C. **Grievance**

1. A consumer may file a Grievance either orally or in writing with the SE within ninety (90) calendar days of the date the dissatisfaction occurred. The legal guardian of the consumer for a minor or incapacitated adult, a representative of the consumer as designated in writing to the SE, or a provider acting on behalf of the consumer and with the consumer's written consent, has the right to file a Grievance on the consumer's behalf.

2. Within five (5) business days of receipt of the Grievance, the SE shall provide the grievant with written notice that the Grievance has been received and the expected date of its resolution.

3. The investigation and final SE resolution process for Grievances shall be completed within thirty (30) calendar days of the date the Grievance is received by the SE and shall include a resolution letter to the grievant.

4. The SE may request an extension of up to fourteen (14) calendar days if the consumer requests the extension, or the SE demonstrates that there is a need for additional information, and the extension is in the consumer's best interests. For any extension not requested by the consumer, the SE shall give the consumer written notice of the reason for the extension within two (2) business days of the decision to extend the timeframe.

5. Upon resolution of the Grievance, the SE shall mail a resolution letter to the consumer. The resolution letter shall include, but is not limited to, the following:

   a. All information considered in investigating the Grievance;

   b. Findings and conclusions based on the investigation;

   c. The disposition of the Grievance; and

   d. The right to appeal the resolution, if applicable.

D. **Appeal**

1. Notice of SE Action. The SE shall mail a Notice of Action to the consumer or provider and all those interested parties affected by the decision within fifteen (15) business days of the date of an Action except for denial of claims which may result in consumer financial liability which requires immediate notification. Exceptions to the fifteen (15) day notification requirement include the following:

   b. The period of advanced notice is shortened to five (5) business days if consumer fraud has been verified;

   c. By the date of the Action for the following:

      i. Death of a consumer;

      ii. A signed written statement from the consumer requesting service termination or giving information requiring termination or reduction of covered services (where the consumer understands that this must be the result of supplying that information);

iii. The consumer's address is unknown and mail directed to the consumer has no forwarding address;

iv. The consumer has been accepted for Medicaid services in another jurisdiction; or

v. The consumer's provider prescribes the change in level of medical care.

2. A consumer may file an Appeal of an SE Action within ninety (90) calendar days of receiving the SE's Notice of Action. The legal guardian of the consumer for minors or incapacitated adults, a representative of the consumer as designated in writing to the SE, or a provider acting on a consumer's behalf with the consumer's written consent, has the right to file an Appeal of an Action on behalf of the consumer. The SE shall consider the consumer, representative, or estate representative of a deceased consumer as parties to the Appeal.

3. The SE has thirty (30) calendar days from the date the oral or written Appeal is received by the SE to resolve the Appeal.

4. The SE shall have a process in place that assures that an oral inquiry from a consumer seeking to Appeal an Action is treated as an Appeal (to establish the earliest possible filing date of the Appeal). An oral appeal must be followed by a written Appeal that is signed by the consumer.

5. Within five (5) business days of receipt of the Appeal, the SE shall provide the appellant with written notice that the Appeal has been received and the expected date of its resolution. The SE shall confirm, in writing, receipt of oral Appeals, unless the consumer or the provider requests an Expedited Resolution.

6. The SE may extend the thirty (30) day timeframe by fourteen (14) calendar days if the consumer requests the extension, or if the SE demonstrates that there is need for additional information, and the extension is in the consumer's best interest. For any extension not requested by the consumer, the SE shall give the consumer written notice of the extension and the reason for the extension within two (2) business days of the decision to extend the timeframe.

7. The SE shall provide the consumer and/or the representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person, as well as in writing.

8. The SE shall provide the consumer and/or the representative the opportunity, before and during the Appeals process, to examine the consumer's case file, including medical records, any other documents and records considered during the Appeals process. The SE shall include as parties to the Appeal, the consumer and his/her representative, or the legal representative of a deceased consumer's estate.

9. For all Appeals, the SE shall provide written notice within the thirty (30) day timeframe of the Appeal resolution to the consumer and the provider, if the provider filed the Appeal. The written notice of the Appeal resolution in the consumer's favor (Medicaid or non-Medicaid consumer) or not resolved wholly in the favor of a non-Medicaid consumer, shall

include, but is not limited to, the following: (a) the result(s) of the Appeal resolution; and (b) the date it was completed. The written notice of the Appeal resolution not resolved wholly in favor of a Medicaid consumer shall include, but is not limited to, the following information: (a) the right to request an HSD/MAD Fair Hearing and how to file for a Fair Hearing; (b) the right to request receipt of benefits while the Fair Hearing is pending, and how to make the request; and (c) that the consumer may be held liable for the cost of those benefits if the Fair Hearing decision upholds the SE's Action.

10. The SE may continue covered services for consumers while the Appeal and/or the HSD/MAD Fair Hearing process (for Medicaid consumers) is pending. The SE shall continue a consumer's covered services a if all of the following are met:

    a. The consumer or the provider files a timely Appeal of the SE Action (within thirteen (13) calendar days of the date the SE mails Notice of Action);

    b. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. This does not include a new annual authorization for services which may be lower than provided in the previous year;

    c. The services were ordered by an authorized provider;

    d. The time period covered by the original authorization has not expired; and

    e. The consumer requests an extension of the benefits.

11. The SE shall provide covered services to the consumer until one of the following occurs:

    a. The consumer withdraws the Appeal;

    b. Ten (10) business days have passed since the date the SE mailed the resolution letter, providing the resolution of the Appeal was against the consumer and the consumer has taken no further action;

    c. HSD/MAD issues a hearing decision adverse to the consumer; or

    d. The time period or service limits or a previously authorized service has expired.

12. If the final resolution of the Appeal is adverse to the member, that is, the SE's Action is upheld, the SE may recover the cost of the services furnished to the consumer while the Appeal was pending to the extent that services were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 CFR §431.230(b).

13. If the SE or HSD/MAD reverses a decision to deny, limit, or delay services and these services were not furnished while the Appeal was pending, the SE shall authorize or provide the disputed services promptly and as expeditiously as the consumer's behavioral health condition requires.

14. If the SE or HSD/MAD reverses a decision to deny, limit, or delay services and the consumer received the disputed services while the Appeal was pending, the SE shall pay for these services.

E. **Expedited Resolution of Appeals**

1. The SE shall establish and maintain an Expedited Review process for Appeals when the SE determines that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function or the child or youth is in the custody or supervision of CYFD and the SE has denied authorization for court-ordered out-of-home treatment. Such a determination is based on:

   a. A request from a consumer;

   b. A provider's support of the consumer's request;

   c. A provider's request on behalf of the consumer; or

   d. The SE's independent determination.

2. The SE shall ensure that the Expedited Review process is convenient and efficient for the consumer.

3. The SE shall resolve the appeal within three (3) business days of receipt of the request for an Expedited Appeal, if the request meets the definition of an Expedited Appeal. In addition to written resolution notice, the SE shall also make reasonable efforts to provide and document oral notice.

4. The SE may extend the timeframe by up to fourteen (14) calendar days if the consumer requests the extension, or the SE demonstrates that there is need for additional information, and the extension is in the consumer's best interests. For any extension not requested by the consumer, the SE shall make reasonable efforts to give the consumer prompt verbal notification and follow-up with a written notice within two (2) business days.

5. The SE shall ensure that punitive action is not taken against a consumer or a provider who requests an Expedited Resolution or a provider who requests an Expedited Resolution or supports a consumer's Expedited Appeal.

6. The SE shall provide Expedited Resolution of an Appeal, if it meets expedited criteria, in response to an oral or written request from the consumer or provider on behalf of a consumer.

7. The SE shall inform the consumer of the limited time available to present evidence and allegations in fact or law.

8. If the SE denies a request for an Expedited Resolution of an Appeal, it shall:

   a. Transfer the Appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the SE received the request;

b. Make reasonable efforts to give the consumer prompt oral notice of the denial, and follow-up with a written notice within two (2) business days; and

c. Inform the consumer in the written notice of the right to file an Appeal if the consumer is dissatisfied with the SE's decision to deny an Expedited Resolution.

9. The SE shall document in writing all oral requests for Expedited Resolution and shall maintain the documentation in the case file.

F. **Special Rule for Certain Expedited Service Authorization Decisions**

In the case of Expedited Service Authorization decisions that deny or limit services, the SE shall, within seventy-two (72) hours of receipt of the request for service, automatically file an appeal on behalf of the consumer, make best effort to give the consumer oral notice of the decision of the automatic Appeal, and make a best effort to resolve the Appeal. For purpose of this Section, an "Expedited Service Authorization" is a certification requesting for urgently needed care or services.

G. **Information About Grievance System to Network Providers**

The SE shall provide information specified in 42 CFR §438.10(g)(1) about its grievance system to all providers and subcontractors at the time they enter into a contract.

H. **Grievance and/or Appeal Files**

1. All Grievance and/or Appeal files shall be maintained in a secure, designated area and be accessible to the State upon request, for review. Grievance and/or Appeal files shall be retained for ten (10) years following the final decision by the SE, HSD/MAD, judicial appeal, or closure of a file, whichever occurs later.

2. The SE shall have procedures for ensuring that files contain sufficient information to identify the Grievance and Appeal, the date it was received, the nature of the Grievance and/or Appeal, all correspondence between the SE and the consumer and the provider (when applicable), the date the Grievance and/or Appeal is resolved, the resolution, and notices of final decision to the consumer and all other pertinent information.

3. Documentation regarding the grievance shall be made available to the consumer, if requested.

I. **Reporting**

1. The SE shall provide information requested or required by the State or CMS.

2. The SE shall provide the Collaborative quarterly reporting of all provider and consumer Grievances, Appeals, and Fair Hearings utilizing Collaborative-provided reporting templates and Grievance codes. The SE shall provide a monthly report to the Collaborative of the analysis of all provider and consumer Grievances, Appeals, and Fair Hearings received from or about consumers, by the SE or its subcontractors, during the quarter. The analysis shall include the identification of any indications of trends as well as any interventions taken to address those trends.

3. The SE shall provide each LC with regular aggregate and trended grievance and appeal information applicable to consumers from the LC's geographic area and compared to the state as a whole.

J. **Provider Grievance and Appeals**

The SE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the SE. Provider grievances or appeals shall be resolved within thirty (30) calendar days. If the provider grievance or appeal is not resolved within thirty (30) calendar days, the SE shall request a fourteen (14) day extension from the provider. If the provider requests the extension, the extension shall be approved by the SE. A provider shall have the right to file an appeal with the SE regarding provider payment issues and/or utilization management decisions. Following the conclusion of this grievance and appeal process, providers may contact the Collaborative CEO.

3.16 FIDUCIARY RESPONSIBILITIES

A. **Financial Viability**

1. Net Worth. The SE shall, at all times, be in compliance with the net worth requirements set for in the New Mexico Insurance Code, NMSA 1978, §§59A-1-1, et seq.

2. Working Capital Requirements. The SE shall demonstrate and maintain working capital as specified below. For purposes of this Contract, working capital is defined as current assets minus current liabilities. Throughout the terms of this Contract, the SE shall maintain a positive working capital, subject to the following conditions:

   a. If the SE's working capital falls below zero, the SE shall submit a written plan to reestablish a positive working capital balance for approval by the Collaborative.

   b. The Collaborative may take any action it deems appropriate, including termination of this Contract, if the SE:

      i. Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time;

      ii. Violates a corrective action plan; or

      iii. The Collaborative determines that the negative working capital cannot be corrected within a reasonable time.

B. **Financial Stability**

1. Financial Stability Plan. Throughout the term of this Contract, the SE shall:

   a. Comply with and be subject to all applicable state and federal laws and regulations including those regarding solvency and risk standards. In addition, the SE shall meet specific Medicaid financial requirements and to present to the Collaborative any information and records deemed necessary to determine its financial condition. The response to requests for information and

records shall be delivered to the Collaborative, at not cost to the Collaborative, in a reasonable time from the date of the request or as specified herein.

b. Remain financially stable.

c. Immediately notify the Collaborative when the SE has reason to consider insolvency or otherwise has reason to believe it or any subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the Chief Executive Officer or Chief Financial Officer to notify the SE's board of the potential for insolvency.

d. Procure and maintain such insurance as is required by current applicable state and federal law and regulations. Such insurance shall include, but is not limited to, the following:

i. Liability insurance for loss, damage, or injury (including death) of third parties arising from acts or omissions on the part of the SE, its agents and employees;

ii. Workers' compensation;

iii. Unemployment insurance;

iv. Reinsurance, unless deemed met by the Collaborative pursuant to Article 3.16.D;

v. Automobile insurance to the extent applicable to the SE's operations; and

vi. Health insurance for employees as further set forth in Article 38.

2. Insolvency Reserve Requirement

a. The SE shall maintain a reserve account to ensure that the provisions of covered services to consumers are not at risk in the event of the SE's insolvency. The SE shall comply with all state and federal laws and regulations regarding solvency, risk, and audit and accounting standards.

b. Per Consumer Cash Reserve. The SE shall deposit an amount equal to three percent (3%) of the monthly capitated payments per consumer into a reserve account with an independent trustee during each month of the first year of this Contract. The SE shall maintain this cash reserve for the duration of this Contract. The Collaborative shall adjust this cash reserve requirement annually, as needed, based on the number of consumers. The cash reserve account may be accessed solely for payment for covered services to consumers in the event that SE becomes insolvent. Money in the cash reserve account remains the property of the SE, including any interest earned. The SE shall be permitted to invest its cash reserves with the Collaborative's approval and consistent with Division of Insurance regulations and guidelines.

c. The SE may satisfy all or part of the Insolvency Reserve Requirement in Article 3.11.B.2 in writing with evidence of adequate protection through any combination of the following that are approved by the Collaborative: net worth of the SE (exclusive of any restricted cash reserve); performance guarantee; insolvency insurance; irrevocable letter of credit; surety bond; and/or a formal written guarantee from the SE's parent organization. At least fifty percent (50%) of the total Insolvency Reserve shall be in restricted cash reserves.

3. Fidelity Bond Requirements. The SE shall maintain in force a fidelity bond or fidelity insurance on any director, officer, employee or partner of the SE who receives, collects, disburses or invests funds in connection with the activities of the SE in an amount not less than twenty-five (25) percent of the total Contract amount.

C. **Other Financial Requirements**

1. Auditing and Financial Requirements. The SE shall:

a. Ensure that an independent financial audit of the CONTACTOR is performed annually. This audit shall comply with the following requirements:

i. Provide the Collaborative with the SE's most recent audited financial statements; and

ii. Provide an independent auditor's report on the processing of the transactions.

b. Submit on an annual basis after each audit a representation letter signed by the SE's Chief Financial Officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

c. Immediately notify the Collaborative of any material negative change in the SE's financial status that could render the SE unable to comply with any requirement of this Contract, or that is significant enough for the Chief Executive Officer or Chief Financial Officer to notify its Board of the potential for insolvency.

d. Notify the Collaborative in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the SE's ability to satisfy its payment or performance obligations under this Contract.

e. Advise the Collaborative no later than thirty (30) calendar days prior to execution of any significant organizational changes, new contracts, or business ventures, being contemplated by the SE that may negatively impact the SE's ability to perform under this Contract.

f. Refrain from investing funds in, or loaning funds to, any organization in which a director or principal officer of the SE has an interest.

2. Inspection and Audit for Solvency Requirements. The SE shall meet all state and federal requirements respect to inspection and auditing of financial records. The SE shall also cooperate with the Collaborative and provide all financial records required by the Collaborative so that it may inspect and audit the SE's financial records at least annually or at the Collaborative's discretion.

3. Third-Party Liability

   a. The SE shall ensure that providers comply with HSD/MAD requirements regarding third party liability, including the HSD/MAD Provider Policy Manual and NMAC 8.302.3.

   b. The SE shall identify third-party coverage of consumers and coordinate benefits with applicable third-parties, including Medicare (see Article 6.15.E).

   c. The SE shall not refuse to provide or reduce covered services solely due to the existence of similar benefits provided under other coverage;

   d. The SE shall provide documentation to the Collaborative enabling the Collaborative to pursue its rights under state and federal law and regulations. Documentation includes payment information on consumers as requested by the Collaborative, to be delivered within twenty (20) business days from receipt of the request. Other documentation to be provided by the SE includes a quarterly listing of potential accident and personal injury cases that are known or should have been known to the SE.

   e. The SE has the sole right of subrogation, for twelve (12) months from the initial date of service to a consumer, to initiate recovery or attempt to recover any third-party resources available to consumers.

   f. The SE shall communicate and ensure compliance with the requirements of this Article 3.16.C.3 by subcontractors that provide services under the terms of this Contract.

D. **Reinsurance**

The SE shall have and maintain a minimum of one million dollars ($1,000,000.00) in reinsurance protection against financial loss due to outlier (catastrophic) cases or maintain self-insurance acceptable to the Collaborative. The SE shall submit to the Collaborative such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance. The SE may request that the Collaborative remove this requirement by providing sufficient documentation to the Collaborative that the SE has adequate protection against financial loss due to outlier (catastrophic) cases. The Collaborative shall review such documentation and at is discretion, deem this requirement to be met.

3.17 PROGRAM INTEGRITY

The SE shall:

A. Have and implement policies and procedures to address prevention, detection, preliminary investigation, and reporting of potential and actual member and provider fraud and abuse. The SE's policies and procedures shall demonstrate the SE's commitment to comply with all state and federal requirements. (See also Article 33 of this Contract.)

B. Have a comprehensive internal program to prevent, detect, investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions.

C. Designate a compliance officer and a compliance committee that are accountable to senior management.

D. Enforce program integrity standards through well-publicized disciplinary guidelines.

E. Have an effective training and education program for the compliance officer and the SE's staff.

F. Have specific controls for prevention and detection, such as claim edits, post-processing review of claims, provider profiling and credentialing, prior authorizations, UM and QM/QI and relevant provisions in the SE's contracts with network providers and subcontractors.

G. Establish effective lines of communication between the compliance officer and the SE's staff to facilitate the oversight of systems that monitor service utilization (including claims and encounter) for fraud and abuse and have a mechanism for a prompt response to detected offense.

H. Make an initial report to the Collaborative within five (5) business days of becoming aware of any activity that, in the SE's professional judgment, is suspicious and may indicate that fraud or abuse has occurred.

I. Promptly conduct a preliminary investigation regarding the activity reported to the Collaborative and report the results of the investigation, including any applicable evidence, to the Collaborative. If requested by the Collaborative, the SE shall conduct a formal investigation and report the results to the Collaborative. If the Collaborative does not request a formal investigation, the SE shall provide full cooperation with any investigation conducted by the State or federal authorities (see also Article 33).

J. Conduct provider profiling to identify potential fraud and abuse and, upon request, provide copies of the reports, including provider names, to the Collaborative.

K. Cooperate with any member agency's investigation unit, the Medicaid Fraud Control Unit (MFCU), the DEA, the FBI and other investigatory agencies.

L. Comply with, and require all of its subcontractors to comply with, the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005.

M. Report the following to the Collaborative:

1. The number of complaints of provider fraud and abuse made that warranted investigation; and

2. For each complaint that warranted investigation, supply the: (1) name and ID number of the provider; (2) source of complaint; (3) type of provider; (4) nature of complaint; (5) approximate dollars involved; and (6) legal and administrative disposition of the case.

N. Have and implement policies and procedures for disciplinary action for employees who do not report fraud and abuse to the SE's fraud and abuse department and/or destroy evidence related to a specific fraud or abuse case or potential case.

O. Comply with Section 1902(a)(68) of the Social Security Act as follows:

1. Establish written policies and for all its employees, agents, or contractors that provide detailed information regarding: the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under Sections 3729 through 3733 of Title 31, United States Code; administrative remedies for false claims and statement established under chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in Section 1128B(f) of the Social Security Act);

2. Include as part of such written policies, detailed provisions regarding the SE's policies and procedures for detecting and preventing fraud, waste, and abuse; and

3. Include in any employee handbook a specific discussion of the laws described in subparagraph (a), the rights of employees to be protected as whistleblowers, and the SE's policies and procedures for detecting and preventing fraud, waste, and abuse.

4. For purposes of this Section, "employee" includes any officer or employee of the SE and a "contractor" or agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the SE, furnishes, or otherwise authorizes the furnishing of, Medicaid services, performs billing or coding functions, or is involved in the monitoring of services provided by the SE.

5. The State, at its sole discretion, may exempt the SE from the requirements set forth in this Section; however, the State shall not exclude contractor that receives at least $5,000,000 in annual payments from the State.

3.18 PROVIDER PAYMENT MANAGEMENT

A. General Provisions

To the extent that the SE reimburses providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the SE shall process, as described herein, the provider's claims for covered benefits provided to consumers consistent with applicable SE and agency policies and procedures and the terms of this Contract including but not limited to timely filing, and

compliance with all applicable state and federal laws, rules and regulations. Additionally, the SE shall institute processes for handling payment to providers for services that do not require the submission of claims as a condition of payment; these processes shall not compromise the ability to obtain encounter data from said providers.

B. **Claims Management System Capabilities**

1. The SE shall maintain a claims management information system that at a minimum possesses the following features: (a) unique identification of the provider of the service, (b) date of receipt - the date the SE receives the claim as indicated by a date-stamp, (c) real-time-accurate history of actions taken on each provider claim - i.e. paid, denied, suspended, appealed, etc., (d) date of payment - the date of issue of the check or other form of payment, (e) tracking of individual services by fund source and/or program, and other data elements as required in this Contract for encounter data submission (see Article 3.19).

2. The SE shall have in place an electronic claims management (ECM) capability that can accept and process claims submitted electronically.

3. The ECM capability shall function in accordance with information exchange and data management requirements specified in Article 3.20.C of this Contract.

4. As part of this ECM function, the SE shall provide on-line and phone-based capabilities for providers to obtain claims processing status information.

5. The SE shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of payments.

6. The SE shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the SE or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

C. **Formats for Paper-Based Claims/Invoices**

1. The SE shall comply at all times with the following paper forms/formats (and all future updates) for Medicaid fee-for-service claims and other methods of invoicing; the SE shall not revise or modify these forms/formats:

Claim Type	**Claim Form**
Professional	CMS 1500
Institutional	CMS 1450 (UB-04)

2. For the forms identified in section 1 above, the SE shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms as well as any program-specific instructions. These shall include, but not be limited to, HIPAA-based standards and federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR §§455.18 and 455.19.

D. **Prompt Payment**

1. The SE shall comply with prompt pay claims processing requirements in accordance with NMAC 8.305.11.

2. The SE shall pay ninety percent (90%) of all clean claims from providers who are in individual or group practice or who practice in shared health facilities within thirty (30) days of date of receipt, and shall pay ninety-nine percent (99%) of all such clean claims within ninety (90) days of receipt.

3. If a claim is partially or totally denied on the basis the provider did not submit all required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.

4. To the extent that the agreement between the provider and the SE stipulates compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the agreement between the provider and the SE or, (ii) the tenth (10^{th}) day of the calendar month if a time period is not specified in the agreement.

5. The SE shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if a consumer has a retroactive eligibility date. In situations of third party benefits, the timeframe for filing a claim shall be one (1) year from the date of service (see NMAC 8.302.2.11.A) for Medicaid claims, and shall begin on the date that the third party documented resolution of the claim for non-Medicaid claims. In situations of enrollment with a retroactive eligibility date, the timeframes for filing a claim shall begin on the date that the SE receives notification of the consumer's eligibility/enrollment.

6. The SE shall report the number and allowed amount of clean claims submitted electronically that were not processed within thirty (30) calendar days of the date of receipt. The SE shall also report the number and allowed amount of clean claims not submitted electronically that were not processed within forty-five (45) calendar days of the date of receipt (see NMAC 8.305.11.9).

7. The SE shall pay interest at the rate of one and one-half percent (1 ½%) for each month or portion of any month on a prorated basis on the amount of a clean claim submitted by a provider and not paid within:

a. Thirty (30) calendar days of the date of receipt, if the claim was submitted electronically; or

b. Forty-five (45) calendar days of the date of receipt, if the claim was not submitted electronically.

8. Interest payments shall be paid out of the SE's administrative funds and not passed through and charged to that funding source as a direct service expenditure unless the late payment to the providers is due to late payment to the SE. In the case of the latter, the interest shall be paid from the applicable funding source.

E. **Claims Payment Accuracy – Minimum Audit Procedures**

1. On a quarterly basis the SE shall submit claims payment accuracy percentage reports to the Collaborative.

2. The report shall be based on an audit conducted by the SE. The audit shall be conducted by a unit or staff independent of the SE's claims management unit.

3. The audit shall utilize a random sample of all processed claims in each quarter. A minimum sample of three hundred (300) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the quarter tested is required. The sample shall be further decomposed into minimum sub-samples of one hundred (100) claims randomly selected from the entire population of claims processed and paid upon initial submission for each month in the quarter.

4. The minimum attributes to be tested for each claim selected (not all attributes may apply to each claim that is selected for the audit) shall include:

a. Claim data correctly entered into the claims processing system;

b. Claim is associated to the correct provider;

c. Service obtained the proper authorization;

d. Member eligibility at processing date correctly applied;

e. Allowed payment amount agrees with contracted rate;

f. Duplicate payment of the same claim has not occurred;

g. Denial reason applied appropriately;

h. Effect of modifier codes correctly applied;

i. Other insurance properly considered and applied; and

j. Proper service/procedure coding.

5. For verification purposes, the SE shall keep track of the population of claims being used in these audits. Additionally, the results of testing at a minimum should be documented to include:

a. Results for each attribute tested for each claim selected;

b. Amount of overpayment or underpayment for claims processed or paid in error;

c. Explanation of the erroneous processing for each claim processed or paid in error;

d. Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and

e. Claims processed or paid in error have been corrected.

F. **Claims Processing Methodology Requirements**

1. The SE's claims management information system(s) shall perform front-end edits, including but not limited to:

a. Confirming eligibility on each consumer as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

b. Coding validation: claims were completed with valid procedure, diagnosis, revenue, provider and other standardized service codes;

c. Third party liability (TPL);

d. Appropriateness of the service/procedure given consumer age, sex and other characteristics;

e. Prior authorization: the system shall determine whether a covered service required prior authorization and, if so, whether the SE granted such approval;

f. Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;

g. Covered service: the system shall verify that a service is a covered service and is eligible for payment; and

h. Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted.

2. The SE shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., not in the future or outside of a consumer's Collaborative eligibility span.

G. **Remittance Advices and Related Functions**

1. In concert with its claims payment cycle the SE shall provide an electronic status report ("remittance advice") indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the SE. A hard-copy remittance advice shall be produced and mailed or faxed upon request.

2. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data (e.g. carrier information).

3. If a claim is partially or totally denied on the basis that the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

H. **Processing of Payment Errors**

The SE shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from Collaborative.

I. **Excluded Providers**

1. The SE shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with the Collaborative or a member agency.

2. The SE shall not pay any claim submitted by a provider that is on payment hold under the authority of the Collaborative or a member agency.

J. **Payment Cycle**

At a minimum, the SE shall run one (1) provider payment cycle per week.

K. **Incentives**

The SE shall offer incentives, such as but not necessarily limited to faster issuance of payments, to providers who submit claims/invoices electronically within a specified timeframe or that meet or exceed data quality standards in their submissions. Incentives will be reviewed and approved by the Collaborative prior to their implementation.

3.19 ENCOUNTER DATA REQUIREMENTS

A. The SE shall comply with the all stipulations related to encounter data in the following documents: NMAC 8.305.10 (SOCIAL SERVICES/MEDICAID MANAGED CARE/ENCOUNTERS), the MCO/CSP Systems Manual, the HIPAA Implementation Guides and the HIPAA Companion Guides published by the Medical Assistance Division of the NM Human Services Department.

B. **Quality of Submission**

1. The SE shall submit encounter data that meets established data quality standards. These standards are defined by the Collaborative and consumer agencies to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. These standards will be revised and amended as necessary to ensure continuous quality improvement. The SE shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with these data quality standards as originally defined or subsequently amended.

2. The SE shall comply with clean claim standards employed by New Mexico Medicaid for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

3. The SE shall be able to submit all available claim data without alteration or omission, including claims that the SE denies due to lack of sufficient or accurate data required for proper adjudication.

4. Where the SE has entered into capitated reimbursement arrangements with providers, the SE shall require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims; the SE shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data.

5. The SE shall be required to submit all data relevant to payments to providers in sufficient detail, as defined by the applicable state agency, to support comprehensive financial reporting and utilization analysis.

6. The SE shall subject all encounter data submissions to systematic data quality edits to verify not only the data content but also the accuracy of claims processing. A pattern of data errors that exceeds 3% per batch shall be considered cause for corrective action and/or sanction.

7. At its discretion, the Collaborative and/or designated state agencies will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: consumer ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, date of claim processing, fund source/program and date of claim payment.

8. Unless otherwise directed, the SE shall address ninety percent (90%) of errors within ten (10) working days, and one hundred percent (100%) of errors within thirty (30) calendar days, of notification of said errors. Such errors will be considered acceptably addressed when the SE has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. The Collaborative and/or designated state agency may require resubmission of the transaction with reference to the original in order to document resolution.

C. **Provision of Encounter Data**

1. Within one (1) week of the end of a payment cycle the SE shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the SE has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within one (1) week of the end of the last payment cycle.

2. The SE shall submit sixty percent (60%) of all encounters within sixty (60) calendar days of the encounter's date of service, eighty percent (80%) of all encounters within ninety (90) days calendar days of the encounters' date of service, and ninety-nine percent (99%) of all encounters within one hundred and twenty (120) calendar days of the encounter's date of service.

3. Encounter data from a subcontractor shall be submitted by the SE directly from its system(s).

4. The SE shall submit encounter data files electronically to the Collaborative and/or designated state agencies in adherence to the procedure and data exchange methods prescribed by the State, and according to specifications and formats defined by the State.

5. In its encounter data submission the SE shall comply with standard code sets and shall ensure the integrity of the encounter data with all reference data sources including provider, consumer and service data.

6. The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the SE has a capitation arrangement.

7. The level of detail associated with encounters from providers with whom the SE does not have a fee-for-service reimbursement arrangement shall be equivalent to the level of detail associated with encounters for which the SE received and settled a fee-for-service claim.

8. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the SE's applicable reimbursement methodology for that service.

3.20 INFORMATION MANAGEMENT AND SYSTEMS

A. General Provisions

1. System Functions

a. The SE shall have information management processes and information systems (hereafter referred to as Systems) that enable it to meet state and federal reporting requirements and other Contract requirements and that are in compliance with this Contract and all applicable state and federal laws, rules and regulations including HIPAA.

b. The SE's Systems shall support daily operations and facilitate the monitoring of the service delivery system and the performance of providers.

c. The SE's Systems shall house required data. These data includes, but is not limited to: individual consumer-specific data such as eligibility and enrollment; claims/invoices; consumer-specific encounter data; reimbursement rates/fee schedules; provider payment rules/logic; distribution of funds; tracking of

services and expenditures across funding streams and by consumer and program; contractor/provider-specific information; consumer assessments and outcomes data; and any other data necessary to measure program effectiveness and ensure compliance with state and federal requirements. The Collaborative reserves the right to modify and/or expand data required as needed.

d. The SE's Systems shall utilize HIPAA-compliant systems and comply with all aspects of federal and state information confidentiality and transaction security requirements for all consumer data exchanged manually or electronically.

2. Systems Capacity, Scalability and Flexibility

a. The SE's Systems shall possess capacity sufficient to handle the workload projected for the start date of operations.

b. The SE's Systems shall have the capability of adapting to any future changes necessary as a result of modifications to the service delivery system and its requirements, including data collection, records and reporting based upon unique consumer and provider identifiers to track services and expenditures across funding streams. The Systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in enrollment estimates, etc. The SE's System architecture shall facilitate rapid application of the more common changes that can occur in the SE's operation, including but not limited to:

i. Changes in pricing methodology

ii. Rate changes

iii. Changes in utilization management criteria

iv. Additions and deletions of provider types

v. Additions and deletions of procedure, diagnosis and other service codes

3. Electronic Messaging

a. The SE shall provide a continuously available electronic mail communication link (e-mail system) with the Collaborative and other agencies as required.

b. The e-mail system shall be capable of attaching and sending documents created using software products other than the SE's Systems as specified by the Collaborative and/or a member agency.

c. As needed and based on the sensitivity of data contained in an electronic message, the SE shall be able to encrypt e-mail messages and/or exchange e-mail messages with the Collaborative and/or consumer agencies over a secure connection and in accordance with applicable state policies.

4. Data Connectivity to Agency Information Systems

The SE shall establish data connectivity as needed to the relevant state agency information systems, in accordance with all applicable state policies, standards and guidelines.

5. Systems Refresh Plan

Annually (on the date prescribed by the Collaborative) the SE shall provide to the Collaborative a systems refresh plan. The plan shall outline how Systems within the SE's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan shall also indicate how the SE will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

6. Information Technology Asset Management

The SE shall comply with state requirements for accounting and disposal of assets including but not limited to compliance with fixed asset tracking, and tracking and maintaining proof of licenses for OEM software and other software acquisitions.

B. **Data and Document Management Requirements**

1. Applicable State and Federal Standards and Requirements

a. The SE's Systems shall conform to HIPAA and other federal and state standards and requirements for data and document management, inclusive of standard transaction code sets, in effect at the time of contract execution unless otherwise stipulated by the applicable state or federal authority.

b. The SE's Systems shall conform to future federal and state standards for data and document management by the standard's effective date.

2. Data Accessibility

The SE's data management applications shall be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant.

3. Data and Document Relationships

a. SE Systems shall accept and maintain consumer identification numbers as submitted by the member agencies. The SE shall also maintain a consumer identification number which shall be cross-walked to all other consumer identification numbers submitted to the SE. This functionality shall facilitate consumer

identification, eligibility/enrollment verification, and claims adjudication by the SE and all subcontractors.

b. When the SE houses indexed images of documents used by consumers and providers to transact with the SE the SE shall ensure that these documents maintain logical relationships to certain key data such as consumer identification and provider identification number.

c. The SE shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular consumer about the same matter/problem/issue.

d. Upon the Collaborative's request, the SE shall be able to generate a listing of all consumers and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular consumers or providers or groups thereof. The SE shall also be able to generate a sample of said document.

4. Retention and Accessibility of Information

a. The SE shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements including but not limited to NMAC 1.15.8 and NMAC 1.18.630. The plan shall also comply with the applicable requirements outlined in this Contract including but not limited to Article 21.

b. The SE shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and seven (7) years old, and seventy-two (72) hour turnaround or better on requests for access to information that is between seven (7) and ten (10) years old.

5. Address Standardization

The SE's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

6. Data Ownership

a. It is recognized that the Collaborative is the owner of all nonproprietary data associated with this Contract. Data include, but are not limited to individual consumer-specific data such as enrollment, claims, encounters, eligibility, financial data such as rates/fee schedules, provider payments, distribution of funds, provider-specific information, and any other data necessary to measure program effectiveness, and ensure compliance with state and federal requirements.

b. The SE shall not share or publish nonproprietary data associated with this Contract, as described in (a) above, without the prior written consent of the Collaborative.

C. **System Integration and Data Exchange Requirements**

1. Adherence to Standards for Data Exchange

   a. By the start of Systems testing activities with the Collaborative, member agencies and providers, the SE's Systems shall be able to transmit, receive and process data in HIPAA-compliant or agency-specific methods and formats where applicable. The specific methods and formats will be detailed in documents that will be provided to the SE within thirty (30) days of Contract execution.

   b. The SE's Systems shall conform to future federal and state specific standards for data exchange by the standard's effective date.

   c. The SE shall partner with the Collaborative and member agencies in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort.

2. HIPAA Compliance Checker

   All HIPAA-covered transactions, including data exchanges, between the Collaborative/consumer agencies and the SE shall be subjected to a mutually agreed level of compliance as measured using an industry-standard HIPAA compliance checker application.

3. Integration to Collaborative/State Website/Portals

   Where deemed that the SE's Web presence will be integrated, to the degree necessary, to the web presence/portal of the Collaborative, a member agency or the State, the SE shall conform to the applicable Collaborative, agency or state standards for website structure, coding and presentation.

4. Compatibility/Interoperability with Collaborative Systems and IS Infrastructure

   All of the SE's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with Collaborative and/or state systems and shall conform to applicable standards and specifications set by the Collaborative and/or the state agency that owns the system.

5. Data Exchange in Support of Specific Functions

   The SE's System(s) shall be capable of generating files in the prescribed formats for secure transmission to Collaborative and member agency systems used specifically for the following purposes (other than the provision of encounter data as described in Article 3.19):

   a. The New Mexico Mortgage Finance Authority (MFA), through the Homeless Management Information System (HMIS) as required by the federal Department of Housing and Urban Development (HUD).

b. Program integrity and compliance.

c. The Collaborative data warehouse that will be maintained by BHSD.

d. The provision of expenditure data by program, fund source and consumer in the prescribed formats to a single information system or a variety of information systems owned and operated by the Collaborative and member agencies.

e. Other specific purposes that may be identified after the start date of operations.

D. **System and Information Security and Access Management Requirements**

1. The SE's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

   a. Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

   b. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities and the ability to create, change or delete certain data (global access to all functions shall be restricted to specified staff jointly agreed to by the Collaborative and the SE); and

   c. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

2. The SE shall make System information available to duly authorized representatives of the Collaborative and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

3. The SE's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the SE and the Collaborative.

4. Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

   a. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

   b. Have the date and identification "stamp" displayed on any on-line inquiry;

   c. Have the ability to trace data from the final place of recording back to its source data file and/or document;

d. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

e. Facilitate batch audits as well as auditing of individual records.

5. The SE's Systems shall have inherent functionality that prevents the alteration of finalized records.

6. The SE shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The SE shall provide the Collaborative with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Contract.

7. The SE shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

8. The SE shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

9. The SE shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the SE's span of control. This includes but is not limited to: no provider or consumer service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

10. The SE shall assure that all SE staff is trained in all HIPAA requirements, as applicable.

11. The SE shall commission a security risk assessment at least annually and communicate the results to the Collaborative as part of an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate state and federal agencies.

    a. At a minimum the assessment shall contain the following: identification of loss risk events/vulnerabilities; analysis of the probability of loss risk and frequency of events; estimation of the impact of said events; identification and discussion of options for mitigating identified risks; cost-benefit analysis of options; recommended options and action plan for their implementation.

    b. The assessment shall be conducted in accordance with the following: requirements for administrative, physical, and technical safeguards to protect health data (45 CFR §§164.304 - 318); rules for conducting risk analysis and risk management activities (45 CFR §164.308); requirements for security awareness training (45 CFR §164.308(a)(5)); requirements for entities to have security incident identification, response, mitigation and documentation procedures (45 CFR §164.308(a)(6)).

E. **Systems Availability, Performance and Problem Management Requirements**

1. The SE shall ensure that critical consumer and provider Internet and/or telephone-based functions and information, including but not limited to confirmation of consumer eligibility/registration (see Article 3.5), ECM, and certain self-service online functions (to be agreed to by the Collaborative and the SE) are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by the Collaborative and the SE. Unavailability caused by events outside of the SE's span of control is outside of the scope of this requirement.

2. The SE shall ensure that the systems within its span of control that support its data exchanges with the Collaborative and member agencies are available and operational according to the specifications and schedule associated with each exchange.

3. The SE shall ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7 A.M. and 7 P.M., Monday through Friday.

4. In the event of a declared major failure or disaster, as defined in the SE's business continuity and disaster recovery plan, the SE's consumer eligibility, provider management and claims processing systems shall be restored within seventy-two (72) hours of the failure's or disaster's occurrence.

5. Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and the availability of critical information as defined in this Section of the Contract, including any problems impacting scheduled exchanges of data between the SE and the Collaborative and/or member agencies, the SE shall notify the applicable Collaborative/agency staff via phone, fax and/or electronic mail within sixty (60) minutes of such discovery. In its notification the SE shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes.

6. Where the problem results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, the SE shall notify the applicable Collaborative staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.

7. The SE shall provide to appropriate Collaborative staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

8. The SE shall resolve unscheduled System unavailability of confirmation of consumer eligibility/registration and ECM functions, caused by the failure of systems and telecommunications technologies within the SE's span of control, and shall implement the restoration of services, within sixty (60)

minutes of the initial identification of System unavailability. Unscheduled System unavailability to all other SE System functions caused by systems and telecommunications technologies within the SE's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the initial identification of System unavailability.

9. Cumulative System unavailability caused by information systems and/or information system (IS) infrastructure technologies within the SE's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period.

10. The SE shall not be held accountable for the availability and performance of systems and IS infrastructure technologies outside of the SE's span of control.

11. Within five (5) business days of the occurrence of a problem with system availability, the SE shall provide Collaborative with full written documentation that includes a corrective action plan describing how the SE will prevent the problem from occurring again.

F. **Business Continuity and Disaster Recovery (BC-DR) Plan**

1. Regardless of the architecture of its Systems, the SE shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved in writing by the Collaborative.

2. The BC-DR plan shall define what constitutes a major failure and a disaster.

3. At a minimum the SE's BC-DR plan shall address the following scenarios: (1) the central computer installation and resident software are destroyed or damaged, (2) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (3) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (4) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

4. The SE's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

5. The SE shall submit a baseline BC-DR plan to the Collaborative prior to the start date of operations and communicate proposed modifications to the Collaborative at least once per year.

6. The SE shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the Collaborative that it can restore System functions per the standards outlined elsewhere in this Section of the Contract. The SE shall provide the results of said tests, along with a corrective action plan where applicable, to the Collaborative.

G. **System User and Technical Support Requirements**

1. The SE shall provide Systems Help Desk (SHD) services to the Collaborative and state agency staff that have direct access to SE systems.

2. The SE's SHD shall be available via local and toll-free telephone service and via e-mail from 7 A.M. to 7 P.M., Monday through Friday, with the exception of State or Federal holidays.

3. The SE's SHD staff shall answer user questions regarding SE System functions and capabilities including but not limited to reporting/decision support systems.

4. The SE's SHD staff shall report recurring programmatic and operational problems to appropriate SE or Collaborative staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate Collaborative login account administrator.

5. The SE shall ensure that individuals who place calls to the SHD during operating hours can leave a message. The SHD shall respond to these messages by noon the following business day if the caller requested callback.

6. The SE shall ensure recurring problems not specific to System unavailability identified by the SHD shall be documented and reported to SE management within one (1) business day of recognition so that deficiencies are promptly corrected.

7. The SE shall have an IS service management system that provides an automated method to record, track and report on all questions and/or problems reported to the SHD.

H. **System Testing and Change Management Requirements**

1. The SE shall have a documented, repeatable change management process for systems development and/or enhancements.

2. The SE shall notify the applicable Collaborative staff person of the following changes to Systems within its span of control within at least ninety (90) calendar days of the projected date of the change.

    a. Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, and encounter data management; and
    b. Conversions of core transaction management Systems.

3. If so directed by the Collaborative, the SE shall discuss the proposed change with the Collaborative/its designee prior to implementing the change.

4. The SE shall respond to Collaborative notification of System problems not resulting in System unavailability according to the following timeframes:

   a. Within five (5) calendar days of receiving notification from the Collaborative the SE shall respond in writing to notices of system problems.

   b. Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

   c. The SE shall correct the deficiency by an effective date to be determined by the Collaborative.

   d. The SE's systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

   e. The SE shall put in place procedures and measures for safeguarding against unauthorized modifications to SE systems.

5. Valid Window for Certain System Changes

   Unless otherwise agreed to in advance by the Collaborative as part of the activities described previously in this Section, the SE shall not schedule System unavailability to perform System maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

6. Testing

   a. The SE shall work with the Collaborative pertaining to any testing initiative as required by the Collaborative.

   b. The SE shall provide sufficient system access to allow verification of system functionality, availability and performance by the Collaborative/its designee during the times required by the Collaborative prior to the start date of operations and as subsequently required during the term of the Contract.

I. **Information Systems Documentation Requirements**

1. The SE shall ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

2. The SE shall develop, prepare, print, maintain, produce, and distribute to the Collaborative distinct System design and management manuals, user manuals and quick/reference guides, and any updates.

3. The SE's System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

4. When a System change is subject to Collaborative prior written approval, and if so directed by the Collaborative, the SE shall submit revisions to the appropriate manuals for prior written approval before implementing said System changes.

5. All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals shall be published in accordance to the appropriate Collaborative and/or Collaborative standard.

6. The SE shall update the electronic version of these manuals immediately; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

J. **Reporting Functionality Requirements**

1. The SE's systems shall have the capability of producing a wide variety of reports that support program management, policymaking, quality improvement, program evaluation, analysis of fund sources and uses, funding decisions and assessment of compliance with federal and state mandates.

2. The SE shall support a mechanism for obtaining service and expenditure reports by funding source, provider and consumer.

3. The SE shall provide a mutually agreed upon mechanism for the Collaborative and designated state agency personnel to access data, including program and fiscal information regarding consumers served, services rendered, etc. and the ability for said personnel to develop and retrieve reports. This requirement could be met by the provision of access to a decision support system/data warehouse. The SE shall provide training in and documentation on the use of this mechanism.

K. **Web-Based Functionality**

1. The SE shall provide Web-based functionality in the form of a "portal" for dispersing information to providers and consumers necessary for and beneficial to their successful participation in the behavioral health system.

2. The portal shall comply with HIPAA and all other federal and state privacy and confidentiality regulations.

3. For inquiry functions, the portal shall allow users to inquire using a wide variety of logical combinations of key criteria. Inquiry responses shall supply the user with the comprehensive data needed for such purposes as: claims status and reconciliation; eligibility verification and benefits verification; prior authorization status including services authorized and services used; identification of network providers and their locations, and for other purposes for which on-line inquiries may be used.

4. The portal shall, at a minimum, offer the following features to providers: eligibility verification; claim status inquiry; prior authorization submission and inquiry; payment amount inquiry; remittance advice availability (access to information contained in a paper remittance advice); claim submission/billing manuals; utilization review manuals and other provider guidance; fee schedules (if/as appropriate), answers to Frequently Asked Questions (FAQs) by providers; formulary information; posting of all general provider correspondence; and contact information for the SE, the Collaborative, and the Local Collaboratives.

5. The portal shall, at a minimum, offer the following features to consumers: provider directory inquiry; consumer handbook; benefits summaries; consumer-oriented educational and outreach materials; general consumer correspondence; information about specific programs available to consumers; answers to Frequently Asked Questions (FAQs) by consumers; and contact information for the SE, the Collaborative, and Local Collaboratives.

6. The Collaborative reserves the right to require additional portal functionality, to review the design and content of the portal prior to development/promotion, and to require certain data to be returned in inquiry responses if not already supplied by the SE.

7. The portal shall be "Bobby-approved" (as the term is defined in this Contract).

L. **Telephone-Based Functionality**

1. The SE shall maintain an automated voice response system (AVRS) for use by providers and consumers who need to inquire on a consumer's status or the provider's status in the SE's system.

2. The AVRS shall, at a minimum offer the following features to providers: eligibility verification, claim status inquiry, and payment amount. For consumers, the AVRS shall, at a minimum, offer the following features: provider directory inquiry.

M. **Community Health Record Requirements**

1. The SE shall participate in any Community Health Record effort designed to tie multiple data elements and service, consumer and provider records into a data warehouse that shall include, but not be limited to, claims/encounter information, formulary information, medically or clinically necessary service information, and a listing of providers by specialty. At such time that the Collaborative requires, the SE shall participate and cooperate with the Collaborative in this effort.

2. The design of the mechanism for accessing the community health record and the record format and design shall comply with HIPAA, other federal and all state privacy and confidentiality regulations.

3. The SE shall work with contracted providers and staff to encourage use of this system.

3.21 REPORTING REQUIREMENTS

A. The SE shall provide to the Collaborative a variety of reports to support the Collaborative's management, policymaking, and decision-making functions. The Collaborative, working with the SE, will provide to the SE in writing a grid of all required reports to include: report name, report specifications, frequency, priority, level of analysis, and submission dates. Such reports shall include information related to QM, UM, financial management, program evaluation, and other state and/or federally mandated areas of responsibility. The content, format and schedule for the submission of such reports shall be determined by the Collaborative. Forty-five (45) days following the approval of the Guidance Memorandum (which specifies report requirements), the SE shall develop and submit any new routine reports required by the Collaborative not appearing in the grid. The SE shall also prepare and submit ad hoc reports required by the Collaborative.

B. The SE shall ensure that reports submitted by the SE to the Collaborative shall meet the following standards:

1. The SE shall verify the accuracy and completeness of data and other information in reports submitted.
2. The SE shall ensure delivery of reports or other required data on or before scheduled due dates.
3. Reports or other required data shall conform to the Collaborative's defined written standards.
4. All required information shall be fully disclosed in a manner that is responsive and with no material omission.
5. Each report shall be accompanied by a brief narrative that describes the content of the report and highlights salient findings of the report.
6. As applicable, the SE shall analyze the reports for any early patterns of change, identified trend, or outlier (catastrophic case) and shall submit a written summary with the report including such analysis and interpretation of findings. At a minimum, such analysis shall include the identification of change(s), the potential reasons for change(s), and the proposed action(s). The report grid (see Article 3.21.A) will indicate the reports needing this level of analysis.
7. The SE shall notify the Collaborative regarding any significant changes in its ability to collect information relative to required data or reports.

C. The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. The Collaborative may impose sanctions on the SE for failure to submit accurate and timely reports.

D. Collaborative requirements regarding reports, report content and frequency of submission may change during the term of the Contract. The SE shall have at least forty-five (45) days from the date of an approved Guidance Memorandum to comply with changes specified in writing by the Collaborative.

E. Required reports fall into three categories: managerial, utilization management and QM/QI, and financial.

1. Managerial reports demonstrate compliance with operational requirements of the Contract. The reports shall include, but not be limited to, information on such topics as:

   a. The composition of the current provider network and capacity to provide services to new consumers and any changes in the composition and/or capacity of the current provider network;

   b. Access standards;

   c. Timeliness of claims payment;

   d. Encounter data;

   e. Identification of third-party liability;

   f. Fraud and abuse detection activities;

   g. Delegation oversight activities;

   h. Required legal timelines for services involving children in State custody. CYFD shall provide the SE with all relevant legal timelines at least thirty (30) days before the start of the Contract year and shall periodically update the timelines on a timely basis during the Contract year in response to changes to the legal timeframes; and

   i. Other topics as mutually agreed upon between the SE and Collaborative, and specified in writing by the Collaborative.

2. UM and QM/QI reports shall demonstrate compliance with the Collaborative's service delivery and quality standards.

   a. The SE's reports shall include, but not be limited to:

      i. Critical incidents;

      ii. Performance measures;

      iii. Grievances and appeals;

      iv. Provider satisfaction;

      v. Regular reporting of UM and QM/QI activity as specified by the Collaborative;

      vi. Other reporting as mutually agreed upon between the SE and the Collaborative, and specified in writing by the Collaborative.

   b. The SE shall provide regular reporting on SE participation in state and/or federally required surveys, studies, reviews, e.g., HEDIS, C/FSP, Child and Family Services Review.

   c. The SE shall report any additional requested data as mutually agreed upon by the SE and the Collaborative each Contract calendar year. In addition, the SE shall submit to the Collaborative a written report of the completed calculation of performance measures, including an analysis of the data and a comparison to the baseline, if available.

3. Financial reports demonstrate the SE's ability to meet its commitments under the terms of the Contract. The SE shall meet the following general requirements regarding financial reports:

   a. The SE shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet. The SE shall include an audited schedule of SE revenues and expenses according to generally accepted accounting principles. The result of the SE's annual audit and related management letters shall be submitted to the Collaborative no later than 150 days following the close of the SE's fiscal year. The audit shall be performed by an independent certified public accountant. The SE shall submit for examination any other financial reports requested by the Collaborative and related to the SE's solvency or performance of this Contract.

   b. The SE and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the SE and its subcontractors, including providers, and the SE and the Collaborative. Such transactions shall include, but not be limited to, claim payments, refunds, and adjustment of payments.

   c. The SE and its subcontractors shall make available to the Collaborative and any other authorized state or federal agency, any and all financial records required to examine compliance by the SE, in so far as the records are related to SE performance under the Contract. For the purpose of examination, review, and inspection of the SE's records, the SE and its subcontractors shall provide the Collaborative access to its facilities.

   d. The SE and its subcontractors shall retain all records and reports relating to agreements with the Collaborative for a minimum of ten years after the date of final payment. In cases involving incomplete audits and/or unresolved audit findings, administrative sanctions or litigation, the minimum ten year retention period shall begin on the date such actions are resolved.

   e. The SE is mandated to notify the Collaborative immediately when any change in ownership or change of control can legally be disclosed. The SE shall submit a detailed work plan during the transition period or no later than the date of the approval of sale by the Insurance Division of the Public Regulation Commission that identifies areas of the Contract that may be affected by the change in ownership or control, including management and staff.

   f. The SE shall submit records involving any business restructuring when changes in ownership interest in the SE of five percent (5%) or more have occurred. The SE's records shall include, but shall not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the SE of five

percent (5%) or more. The SE shall provide these records no later than the date that they are required to report the information to the Securities and Exchange Commission or other regulatory authority.

g. The Collaborative reserves the right to comment on the impact of any sale or change of ownership and may terminate this Contract if in its sole discretion such sale or change of ownership may have an adverse impact on the SE's ability to perform this Contract. Any such termination shall be subject to the provisions of Articles 9, 10, and 11.

F. The SE shall make available and ensure that its providers and subcontractors make available all data required by federal grants, in compliance with federal guidelines.

G. To the extent that the SE has access to, or can reasonably create or get access to, such data, it shall support the ability of the State to demonstrate fulfillment of all relevant state, federal, foundation and other fund source requirements (including but not limited to the Governor's Performance & Accountability Measures (related to behavioral health), maintenance of effort; set-asides; Treatment Episode Data Set (TEDS) reporting; performance measurement; National Outcome Measures (NOMS), Uniform Reporting System (URS) Basic and Developmental Tables, required Block Grant applications report information; and U.S. Department of Housing and Urban Development (HUD) requirements under 24 CFR Part 576 related to reporting, funding and monitoring of providers) in the following manner:

1. Submit reports throughout the year related to financial and payment issues; data elements; service utilization and encounter data; state and federal requirements; quality management; performance measures; incidents of abuse or neglect; complaints and grievances; consumer satisfaction; and, progress in development of the Collaborative service delivery system;

2. Work with the Collaborative to develop the reports for the previously mentioned purposes, specifically reports necessary to meet the State and federal reporting requirements. Reports shall be developed in order of priority and by the dates as determined by the Collaborative;

3. Work, in conjunction with the Collaborative, throughout the Contract period in the design of additional/new reports and queries and modification of existing reports and queries necessary to streamline reporting and meet the state and federal reporting requirements.

ARTICLE 4 – LIMITATION OF COST

In no event shall payments under this Contract for Medicaid fee-for-service consumers exceed payment limits set forth in 42 CFR §447.362. In no event shall the Collaborative pay twice for the provision of services.

ARTICLE 5 – COLLABORATIVE RESPONSIBILITIES

5.1 OVERALL ROLE

A. The Collaborative's overall role is to provide leadership, planning, policy direction and oversight for all covered services. This role includes selecting, contracting and ongoing communication to ensure effective working relationships with the SE. In this capacity the Collaborative shall do the following:

1. Establish and maintain all Medicaid eligibility information and transfer eligibility information to the SE. The SE shall have the right to rely on eligibility and enrollment information transmitted to the SE by the Collaborative. The Collaborative will work with the SE to develop protocols for determining the appropriate payer when a Medicaid-covered individual has multiple funding sources for a Medicaid-covered service;
2. Provide the SE with eligibility and priority determination criteria related to non-Medicaid consumers;
3. Compensate the SE as specified in Article 6;
4. Clarify or change any unclear or inconsistent State policies or rules identified by the SE so that the Collaborative and the SE approaches will be consistent and support implementation of the single statewide behavioral health delivery system contemplated by State law;
5. For Medicaid consumers, provide a mechanism for fair/administrative hearings to review SE Action;
6. Conduct review and monitoring activities as needed to meet CMS, SAMHSA or other funder requirements for State oversight responsibilities;
7. Establish requirements for review and make decisions concerning the SE's requests for disenrollment of Medicaid consumers;
8. Determine the period of time within which a Medicaid consumer covered cannot be reenrolled with the SE, when it has successfully requested his/her disenrollment;
9. Provide Medicaid consumers with specific information about services and benefits;
10. Have the right to receive all information regarding third-party liability from the SE so that it may pursue its rights under state and federal law;
11. Provide Guidance Memoranda that specify the content, format and schedule for the SE's reports and deliverables submission;
12. Work with the SE to consolidate the number and kinds of reports to provide the information and data needed for fund source reporting and for performance accountability while minimizing unnecessary or duplicate reporting;
13. Inspect, examine, and review the SE's financial records as necessary to ensure compliance with all applicable state and federal laws and regulations;

14. Identify federally required or other essential data elements and specifications related to data reporting requirements for the SE to use in reporting;

15. Monitor encounter and other data submitted by the SE;

16. Ensure that no requirement or specification established or provided by the Collaborative under this Section conflicts with requirements or specifications established pursuant to HIPAA and the regulations promulgated thereunder;

17. Cooperate with the SE in the SE's efforts to achieve compliance with HIPAA requirements;

18. Work with the SE on operational matters through the use of the Steering Group, which shall meet on a regularly scheduled basis, and shall include participation by appropriate SE staff as needed but on at least a monthly basis;

B. Through the use of the Steering Group, cross-agency teams (CATs), and any ad hoc cross-agency group, the Collaborative shall provide ongoing liaison, support and interaction with the SE to promote the effectiveness of the partnership. This shall include supplying guidance and technical information at the required level of specificity in a timely fashion.

1. The CATs will focus on the following key areas of potential interaction with the SE:

   a. The Oversight CAT will establish and implement guidelines for multi-agency Contract monitoring and Contract management of the SE to ensure Contract compliance, quality performance, and quality of care of the SE, its contractors and delegates. It will ensure the Collaborative's goals and requirements are met.

   b. The Local Collaboratives CAT will support and coordinate the work of the Collaborative-recognized LCs, ensuring their input and participation in planning, coordination and review of the service system in their areas.

      i. Interagency Staff Teams, as a subset of the LC CAT, will be responsible for translating state policy to Local Collaboratives and Native American Tribes, Nations, and Pueblos within their designated area. They will work with regional SE staff and the LCs to identify needs and develop programmatic recommendations and to resolve problems or issues that may arise regarding services, service delivery, consumer and family or provider concerns, and issues affecting service quality. The staff teams will advise the SE.

   c. The Policy and Planning CAT will provide policy recommendations to the Collaborative as well as the development of a comprehensive and integrated statewide behavioral health planning process.

d. The Capacity, Program Development and Research/Evaluation CAT will develop improved workforce and program capacity for effective practices and coordinate and support an effective program of research/evaluation to ensure continued improvement.

e. The Administrative Systems and Supports CAT will develop and implement more efficient state administrative systems as needed to support success of the Collaborative.

2. The Oversight CAT shall be responsible for Contract oversight of the SE. The Oversight CAT will address quality issues and other program development issues that may arise, and will advise and direct the SE.

3. These teams, as well as other staff work activities, will be coordinated through the Steering Group and will encourage participation and communication with the SE as needed to ensure effective partnership.

C. The Collaborative shall establish a single point of contact and coordination for work with all state staff through the Collaborative CEO, whose role shall include primary liaison with the SE.

5.2 ADVISORY GROUPS; RELATIONSHIP BETWEEN STATE AND SE STAFF

A. The Collaborative shall, in the administration of this Contract, seek input on behavioral health care-related issues primarily from the BHPC and also from the LCs. The Collaborative may seek the input of the SE on issues that may affect the SE raised by the BHPC or LCs.

B. Performance by the SE shall not be contingent upon time availability of the Collaborative personnel or resources, with the exception of specific responsibilities stated in the RFP and the normal cooperation that can be expected in such a Contract. The SE's access to the Collaborative personnel shall be granted as freely as possible. However, the competency/ sufficiency of the Collaborative staff shall not be reason for relieving the SE of any responsibility for failing to meet required deadlines or producing unacceptable deliverables.

C. To the extent the SE is unable to perform any obligation or meet any deadline under this Contract because of the failure of the Collaborative to perform its specific responsibilities under the Contract, the SE's performance shall be excused or delayed, as appropriate. The SE shall provide the Collaborative, through the Collaborative CEO, with written notice as soon as possible, but in no event later than the expiration of any deadline or date for performance, that identifies the specific responsibility that the Collaborative has failed to meet, as well as the reason the Collaborative's failure impacts the SE's ability to meet its performance obligations under the Contract.

D. The SE shall be held harmless for implementation delays when the SE is not responsible for the cause of the delay.

ARTICLE 6 – PAYMENT AND FINANCIAL PROVISIONS

6.1 GENERAL FINANCIAL PROVISIONS

A. The Collaborative, through its various member agencies, shall pay to the SE in full payment for non-Medicaid services satisfactorily performed pursuant to this Contract an amount, including all applicable taxes and expenses not to exceed the amounts shown in Appendix xxx (Funding Table).

B. The dollar amounts shown in Appendix xxx (Funding Table) for Medicaid managed care and Medicaid fee-for-service are estimates. Actual payment will depend on the number of Medicaid consumers and other factors.

6.2 TAXATION

A. To the extent, if any, it is determined by the appropriate taxing authority, that the performance of this Contract by the SE is subject to taxation, the amounts paid by the Collaborative to the SE under this Contract, shall include such applicable tax(es) and shall be paid out of non-direct service amounts. Therefore, the amount paid by the State shall include all taxes that may be due and owing by the SE. The SE shall report and remit all applicable taxes to the appropriate taxing agency

B. The SE shall account for any performance under this Contract subject to a premium tax for Medicaid managed care services and shall specifically account for Medicaid managed care services, so that any applicable premium tax shall be attributed only to those Medicaid services. The SE shall report and remit all applicable taxes to the appropriate taxing agency.

6.3 ADMINISTRATIVE EXPENSES

A. **Ceiling on Administrative Expenses**. The Collaborative has set ceilings on the percent of funding, by funding source, that can be used for non-direct services (administrative expenses) under the terms of this Contract as shown in Appendix xxx (Funding Table). This percentage is based on the amount of funds to be spent on direct services; it is not a straight percentage of total funding.

B. **Report on Administrative Expenses**. The SE shall submit to the Collaborative, within forty-five (45) calendar days of the end of the state fiscal year, a report on all administrative expenses paid during the contract period. Such data, including claims data, shall be submitted in the format specified by the Collaborative to determine if the ceiling on administrative expenses has been exceeded by the SE.

C. **Administrative Expenses**. The following are the Collaborative's designated administrative expense functions:

1. Network development and contracting;
2. Direct provider contracting;
3. Credentialing/re-credentialing;
4. Care coordination;
5. Information systems;
6. Encounter data collection and submission;
7. Claims processing;

8. Consumer and Family Advisory Board;
9. Member Services;
10. Training and education for providers and consumers;
11. Financial reporting;
12. Licenses;
13. Taxes;
14. Plant expense;
15. Staff travel;
16. Legal and risk management;
17. Recruiting and staff training;
18. Salaries and benefits;
19. Non-medical supplies;
20. Non-medical purchase service;
21. Depreciation and amortization;
22. Audits;
23. Grievances and appeals;
24. Capital outlay;
25. Reporting and data requirements;
26. Compliance;
27. Profit;
28. Surveys;
29. Quality Assurance;
30. QI/QM;
31. Marketing and outreach;
32. Criminal background checks;
33. Insurance premiums and associated costs for insurance coverage other than reinsurance; and
34. Postage costs.

D. **Special Mention of Certain Health Expenses**. The Collaborative agrees that payments made by the SE to providers, including but not limited to payments relating to costs incurred by delegated providers in furnishing covered services and payments made through a provider quality incentive program are to be categorized as direct service expenses or services under this Contract and are properly included by the SE in meeting the requirement that no less than the specified percentage of revenues are expended on direct services under this Contract. The SE agrees that any provider quality incentive program shall be submitted to the Collaborative for approval and will utilize performance measures

designed to provide an incentive to the SE's provider network to improve quality, access, and satisfaction for consumers.

E. **Interest**. The SE shall ensure that any interest earned on payments from the Collaborative to be used for direct services (the percent of funding, by funding source, that shall be used on direct services) shall also be used for direct services. The SE shall not retain the interest earned from direct services payments for administrative expenses or profit.

6.4 VALUE ADDED SERVICES

A. The SE shall apply a minimum of four and one-half (4.5) percent of the total amount of the Medicaid managed care revenue toward Value Added Services, which shall include two components: (a) community reinvestment and (b) non-entitlement services offered to individual Medicaid managed care consumers. The cost of Value Added Services cannot be included when the Collaborative determines the payment rates.

B. The community reinvestment portion of Value Added Services shall be used for Collaborative-approved projects and activities that, in general, build new capacity and expand the existing capacity of New Mexico's communities to deliver a wide variety of sustainable behavioral health services. The Collaborative may identify additional funding from other sources to be used for community reinvestment. Community reinvestment funds can be used for direct service-related expenditures and/or for administrative expenses. Use of community reinvestment dollars for administrative activities must be identified and included within the total administrative allocation. Before expending these funds, the SE shall consult with and obtain approval from the Collaborative on the process and criteria for determining use of these funds.

C. As part of Value Added Services, the SE shall offer individual Medicaid managed care consumers non-entitlement services in accordance with Medicaid regulations. These services are not included in the Medicaid benefit package. The Collaborative shall provide direction on the types and quantities of these non-entitlement services to be funded with final authority as to which non-entitlement services are to be provided to individual consumers remaining with the SE. The SE shall manage these non-entitlement services using tools it employs for managing covered services, such as utilization management, to ensure non-entitlement services are correctly delivered and clinically justified.

D. The SE shall manage its budget for Value Added Services and shall not receive additional reimbursement from the Collaborative should its Value Added Services expenditures exceed its budget.

E. The SE shall also make available $250,000 in addition to the four and one-half (4.5) percent required by the Contract in Article 6.3.A. These funds may be used to purchase any licenses associated with the Addiction Severity Index – Multimedia Version (ASI-MV).

F. To ensure that Value Added Services are appropriately budgeted and expended to support the vision and goals of the Collaborative for the behavioral health delivery system, the SE shall work with the Collaborative to develop and implement a Value Added Services Plan for annual community reinvestment initiatives as well as non-entitlement services offered to individual Medicaid managed care consumers for each Contract year.