HSD Responses to Questions Submitted for Turquoise Care MCO RFP # 23-630-8000-0001 for Model Contract Negotiation Questions and Proposed Language

RFP # 23-630-8000-0001

Questions & Answers Organized by Topic Section

ORIGINAL Question #	Source: RFP, Contract or Data Book	Page #	Text from RFP, Contract, or Data Book related to question	Offeror Questions	HSD Responses
CISC					
1	Contract	14	Definitions: Child(ren) in State Custody (CISC) means child(ren) and youth in the legal custody of CYFD's Protective Services division, including Native Children and children never removed from the Respondent's home or children returned to the Respondent's home following a removal. (Respondent(s) are defendant(s) in an abuse and neglect case under the New Mexico Children's Code.)	*The definition of CISC on page 14 of the contract does not appear to align with the definition referenced in the Kevin S. Corrective Action Plan.* *Can HSD share their approach to how they will automate notification to the MCO to ensure prompt identification of these Members? For example. dual COEs in which the MCO receives a dedicated CISC COE <or> an identifier*	The definition is not outlined in the corrective action plan. The definition utilized in the contract is outlined in the settlement agreement. The State will later communicate further detail on CISC member notification processes.

				provided on the enrollment roster.	
20	Data Book		CISC population	Is the Data Book from the 2022 RFP consistent with the CISC member definition listed in the revised Turquoise Care contract? Will HCA release a revised Data Book with updated data and in alignment with the definition of CISC members?	The CISC information included in the Turquoise Care Medicaid Managed Care Request for Proposals RFP#23-630-8000-0001 Data Book from September 30, 2022 aligned with the definition as described in the Turquoise Care Medicaid Managed Care Request for Proposals RFP# 23-630-8000-0001 Appendix L Model Contract Issue date September 28, 2022. HCA will not release a revised Data Book.
21	Data Book		CISC population	Is BH cohort 202 consistent with the current CISC definition?	Please refer to the Behavioral Health Rate Cohort definition described in the Managed Care Organization Systems Manual (dated August 2022) located on the Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) and Procurement Library website and the Child(ren) in State Custody (CISC) definition described in the Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023).
22	Data Book		General	Can HCA provide an estimate of the total expected population size for CISC at the go-live date?	During readiness the CISC population would be re-examined in months prior to go-live, including during open enrollment. Disclaimer: CISC population varies up to daily and has consistent churn. Monthly updates will be provided.

RATES					
2	Contract	23	Definitions: Go-Live means the date on which the CONTRACTOR assumes responsibility for the provision of Covered Services to Members. As of the date of this Agreement, the Go-Live date is July 1, 2024.	When will the capitation rates for Turquoise Care and CISC be shared with Contractors?	Approximately two months before the effective date of the rates.
11	Contract	116	4.4.10.7.8 The CONTRACTOR shall submit all payments to individuals and entities performing shared functions of Care Coordination as Encounters (per Section 4.10 of this Agreement) for each Member served by the individual or entity.	How will delegated functions and associated costs be accounted for in the rates provided to the MCO?	Care coordination expenditures, both through the Full Delegated Model and the Shared Functions Model, will be included in the Turquoise Care MCO capitation rates. The development of care coordination expenditures for the Turquoise Care MCO capitation rates may include, but may not be limited to, historical Centennial Care coordination information as well as ad-hoc Turquoise Care MCO data requests.
15	Contract	344	6.4.5.1 The Capitation Rates for the CISC program are represented by Rate Cohort PH CISC, 0-21 years, and includes Covered Services outlined in Attachment 1: Turquoise Care Covered Services (Covered Services). Behavioral Health services for the population enrolled in the CISC Rate Cohort are represented by the Behavioral Health Rate Cohort BH CISC, 0-21 years	For the CISC contractor, how will capitation rates be paid for LTSS services received by members in CISC since the Data Book includes a cohort for LTSS (CISC)?	HCA and Mercer expect two Rate Cohorts for the CISC population. The two Rate Cohorts are PH CISC, 0-21 years and BH CISC, 0-21 years, as described in the Turquoise Care Medicaid Managed Care Request for Proposals RFP# 23-630-8000-0001 Appendix L Model Contract Issue date September 30, 2022, later revised as Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023), and the Turquoise Care Medicaid Managed Care Request for Proposals RFP#23-630-8000-0001 Data Book Narrative. Rather than creating a separate Rate Cohort for Long-Term Services and Supports (LTSS) utilized by the CISC population, HCA and Mercer expect to include LTSS utilized by the

					CISC population in the PH CISC, 0-21 years Rate Cohort. The CISC information included in the Turquoise Care Medicaid Managed Care Request for Proposals RFP#23-630-8000-0001 Data Book was broken out by Physical Health, Behavioral Health and LTSS and not by the expected CISC Rate Cohorts.
14	Contract	339	6.4.1.4 HCA may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the risk-adjusted Capitation Rates for Covered Services not subject to risk-adjustment.	As the CISC Contractor, the impact of the new services (FFT, trauma focused CBT, EMD and DBT) included in the draft SPA 23-0006 Evidence Based Practice and SPA 23-0008 High Fidelity Wrap will be material to PHP, and those services are not included in the data book. For the new services included in draft SPA, will those services be subject to risk adjustment? In addition, can HCA provide detail of which services will and will not be subject to risk adjustment?	Correct, services that were implemented after December 31, 2021 would not have been included in the Turquoise Care Medicaid Managed Care Request for Proposals RFP#23-630-8000-0001 Data Book Exhibits because the Data Book summarized historical claim-level encounter data processed through the State's Medicaid Management Information Systems (MMIS) for January 1, 2019 through December 31, 2021 with run-out through March 31, 2022 . Any impact of new benefits not reflected in the base data time period utilized for the development of capitation rates will be addressed through separate program change adjustments. Regarding risk adjustment, please refer to questions 16 and 18 from the document NM-HSD-Official-Responses-to-RFP-Questions-23-630-8000-0001_Final.
38	Contract	9	§1.12 The CONTRACTOR's Capitation Rate will be established by HCA. HCA's actuaries will develop components of the Capitation Rates,	Effective collaboration in the setting of an actuarially sound Capitation Rate is an important part of aligning reasonable expectations between the parties for the future performance of this	HCA will review references to capitation rates in the Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023 and consider revising to ensure consistency of references throughout the document.

			to include the medical services components, premium tax, gross receipts tax for provider payments, and the administrative expense portion of the Capitation Rates.	contract. Questions: Will the Capitation Rate language in Section 1.12 align with the actuarial standards requirements language set forth elsewhere in the Contract (see e.g., Section 6.1.4, et seq.), as well as with the November 15, 2022 HCA Official Responses to Questions provided in connection with this RFP (see Q&A No. 15; "the State will provide Contractors information on the development of the capitation and an opportunity to ask questions and provide feedback.")? Will Contractor have proposed Capitation Rates prior to the date that HCA anticipates Contractor will sign the Agreement (9/28-10/13)? What is the anticipated outcome if Contractor and HCA are unable to mutually agree upon any Rate	The capitation rates established by HCA will be developed and certified as actuarially sound by Mercer, then submitted to the Centers for Medicare & Medicaid Services (CMS) for review and approval. Standards for the development and certification of capitation rates as actuarially sound are established by CMS at 42 CFR 438, the Medicaid Managed Care Rate Development Guide published annually by CMS. HCA anticipates providing capitation rates effective July 1, 2024 approximately two months before the effective date. As described in Section 6.5.1 of the Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023), the Capitation Rates awarded are not subject to negotiation during the term of the Agreement.

				established by HCA after the Agreement has been executed? Proposed Alternate Language §1.12: "The CONTRACTOR's Capitation Rate will be established by HCA in accordance with the actuarial standards set forth in Section 6.1.4. HCA's actuaries will develop components of the Capitation Rates, to include the medical services components, premium tax, gross receipts tax for provider payments, and the administrative expense portion of the Capitation Rates. HCA will provide Contractor information on the development of the Capitation Rate and will provide Contractor an opportunity to ask questions and provide feedback to HCA prior to the Capitation Rate becoming effective for payment purposes.	
48	Contract	339	§6.4 Capitation Rates The Capitation Payments made by HCA to the CONTRACTOR are based on the Capitation Rates for the Members enrolled with the CONTRACTOR. The Rate Cohorts designate the Covered Services and/or population	Effective collaboration in the setting of an actuarially sound Capitation Rate is an important part of aligning reasonable expectations between the parties for the future performance of this	Please refer to response to question #38.

			characteristics (age/gender/geography) of the Capitation Rate. HCA is exploring changes to the Rate Cohort structure which may include but is not limited to: the implementation of a per-delivery maternity payment separate from monthly Capitation Payments, consolidation of existing Rate Cohorts, and/or modifications to risk HCA is exploring changes to the Rate Cohort structure which may include but is not limited to: the implementation of a per-delivery maternity payment separate from monthly Capitation Payments, consolidation of existing Rate Cohorts, and/or modifications to risk adjustment. During the term of this Agreement, HCA reserves the right to modify or change the number assigned to the Rate Cohorts described in this section, if necessary, due to HCA MMIS requirements.	contract. Question: Can the State confirm that it will provide Contractors with information on the development of the capitation rates and an opportunity to ask questions and provide feedback consistent with its previous guidance? (See ex: RFP Q&A No. 15; "the State will provide Contractors information on the development of the capitation and an opportunity to ask questions and provide feedback.")?	Clarifying answer: MAD will meet with each MCO individually. At that time rates will be presented and the MCO can propose questions for MAD response. Questions/responses does not guarantee any rate change.
49	Contract		§6.5 Capitation Rates Adjustments § 6.5.1 The Capitation Rates awarded are not subject to negotiation during the term of the Agreement. HCA may, at its option, review the Capitation Rates to determine if an adjustment is needed for reasons, including but not limited to, the following:	Effective collaboration in the setting of an actuarially sound Capitation Rate is an important part of aligning reasonable expectations between the parties for the future performance of this contract. Questions: Will the Capitation Rate adjustments contemplated	Please refer to response to question #38.

				in §6.5.1 align with the actuarial standards requirements language set forth elsewhere in the Contract? Will the State provide Contractors with information on the development of the capitation and an opportunity to ask questions and provide feedback?	
AUTO ASSIGNMENT					
4	Contract	80	4.2.5.1 HCA will auto-assign a Recipient to a Turquoise Care MCO in specified circumstances, including but not limited to: (i) the Recipient does not select an MCO at the time of eligibility or (ii) the Recipient cannot be enrolled in the requested MCO pursuant to the terms of this Agreement (e.g., the CONTRACTOR is subject to and has reached its enrollment limit).	Please explain how (ii) of this provision is to be reconciled with the following contract provisions: (1) 4.2.5.2.4 which states that the upper enrollment limit established by HCA will not prevent or limit enrollment in any Turquoise Care MCO based upon Recipient/Member choice; and (2) 4.2.5.5 which states that Member choice shall be the primary driver for MCO enrollment and supersedes auto-assignment in all cases during the initial enrollment and open enrollment periods.	Auto-assignment only applies when a Member does not select an MCO (member choice). If an MCO has reached the upper enrollment limit and a Member selects that MCO, Member choice will supersede the upper limit and the Member will be enrolled with the Member's selected MCO.

7	Contract	81	4.2.5.3.5 If a Turquoise Care MCO exceeds the upper enrollment limit established by HCA pursuant to 4.2.7 of this Section, auto-assignment into that Turquoise Care MCO will be limited to Recipients meeting the auto-assignment criteria as described in 4.2.5.3.1 through 4.2.5.3.5 of this Section.	Should the reference to 4.2.7 really be 4.2.8 which is the provision pertaining to Enrollment Limits?	Yes – the Model Contract has been updated to reference 4.2.8
5	Contract	80	4.2.5.2.2. Centennial Care 2.0 Members who do not select a Turquoise Care MCO and whose current Centennial Care 2.0 is awarded a contract to become a Turquoise Care MCO will remain enrolled in their current MCO.	Are Members who elect to remain with their existing MCO by not selecting another MCO during open enrollment considered to have made a choice to remain with their existing MCO?	Section 4.2.5.2.2 applies only during the initial open enrollment period and requires that Members currently enrolled in a Centennial Care 2.0 MCO awarded a Turquoise Care contract who do not exercise choice will remain enrolled in their current MCO. The State's intent is to ensure Member continuity of care. The upper enrollment limit does not apply in this circumstance. Members will be given one opportunity to request a change of MCO up to three months following such assignment, as required in Section 4.2.10.1.
6	Contract	80	4.2.5.2.4 The upper enrollment limit established by HCA pursuant to 4.2.7 of this Section will not prevent or limit enrollment in any Turquoise Care MCO based upon Recipient/Member choice.	Should the reference to 4.2.7 really be 4.2.8 which is the provision pertaining to Enrollment Limits?	Yes – the Model Contract has been updated to reference 4.2.8
8	Contract	82	4.2.8 Enrollment Limits	Please describe how the limits will be applied (i.e., at a cohort level)? Please confirm that CISC enrollment will not count towards the upper enrollment limit for Turquoise Care.	CISC enrollment will not contribute to the MCO's upper enrollment limit as it is a population-specific separate contract. All non-CISC contracts will not be subject to established upper enrollment limits.
27	4.2.8	82	HCA will establish an upper enrollment limit for Turquoise Care MCOs following the RFP awards to CONTRACTORs.	We would like to discuss enrollment, membership, and auto assignment with the state of New Mexico.	As provided in Section 4.2.1, the CONTRACTOR is not entitled to an equal share or number of members or auto-assigned members. HCA will not consider a

				How will the HCA ensure viability of plans without a minimum threshold? We recommend reinstating the 10% minimum enrollment threshold with preferred auto-assignment, and/or 30-35% maximum membership cap. If no minimum or membership cap is in place, will NM consider a different rate structure for new MCO entrants as they will have the same mandatory positions servicing a smaller Medicaid population for at least the first 2 years of the contract?	different rate structure for new MCOs. Exceptions for key and required staff (including staff serving in more than one role) may be submitted to HCA for prior approval.
54	Model Contract 4.2.5.2.2	80	Centennial Care 2.0 Members who do not select a Turquoise Care MCO and whose current Centennial Care 2.0 MCO is not awarded a contract to become a Turquoise Care MCO will be auto-assigned during initial enrollment as determined by HCA.	Given that there will be four MCOs available for members, could the Department share how auto assignment work for the new contractors? Will members from Western Sky be assigned to Molina and United equally? How will auto assignment of new members work going forward? Will Molina and United receive auto-assignment of new members until a fair and	Auto assignment policy decisions will be determined in January. The auto-assignment policy will factor in an exiting plan and two new plans. The plans are strongly encouraged to proactively seek membership, not solely relying on auto-assignment.

				reasonable amount of enrollment is achieved?	
CARE COORDINATION					
9	Contract	93	4.4.4.2.1 Care Coordination Level 0 (CCL0) for Members the CONTRACTOR was unable to reach after making reasonable outreach efforts as described in Section 4.4.4.4.3, for Members assessed to not have a current need for an assigned Care Coordinator; or for Members who have been contacted and refuse Care Coordination; 4.4.4.2.2 Care Coordination Level 1 (CCL1) for Members assessed to have moderate health risk factors and a current need for an assigned care coordinator; and 4.4.4.2.3 Care Coordination Level 2 (CCL2) for Members assessed to have high health risk factors and a current need for an assigned care coordinator.	Would HSD consider utilizing 1, 2 and 3 as the care coordination levels rather than 0, 1 and 2 as this change will have widespread implications including system configuration, updates to all existing levels in Omnicaid, updates to policies/procedures and training materials. Additionally, providers, waiver case managers, delegated entities, and community organizations have come to recognize levels 2 and 3 as representative of Members actively engaged in care coordination.	The State will maintain the new contract requirements on levels 0, 1, and 2 for care coordination. This redesign of care coordination does acknowledge the need for system updates and updates to policies and procedures. The State intends the new requirements to progress the role of care coordination within the managed care health care system.
10	Contract	97, 99	4.4.5.2.1 The Contractor shall assign Members to CCL 0 as follows ... Members not assessed to have a need for an assigned care coordinator	PHP's population health strategy to target, identify, and address Members' risk and as identified by constant data surveillance or other metrics which then trigger activities and interventions is designed to	The contract has been updated to include: In addition to outreach and engagement efforts, CCL0 care coordinators are responsible for reviewing and monitoring data including, but not limited to, encounters, utilization patterns including hospital and ED visits for individuals that are

			4.4.5.7.1.1 The CONTRACTOR's maximum caseload ratios shall not exceed the following: CCL0-1:150	address the risks for target populations and each Member. The requirement for a ratio of 1:150 for CCL0 Members will have a significant workforce impact, estimated to be in excess of additional 2,000 care coordinators for PHP's membership, which diverts clinical resources away from direct service. Is the reference for CCL0 caseloads at 1:150 accurate for members assessed not to have a current need for an assigned care coordinator? Will HCA consider increasing or eliminating the caseload ratio for CCL0 for Members other than those who are unable to reach or who have declined care coordinator? An adjustment to this requirement will also be helpful to allow time to achieve delegated care coordination for this group of Members.	high-risk (would benefit and fit within the parameters of CCL1 or CCL2), pharmacy trends, or difficult to engage or refused to engage. CCL0 care coordinators are to monitor for membership in CCL0 on the high-cost high-needs report. CCL0 care coordinators are to re-engage in outreach upon indication of connection with an inpatient, crisis utilization, or ED facility. This can include face-to-face approach while inpatient, prior to discharge. Upon a member change in clinical presentation, CCL0 care coordination would attempt to engage again if the member previously was difficult to engage or refused.
32	4.4.1.4	88	Care Coordination may be provided to a Member by or through the CONTRACTOR using one (1) of the Care Coordination models offered by the CONTRACTOR. The CONTRACTOR may offer one (1) or more of the following three (3) models: CONTRACTOR-Driven, Full Delegation, or	Please confirm that the intent of this contract language is to ensure all MCOs offer the option of the Full Delegated Model for its prenatal/postpartum members.	This is to require delegated care coordination, as stated: the CONTRACTOR must offer the Full Delegation Model of Care Coordination for all prenatal and Postpartum Members. Members can decline care coordination at any time. The health plan is not permitted to

			Shared Functions Models of Care Coordination. In addition, the CONTRACTOR must offer the Full Delegation Model of Care Coordination for all prenatal and Postpartum Members. The CONTRACTOR shall promote, support, and expand the availability and use of the Full Delegation Model and the Shared Functions Models (when offered) of Care Coordination. The CONTRACTOR shall ensure its Members' Care Coordination needs are met regardless of the model of Care Coordination used to provide Care Coordination to a Member.		offer contractor-lead care coordination for prenatal and Postpartum members. Contract edit: For those that decline care coordination, if their circumstances change, the Contractor would be required to offer care coordination again upon change in circumstance (e.g. entering into auto-assigned category such as pregnant member).
39	Contract	89	§ 4.4.1.4 Care Coordination may be provided to a Member by or through the CONTRACTOR using one (1) of the Care Coordination models offered by the CONTRACTOR. The CONTRACTOR may offer one (1) or more of the following three (3) models: CONTRACTOR-Driven, Full Delegation, or Shared Functions Models of Care Coordination. In addition, the CONTRACTOR must offer the Full Delegation Model of Care Coordination for all prenatal and Postpartum Members. The CONTRACTOR shall promote, support, and expand the availability and use of the Full Delegation Model and the Shared Functions Model (when offered) of Care Coordination. The CONTRACTOR shall ensure its Members' Care Coordination needs are met regardless of the model of Care Coordination used to provide Care Coordination to a Member.	The Agreement requires a "Full Delegation Model of Care Coordination for all prenatal and Postpartum Members." The geography of NM generally prohibits the ability of a Contractor to offer the Full Delegation Model of Care Coordination to ALL prenatal and postpartum Members. Rural and smaller providers often lack the patient volume needed to make such arrangements financially and administratively viable and will be challenged by requirements of VBP full delegation agreements. Question: For prenatal and postpartum members, can	This is a way to further support areas including, but not limited to, OB desert communities and support population health at the community level.

				Contractor utilize the Full Delegation Model and the Shared Functions Model? Proposed Alternate Language §4.4.1.4 Care Coordination may be provided to a Member by or through the CONTRACTOR using one (1) of the Care Coordination models offered by the CONTRACTOR. The CONTRACTOR may offer one (1) or more of the following three (3) models: CONTRACTOR-Driven, Full Delegation, or Shared Functions Models of Care Coordination. In addition, the CONTRACTOR must offer the Full Delegation, or Shared Functions Models of Care Coordination for all prenatal and Postpartum Members. The CONTRACTOR shall promote, support, and expand the availability and use of the Full Delegation Model and the Shared Functions Model (when offered) of Care Coordination. The CONTRACTOR shall ensure	

				its Members' Care Coordination needs are met regardless of the model of Care Coordination used to provide Care Coordination to a Member.	
42	Contract	98	§4.4.5.3.1 The CONTRACTOR shall assign Members to CCL1, at a minimum, as follows: §4.4.5.3.1.2 Child and maternal health Members, including Members in the MHV program. §4.4.5.3.1.6 Members with multiple (three or more) complaints, grievances, or appeals related to the Member's experience with the service delivery system.	Members in higher levels of care coordination receive a comprehensive need assessment (CNA) to assess physical, behavioral and long-term care needs and receive person centered care. Questions: Is HCA's intent that all healthy children and maternal health members be assigned to care coordination regardless of whether the CNA indicated they needed a higher level of care coordination? Will the calculation of actuarially sound Capitation Rates include the additional costs necessary to implement and maintain the new "Care Coordination Level One" requirements? Proposed Alternate	The contract has been updated to replace "child and maternal health" with Intent: perinatal and maternal health members Answer: Members with multiple grievances and appeals are required to be offered the level of care coordination CCL1. Members have the right to decline care coordination.

				Language: Consider modifying §4.4.5.3.1.2 to exclude members whose assessment results indicate a higher level of care condition is not needed. Including healthy members in ccl 1 potentially takes away focus from members who most need care coordination. Care Coordinators currently assist those members in their caseloads with complaints, grievances and or appeals and if members call to request CC. We have concerns that members with multiple grievances will not be interested in CC and the resources needed to triage these members will decrease the time CCs have for member who need CC. Members would be better served by having an A & G representative available for guidance.	
43	Contract	99	§4.4.5.4.1 The CONTRACTOR shall assign Members to CCL2 who, at a minimum, have the following:	Many members have a SUD and are SMI/SED but are managed and are following clinical recommendations and/or medication requirements.	Member assignment to CC Levels are required to be in alignment with contract requirements in 4.4.5.4.1. Member preferences for care coordination delivery are to be documented and taken into account, while not changing the CC Level assignment. Members reserve the right to

			§4.4.5.4.1.1 HCHN Members; §4.4.5.4.1.2 Members with SUD; §4.4.5.4.1.3 Members with SED; §4.4.5.4.1.4 Members with SMI; §4.4.5.4.1.5 Justice-Involved Individuals; §4.4.5.4.1.6 Members with TBI; §4.4.5.4.1.7 Members with housing insecurity; §4.4.5.4.1.8 CISC Members;	Questions: Will members still have the ability to request either a higher or lower level of Care Coordination than is indicated by the CNA? Will the calculation of actuarially sound Capitation Rates include the additional costs necessary to implement and maintain the new "Care Coordination Level Two" requirements? Proposed Alternate Language: In order to focus on members that most need care coordination, assessments should be done by clinicians or based on impairment or functioning concerns, such as: 1 or more ER visits or hospitalizations within the last 6 months for a BH/SU diagnosis.	decline care coordination. HCA strongly encourages Contractors to educate members on the benefits of care coordination. If the member requests fewer contacts, this should be documented, however would not impact the coordination level of care coordination including coordination with and oversight of service providers. Actuarial rates will take into account the contract requirements

			§4.4.5.4.1.9 CARA Members; and §4.4.5.4.1.10 Members in out-of-state placements.		
44	Contract	100	§4.4.5.7 Caseload Ratios §4.4.5.7.1 The CONTRACTOR shall establish and maintain maximum caseloads ratios per care coordinator for Members in CCL0, CCL1, and CCL2. The CONTRACTOR's maximum caseload ratios shall not exceed the following: §4.4.5.7.1.1 CCL0 - 1:150 §4.4.5.7.1.2 CCL1 - 1:75	The change in Caseload Ratios will place significant strain on current workforce issues. It is estimated that it would be necessary to hire 1600 additional CCs to satisfy the ratio for CCL0. Additionally, the role and function of the CCs for Level 0 is not clear. Questions: What is HCA's vision for managing members in CCL0? Will Contractors be required to assign care coordinators to CCL0 members?	HCA's Vision for the modified Care Coordination approach intends to make care coordination more robust, accessible and utilized across membership, including difficult to engage members. All care coordination should impact and improve member outcomes. CCL0 care coordination requires the plan to continue outreach and intervention engagement more consistently and strategically optimizing opportunities for early intervention. A member can always escalate up a level as indicated and clinically needed. CCL0 level would be assigned in accordance with contract requirements.

			§4.4.5.7.1.3 CCL2 - 1:50	Do these ratios account for workforce issues and do they potentially take away resources from members who most need care coordination? Proposed Alternate Language: Target care coordination to populations who most need it and do not establish a case load ratio for Level 0 members.	
55	Model Contract – 4.4.4.2	93	4.4.4.2 The CONTRACTOR shall use HCA's standardized HRA, CNA (when indicated), CONTRACTOR'S utilization data, and/or Claims data to determine Member need for Care Coordination and assign a CCL to each Member. The CONTRACTOR shall assign CCLs as follows: 4.4.4.2.1 Care Coordination Level 0 (CCL0) for Members the CONTRACTOR was unable to reach after making reasonable outreach efforts as described in Section 4.4.4.4.3, for Members assessed to not have a current need for an assigned care coordinator; or for Members who have been contacted and refuse Care Coordination; 4.4.4.2.2 Care Coordination Level 1 (CCL1) for Members	Given the change of CCLs from Centennial Care Contract to the new Turquoise Care Contract and the removal of levels 3-5, will HCA prior to go live, provide guidance on assigning and planning responsibilities to transition members to new CCLs?	The guidance for reassignment is in the contract language, starting on the go-live date in accordance with care coordination requirements. Transition period for MCOs to transition members in their system based on the new CC requirements will be allotted a 60-day transition period for reassignment/alignment.

			assessed to have moderate health risk factors and a current need for an assigned care coordinator; and 4.4.4.2.3 Care Coordination Level 2 (CCL2) for Members assessed to have high health risk factors and a current need for an assigned care coordinator.		
56	4.4.5.7.1	99	4.4.5.7 Caseload Ratios 4.4.5.7.1 The CONTRACTOR shall establish and maintain maximum caseloads ratios per care coordinator for Members in CCL0, CCL1, and CCL2. The CONTRACTOR's maximum caseload ratios shall not exceed the following: 4.4.5.7.1.1 CCL0 - 1:150 4.4.5.7.1.2 CCL1 - 1:75 4.4.5.7.1.3 CCL2 - 1:50	Dependent on the initial enrollment of the MCO and with the changes in care coordination caseload ratios, with HCA's prior approval, may an MCO scale its Care Coordinator staffing for the CCLO ratio? (1:150)	Same as above - refer to answer for question 55 - remaining 0,1, 2
CONTRACTING REQUIREMENTS (INCLUDING VBP)					
12	Contract	157	4.8.1.3 The CONTRACTOR shall enter into new contracts with providers for Turquoise Care, unless the provider and the CONTRACTOR mutually agree to forgo entering into a new agreement	We are preparing amendments to all provider contracts to update the contract for all Turquoise Care requirements. Under the terms of our current contracts, such amendments are deemed accepted unless the provider objects, which providers are contractually permitted to do. Is a provider signature necessary to document	Section 4.8.1.3 permits the CONTRACTOR and provider to forgo entering into a new agreement based upon mutual agreement. While the CONTRACTOR is expected to have evidence of the mutual agreement, the requirement does not specifically require a provider's signature of mutual agreement to meet the standard. CONTRACTORS should discuss proposed approaches to "evidence of mutual agreement" to confirm HCA deems the approach compliant.

				mutual agreement if they do not object?	
35	4.9.1.2	187	The CONTRACTOR shall submit to HCA for prior review and written approval, templates/sample provider agreements for each type of Contract Provider. Any changes to templates/sample provider agreements that may materially affect Members shall be approved by HCA in writing prior to execution by any provider.	Upon submission of our provider agreements, what is the typical turnaround time for state approval? We are requesting approval by 11/1 to initiate signed contracts. When are we able to send these in for approval?	Provider agreements are reviewed during the desk audit phase of Readiness Review. The state cannot commit to having these approved by 11/1. HCA will prioritize contract review.
40	Contract	91	§4.4.3.1.2 The CONTRACTOR shall use local resources, such as I/T/Us, primary care and specialty clinics, Patient Centered Medical Homes (PCMHs), Health Homes, Core Service Agencies (CSAs), School-Based Health Center (SBHCs), CHWs, Community Health Representatives (CHRs), High Fidelity Wrap-Around (HFW) Teams, Paramedicine programs, community-based agencies, PCS agencies, Centers for Independent Living, and Tribal services, reimbursing them in mutually agreeable arrangements, to assist in performing the Care Coordination functions specified throughout Section 4.4 of this Agreement. The CONTRACTOR shall perform monitoring and oversight of all Care Coordination functions delegated to local resources, per Section 7.14.2.1.3 of this Agreement.	The Agreement requires Contractors to "perform monitoring and oversight of all Care Coordination functions delegated to local resources, per Section 7.14.2.1.3." While the intent of this provision may be to ensure quality improvement metrics are in place, "local resources" and small providers will struggle to meet the requirements established by the National Committee for Quality Assurance and applicable Medicaid rules that govern administration of the Medicaid program. Question:	Quality monitoring is not limited to NCQA metrics, and this should not be a barrier in monitoring and oversight of care coordination. MCOs are required to monitor services and supports for attributed members. Delegated resources require coordination and oversight of the efficacy of the supports, including but not limited to member outcomes, engagement, etc.

				Can HCA confirm that in accordance with previous communications from HSD, Section 7.14.2.13 does not apply to Delegated Entities that are not Subcontractors or Major Subcontractors? Proposed Alternate Language §4.4.3.1.2 The CONTRACTOR shall use local resources, such as I/T/Us, primary care and specialty clinics, Patient Centered Medical Homes (PCMHs), Health Homes, Core Service Agencies (CSAs), School-Based Health Center (SBHCs), CHWs, Community Health Representatives (CHRs), High Fidelity Wrap-Around (HFW) Teams, Paramedicine programs, community-based agencies, PCS agencies, Centers for Independent Living, and Tribal services, reimbursing them in mutually agreeable arrangements, to assist in performing the Care Coordination functions specified throughout Section 4.4 of this Agreement. The	

				CONTRACTOR shall perform monitoring and oversight of all Care Coordination functions delegated to local resources. per Section 7.14.2.1.3 of this Agreement. Contractors will develop an audit tool similar to the existing delegation of care coordination appendix for use in evaluating the Full Delegation Model of Care Coordination. This tool will be approved by HCA prior to use. Entities participating in delegated care coordination arrangements are not considered Major Subcontractors or Subcontractors per Section 7.14.	
41	Contract	98	§4.4.5 Care Coordination Assignment §4.4.5.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR's process for the assignment of a Care Coordination Level, a change in Care Coordination Level, assignment of care coordinators, and care coordinator caseload	Centennial Care Contractors recently completed system changes requiring major IT infrastructure upgrades pursuant to LOD #66. Under the current system, members receive a health risk assessment (HRA) and are placed in an appropriate level of care coordination - Level 1, 2 or 3. Care coordination services are provided and	Same as above – refer to answer to question 40.

			ratios. The process shall be consistent with the Care Coordination assignment requirements in this Section 4.4.5 and dependent on the outcome of the CNA. §4.4.5.2 Care Coordination Level Zero (CCL0) §4.4.5.2.1 The CONTRACTOR shall assign Members to CCL 0, as follows: §4.4.5.2.1.1 Members the CONTRACTOR was unable to reach after making reasonable outreach efforts as described in Section 4.4.4.4.3, §4.4.5.2.1.2 Members assessed to not have a current need for an assigned care coordinator; §4.4.5.2.1.3	coordinated with the eligible member and their family, as appropriate. Questions: Can you provide clarification regarding the need for and intent of adding the new "Care Coordination Level Zero?" Today we conduct quarterly data mining and conduct an HRA for change of condition for these members. Are there other expectations for this population? What is HCA's vision for managing members in CCL0? Will the calculation of actuarially sound Capitation Rates include the additional administrative costs necessary to implement and maintain the new "Care Coordination Level Zero?" (ex: Costs to hire, train and retain Care Coordinators sufficient to meet ratios in §4.4.5) Proposed Alternate	

			Members who have been contacted and refuse Care Coordination;	Language: Maintain current Levels 1,2 and 3 and do not add a new “Level 0”	
45	Contract	158	§4.8.1.3 The CONTRACTOR shall enter into new contracts with providers for Turquoise Care, unless the provider and the CONTRACTOR mutually agree to forgo entering into a new agreement.	Many, perhaps most, providers do not wish to repaper their contract in whole or in part and will not take the time to respond to an MCO’s request to confirm that. This language creates unnecessary burden for providers and creates uncertainty for the MCOs. Question Is it the HCA’s goal to allow providers who wish to the ability to revisit select elements of their current contracts? Proposed Alternate Language: The CONTRACTOR shall enter into new or amended contracts with providers for Turquoise Care, unless the provider and the CONTRACTOR mutually agree to forgo entering into a new or amended	Section 4.8.1.3 permits the CONTRACTOR and provider to forgo entering into a new agreement based upon mutual agreement. While the CONTRACTOR is expected to have evidence of the mutual agreement, the requirement does not specifically require a provider’s signature of mutual agreement to meet the standard. CONTRACTORS should discuss proposed approaches to “evidence of mutual agreement” to confirm HCA deems the approach compliant.

				agreement or the provider fails to respond within 30 Calendar Days to the CONTRACTOR's request for such mutual agreement.	
46	Contract	188	§4.9.1.1 In order to maximize VBP initiatives and advance initiatives in Turquoise Care, the CONTRACTOR is required to enter into new contracts with provider organizations to establish its Turquoise Care provider network. In limited circumstances, HCA may consider exceptions when certain Providers and the CONTRACTOR mutually agree to forgo this requirement.	BCBSNM shares HCA's goal of maximizing VBP arrangements. This contract language was originally included to expand VBP arrangements when they were first introduced. Many of our providers are participating in VBP arrangements, and those who are not are unable to productively participate in VBP arrangements and/or do not wish to do so. Legacy MCOs are already sufficiently incentivized by DSIPT requirements to identify and successfully contract with those providers that can successfully navigate and benefit all stakeholders by VBP arrangements. Question Can Section 4.9.1.1 be more narrowly tailored to require legacy MCOs to let it be known that the MCO will individually consider and respond to any	MCOs are to actively pursue VBP arrangements with providers and continue to incentivize in alignment with the DSIPT. There is no intent to have contract language differentiating requirements for legacy and new MCOs with relation to DSIPT requirements.

				provider's request to participate in any of the MCO's VBP arrangements? (Give those providers that want to pursue VBP with an MCO the opportunity to do so while not burdening the other providers who don't or can't?) Proposed Alternate Language: In order to maximize VBP initiatives and advance initiatives in Turquoise Care, the CONTRACTOR is required to publish notice to providers that CONTRACTOR will individually consider and respond to any provider's request to participate in any such initiatives available from the CONTRACTOR enter into new contracts with provider organizations to establish its Turquoise Care provider network. In limited circumstances, HSD may consider exceptions when certain Providers and the CONTRACTOR mutually agree to forgo this requirement.	

47	Contract	210	§4.10.7.1.2. VBP Arrangements must include provisions whereby providers are held accountable to quality goals via performance measures (PMs) and savings are passed directly to the front-line providers and teams making the necessary interventions to improve quality. When selecting PMs for VBP contracts, the CONTRACTOR must adhere to any PM requirements promulgated by HCA, and the New Mexico Primary Care Council for Primary Care VBP targets.	BCBSNM acknowledges and agrees that arrangements must include provisions whereby providers are held accountable to quality goals via performance measures (PMs) and savings are passed directly to the front-line providers and teams making the necessary interventions to improve quality. Questions Please clarify that the reference to PMs means the basic definition of PMs in the TC contract. Will HCA excuse sharing savings with groups if doing so will require cost-prohibitive stop loss insurance under the Physician Incentive Plan rule? Please confirm that the reference to “savings” for frontline workers does not mean “all” savings because, for example, provider group entities need to apply a portion of a quality payment to cover their administrative costs associated with their	The TC PMs are selected to assess MCO overall performance with the Medicaid program outcomes and although the MCOs would benefit from aligning the VBP PMs with Contractual PMs this is not a requirement. PMs should be selected to align with the providers specific populations being served and should align with nationally recognized standards from quality assurance measure stewards. Post execution, HCA will be open to discussions regarding potential savings and incentive plans. Post execution, HCA will be open to discussions regarding potential savings and incentive plans.

				quality interventions and provider group entities (which includes non-profit organizations) expect to receive a reasonable margin/profit for being successful in a VBP program? Proposed Alternate Language: VBP Arrangements must include provisions whereby providers are held accountable to quality goals via performance measures (PMs) and savings a portion of savings are passed directly to the front-line providers and teams making the necessary interventions to improve quality unless doing so requires cost-prohibitive stop loss insurance under 42 CFR 422.208. When selecting PMs for VBP contracts, the CONTRACTOR must adhere to any PM requirements promulgated by the Medicaid program, and the New Mexico Primary Care	

				Council for Primary Care VBP targets.	
57	Model Contract - VBP Level Minimum Requirements for New Contractors	438	Contract Year 1 listed as January 1 - December 31, 2024	Will the contract be revised to align with the new launch dates for the contract year (July 2024 - June 2025) or match other DSIPTs which state July 1, 2024 - December 31, 2024?	The TC contract will remain on a calendar year. July 1-December 31, 2024 will be a baseline timeframe for DSIPTs.
PENALTIES/DSIPT					
16	Contract	349	6.9.1 HCA shall impose performance penalties of one-and-a-half percent (1.5%), net of premium taxes, New Mexico Medical Insurance Pool assessments and New Mexico Health Insurance Exchange assessments, of HCA Capitation Payments, including one (1)-time lump sum payments, if DSIPTs are not met. Capitation Payments are based on the full capitation cycle which, generally, runs the first Monday after the first Friday of each month. 6.9.2 The DSIPTs are outlined in Attachment 2.	The table of sanctions on page 367 states: 19. Failure to meet DSIPTs as described in Section 6.9 and Attachment 2: Delivery System Improvement Performance Targets (DSIPTs) of this Agreement. Two percent (2.0%) of Capitation Payments as specified in Section 6.9 of this Agreement, for failure to meet a DSIPT. Please confirm the correct level of penalty for DSIPTs.	The contract has been updated to reflect 2%.
18	DSIPT Objective	431-432	The Contractor shall increase the percent of agency-based authorized personal care services delivered to Members. Performance targets are as follows: For July 1, 2024-December 31, 2024 of CY24, eight-eight percent (88%) of authorized personal care services shall be provided to Members. For CY25, ninety percent (90%) of authorized personal care services shall be provided to Members. For CY26, ninety-two (92%) of authorized personal care services shall be	PHP recommends that the Personal Care Services (PCS) Fulfillment DSIPT referenced on pages 431-432 of the contract be applicable to Members receiving this service via the consumer-delegated model instead of both the consumer-directed and consumer-delegated	HCA does not intend to change the DSIPT as prescribed for PCS.

			provided to Members. For CY27, ninety-four percent (94%) of authorized personal care services shall be provided to Members. For CY28, ninety-six percent (96%) of authorized personal care services shall be provided to Members. For purposes of this DSIPT the performance target shall be calculated as follows: NUMERATOR: Total number of hours of agency-based personal care services provided to Members verified through Electronic Visit Verification (EVV). DENOMINATOR: Total number of hours of authorized agency-based personal care services for Members.	models. This would be consistent with the Policy Manual. Members who receive their PCS via the consumer-directed model are responsible for identifying their own caregivers to include backup caregivers as the Member oversees their service care delivery and the agency acts as a fiscal intermediary agency to process all financial paperwork.	
19	DSIPT Objective	433	Support of pharmacist billing: The CONTRACTOR shall increase the percent of counseling claims submitted by pharmacists in retail pharmacy settings. For the purposes of this DSIPT, following the baseline year, the CONTRACTOR shall increase total claims (CPT 99401) for pharmacy counseling submitted by pharmacists in retail pharmacy settings by one percent (1%). For all subsequent years of the contract, the percent shall increase, at minimum, an additional one percent (1%) each calendar year. Reporting for this DSIPT will utilize claims data.	Retail pharmacy systems are set up to bill for medications only and the NCPDP format doesn't accommodate billing for CPT codes. Is it HCA's intent to require pharmacies to submit CMS 1500 claims for pharmacy counseling services under 99401?	The goal is submission on the 1500, not at the point of sale via PBM's. This is to increase utilization of pharmacist prescriptive authority.
28	4.10.7.2.2	211	Primary Care VBP requirements 4.10.7.2.2 The CONTRACTOR shall execute and facilitate all components of the PCPR payment model, including standardized metrics, reporting, payment structures, patient attribution, data intermediary capabilities, technical assistance, and practice transformation support. The CONTRACTOR	This new language notes that all contractors shall execute and facilitate all components of the PCPR payment model – including standardized metrics, reporting, payment structures, patient attribution, data	This contract language is to require MCO compliance as the PCPR is launched in alignment with HCA and PCC statewide. There is not an expectation that MCOs would create their own VBPs outside or in addition to the VBP PCPR with the State's initiative. Specific guidance from HCA and PCC is anticipated to be available in early Fall.

			shall implement PCPR as outlined in the in the Turquoise Care Primary Care VBP Guidebook document due to be released fall of 2023. The CONTRACTOR shall use Provider metrics (access to care, equity, HEDIS, and patient satisfaction) as outlined by HCA and the New Mexico Primary Care Council.	intermediary capabilities etc. However, the Turquoise Care Primary VBP Guidebook with all those details will not be available until sometime this fall. Please clarify if it is the state's intention to implement this program with standards across all MCOs and to allow MCOs to create their own primary Care VBC programs? Also, when will the booklet with the requirements be available?	
29	Table 1 – VBP Level Minimum Requirements for New CONTRACTOR	438	Table 1 Level Minimum VPB Requirements – lists January 1, 2024, as the first year, January 1, 2025 as the second-year measurement period.	The effective date for the first period begins January 1st, however our go live date is July 1, 2024. Please clarify how we will be measured and comply.	Jan 2025 begins the first year for VBP allowing six months to transition. The first six months of the contract will be used for data collection only.
50	Contract	365	§7.3.3.6.7 Other Monetary Penalties	Though presented as penalties in the contract, the funds at risk in Section 7.3.3.6.7 may be considered a Performance Withhold in terms of Actuarial Standards of Practice and, as such, the rates should reflect the value of the portion of the withhold for the operational targets in accordance with Actuarial Standard of Practice No.	All items, except for Item 19, from Section 7.3.3.6.7 Other Monetary Penalties from the Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023), are as operational in nature and thus not subject to the applicable requirements described in 42 CFR 438. HCA expects the Turquoise Care MCOs to meet the operational objectives and requirements of the Turquoise Care Medicaid Managed Care Request for Proposals (RFP#

				49, Section 3.2.15. Question How will the increase of funds placed at risk be factored into actuarial soundness of rates? Does HCA agree that retroactive data can not be used to determine or calculate any monetary penalty? (Penalties can only be based on data and performance from July 1, 2024, forward).	23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023. HCA agrees that data prior to July 1, 2024 would not be used to evaluate performance on operational penalties after July 1, 2024.
51	Contract	365	§7.3.3.6.7 Other Monetary Penalties 5. Failure to assign a Member to the required Care Coordination Level (CCL0, CCL1, or CCL2) as described in Section 4.4 of this Agreement. One thousand dollars ($1,000) per Member for which the CONTRACTOR fails to assign the Member to the required CCL.	Question How will HCA determine how members are inappropriately "leveled" in penalty #5?	HCA will determine inappropriately leveled care coordination assignment through methods such as, but not limited to, care coordination audits, complaints, grievances, appeals. Some examples can include: - all CISC must be in CC L2 or CC L3. A penalty may be applied if a CISC is not in CC L2 or CC L3 unless there is a signed declination form. - if a pregnant person is leveled in 0, a penalty may be applied unless there is a signed declination form
52	Contract		§7.3.3.6.7 Other Monetary Penalties 9. Failure to meet Non-Emergency Medical	There is an NEMT critical care appointment standard in 4.8.8.6.14.2 that would be subject to penalties under Financial Penalty Number 11 for failure to meet appointment	Contract edit: 9. Failure to meet General Non-Emergency Medical Transportation (NEMT) minimum standards for Members to access appointments. This excludes critical care NEMT.

			Transportation (NEMT) minimum standards for Members to access appointments.	standards. Question Does HCA intend to penalize the MCOs twice for the NEMT critical care appointments—with up to 5% of capitation under number 9 and with uo 2% of capitation under number 11?	
MLR					
3	Contract	62, 64	3.3.3.26 and 3.3.5 Additional Required Staff	Please identify any of the staff costs for new positions that are considered medical costs for purposes of calculating the MLR?	The additional staff added are not considered medical costs.
17	Contract	358	7.2.10.1.3 Aggregation Method: The CONTRACTOR shall calculate the medical loss ratio for Other Adult Group and Non-Other Adult Group populations.	Will HCA consider PHP's language submitted in our proposal, as follows: For the CISC CONTRACTOR, the MLR for the non-CISC Members will be calculated separately from the MLR for the CISC Members. The MLR for CISC will be calculated using CISC as a separate line of business for Net Capitation Revenue, Total Medical Expense, Administrative Expense and Underwriting Gain for year 1 actual costs	HCA does not anticipate making adjustments to Section 7.2.10.1.3 of the Turquoise Care Medicaid Managed Care Request for Proposals RFP# 23-630-8000-0001 Appendix L Model Contract Issue date September 30, 2022, later revised as Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023), at this time. However, HCA may consider this proposal for future updates to the Turquoise Care Medicaid Managed Care Request for Proposals RFP# 23-630-8000-0001 Appendix L Model Contract Issue date September 30, 2022, later revised as

				as a baseline. Years 2 and beyond will be adjusted as the program matures.	Turquoise Care Medicaid Managed Care Request for Proposals (RFP# 23-630-8000-0001) Appendix L Model Contract (Issue date September 28, 2023). Last round related answer: *The Minimum Medical Loss Ratio (MLR) and Underwriting Gain Limitation will be considered when developing capitation rates.*
OTHER					
13	Contract	172	4.8.8.7.3 The CONTRACTOR shall submit the survey scripts to HCA for prior written approval, allowing HCA less than thirty (30) days to review and approve the scripts.	Should this read “no less than” instead of “less than”?	Contract edit: “no less than”
23	Data Book		General	Can HCA provide a summary of statewide enrollment by IDD, age/gender, and CARA status for the Data Book period to all for better understanding of the CISC population?	This data will be discussed after being updated and execution of contracts.
24	LOD 96		General	LOD 96 Well Child Check requirements do not appear to have been incorporated into the contract. Will those be added?	These requirements will be included in Turquoise Care Contract Amendment #1.
25	LOD 99		General	LOD 99 High Fidelity Wraparound requirements do not appear to have been incorporated into the contract. Will those be added?	These requirements will be included in Turquoise Care Contract Amendment #1.

26	LOD 100		General	LOD 100 Coordination of Treatment Foster Care requirements do not appear to have been incorporated into the contract. Will those be added?	These requirements will be included in Turquoise Care Contract Amendment #1.
30	4.15.5.1 provider directory	251/ 252	The Provider's race and/or ethnicity; and a photograph of the Provider; and hospital listings, including locations of emergency settings and Post-Stabilization Services, with the name, location, and telephone number of each facility/setting.	We would like to confirm that the pictures for providers are at the professional level. Not individual HCBS providers, audiologists, technicians, etc. Are vendor's providers included—i.e., dental/vision?	HCA confirms that the requirement for a photograph of the Provider applies only to Providers at the professional level.
31	4.15.7.5	253	Printed copies of the Provider directory shall be updated monthly and the electronic version shall be updated no later than two (2) Business Days after the CONTRACTOR receives updated Provider information.	UHC validates certain provider information to ensure changes don't impact claim payment and other processes. As a result, updates may take longer than two business days, therefore UHC requests a longer TAT.	The state will not adjust this requirement of 2 business days.
33	3.1.1.1/3.1.1.2	54	3.1.1.1 The CONTRACTOR shall be either: (i) National Committee for Quality Assurance (NCQA) Health Plan accredited in the State of New Mexico or (ii) accredited in another state where the CONTRACTOR currently provides Medicaid services and initiates the NCQA accreditation process for the State of New Mexico upon notice of award and achieves New Mexico NCQA Health Plan accreditation within one (1) year from Go-Live. The CONTRACTOR shall provide HCA the current and each reoccurring NCQA Health Plan accreditation award letter, the	New entrants cannot achieve this timeline for the following reasons: Most measures require a minimum of 12 months of continuous enrollment within the Measurement Year As the NM contract	Contract edit: ...accredited in another state where the CONTRACTOR currently provides Medicaid services and initiates the NCQA accreditation process for the State of New Mexico upon notice of award and achieves New Mexico NCQA Health Plan accreditation within one and a half (1.5) years from Go-Live. The Contractor is required to declare intent and timeline to achieve LTSS/HE accreditation no later than December 31, 2026.

			Accreditation Certificate, Accreditation Summary Report and the HEDIS Score Sheet within thirty (30) Calendar Days of receipt. 3.1.1.2 The CONTRACTOR shall, within eighteen (18) months of Go-Live, obtain NCQA Distinction in Multicultural Health Care/Health Equity Accreditation and Long-Term Services and Supports (LTSS) Distinction in the State of New Mexico. (The NCQA Distinction in Multicultural Health Care is scheduled to change to transition to NCQA "Health Equity Accreditation" and "Health Equity Accreditation Plus" for surveys after July 2022.) The CONTRACTOR shall provide HCA the current and each reoccurring NCQA accreditation and distinction award letter from NCQA to HCA within thirty (30) Calendar Days of receipt.	effective date is 7/1/24, the plan will not run its first HEDIS until QI 2026 with results available in late Q2 2026 Full Health Plan Accreditation and HEA Accreditation both contain standards that utilize HEDIS data that drive the identification and selection of quality initiatives. LTSS Distinction is only available to plans that have or are pursuing Accreditation. As a result of lack of HEDIS data until late Q2 2026, Full Health Plan Accreditation with LTSS Distinction and HEA Accreditation cannot be obtained until end of year 2026. UHC will apply for interim accreditation within the first contract year, however we believe full accreditation/LTSS/HEA cannot be achieved until end of 2026, please confirm.	
34	3.1.2	55	The CONTRACTOR shall participate in a readiness review period beginning upon	When should we expect to receive detailed readiness	The updated procurement timeline has been published to the Turquoise Care webpage as

			signature of this Agreement by all parties and through June 2024. The CONTRACTOR must obtain HCA prior written approval of all readiness elements prior to July 1, 2024.	review dates and expected desk documentation dates?	of September 28, 2023. HCA is developing a comprehensive set of readiness materials to meet the requirements for desk review and on-site review activities. The MCO should expect detailed information regarding dates and expectations late November during a formal kick-off meeting. The MCOS will receive a RFI in December and should expect to submit some materials as early as January. On-site reviews are likely to occur in mid-March. MCO's should begin updating or developing contractually required materials including policy and procedures, as soon as possible.
36				When should we expect to receive the Turquoise Care Data Books? CareLink manual? Companion guides? Standard HRAs/ Reporting templates, Etc? Should new entrant MCOs use the existing Centennial Care companion guides listed at the following site xxxxxx or if not, when will new guides be available. https://www.hsd.state.nm.us/providers/hippa-standard-companion-guides/ Are these companion guides the versions that will be used for implementation, or will new versions be available? If new versions, please	The data books that were provided to the MCO's during the procurement will not be updated and are available in the procurement library. HCA is working to update the companion guidance including any changes to manuals, reporting templates etc. The delivery date is not yet available however, HCA will allow ample time for the MCO to make any changes as result of updated materials. The MCO should begin updating systems, people and policy based on the requirements in the contract.

				advise when UHC can expect those to be available.	
37	4.21.1.1.7	305	Upon HCA direction, transmit electronic remittance (835, 837 PACDR,) and EDI response files to HCA System Integrator	Please confirm this will not be implemented for 7/1/24 go live.	Contractors will be required to go live 7/1/24. Testing will be done prior to 7/1/24 to ensure system functionality is ready for go-live.
53	Model Contract – 1.3.3	6	All applicable instruments HCA may use from time to time to communicate, update, and clarify information, including but not limited to: letters of direction, Managed Care Policy Manual, Managed Care Organization (MCO) Systems Manual, guidance memoranda, correspondence, and other communication, including all updates and revisions thereto, or substitutions and replacements thereof. These instruments are governed by the provisions of this Agreement, in the event of conflict.	Will HCA issue an updated Managed Care Policy Manual, Managed Care Organization (MCO) Systems Manual and Behavioral Health Policy and Billing Manual for Turquoise Care to ensure compliance to the contract in advance of readiness activities?	An updated Managed Care Policy Manual, MCO Systems Manual and Behavioral Health Policy and Billing Manual will be issued for Turquoise Care.