOR**

By: [Signature] Date: 7-2-14  
Title: President

**STATE OF NEW MEXICO**

By: [Signature] Date: 10/9/14  
Sidonie Squier, Cabinet Secretary  
Human Services Department

By: [Signature] Date: 10/14/14  
Danny Sandoval, CFO  
Human Services Department

**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

By: [Signature] Date: 10/7/14

Title: Cabinet Secretary

By: [Signature]


Title: Deputy Cabinet Secretary, CYFD

By: [Signature] Date: 10/23/14

Title: Secy, HSD

CERTIFIED FOR LEGAL SUFFICIENCY:  
[Signature] 10/7/14  
Department of Health  
Assistant General Counsel  
Date: 10-20-14

**Approved as to Form and Legal Sufficiency:**

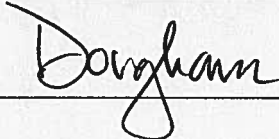
By:   
\_\_\_\_\_  
Christopher P. Collins, Chief Legal Counsel  
Human Services Department

Date: 9/30/14

The records of the Taxation and Revenue Department reflect that the CONTRACTOR is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

**TAXATION AND REVENUE DEPARTMENT**

**ID Number: 02-084519-00-7**

By:   
\_\_\_\_\_

Date: 10.28.14

Title: \_\_\_\_\_