

**STATE OF NEW MEXICO  
INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE  
STATEWIDE BEHAVIORAL HEALTH SERVICES CONTRACT**

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**STATE OF NEW MEXICO  
INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE  
STATEWIDE BEHAVIORAL HEALTH SERVICES CONTRACT**

This Agreement ("Contract") between the State of New Mexico ("State") Interagency Behavioral Health Purchasing Collaborative ("Collaborative") and United HealthCare Insurance Company and United Behavioral Health through their joint venture OptumHealth New Mexico, the Statewide Entity ("SE"), as Contractor ("SE" or "Contractor") is entered into by and between the parties on this 22d day of January, 2009.

Upon becoming effective, the term of this Contract shall be from July 1, 2009 through June 30, 2013, or at an effective date determined by the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS"), or otherwise amended or terminated pursuant to its terms. Under no circumstances shall this Contract exceed a total of four (4) years in duration. Further, this Contract shall not become effective until approved in writing by the New Mexico Department of Finance and Administration and CMS.

**ARTICLE 1 – RECITALS**

- 1.1 The Collaborative is a legal entity with the authority to contract for the services as set forth in this Contract and to make decisions regarding the administration, direction and management of state-funded behavioral health services and care. It is comprised of the following New Mexico State Agencies: the Department of Health (DOH); the Human Services Department (HSD); the Children, Youth and Families Department (CYFD); the Aging and Long Term Services Department (ALTSD); the Department of Finance and Administration (DFA); the Mortgage Finance Authority (MFA); the Public Education Department (PED); the Department of Transportation (DOT); the New Mexico Corrections Department (NMCD); the Division of Vocational Rehabilitation (DVR) of PED; the Department of Labor (DOL); the Health Policy Commission (HPC), the Developmental Disabilities Planning Council (DDPC); the Governor's Commission on Disabilities (GCD); the Indian Affairs Department (IAD); the Governor's Senior Health Policy Advisor; and the Administrative Office of the Courts (AOC). Each of these agencies funds or provides behavioral health services. Many of these agencies also provide critical support services for persons covered by this Contract. In addition, valuable input is provided by *ex officio* representatives of the New Mexico Public Defender, the Children's Cabinet Coordinator in the Office of the Lieutenant Governor, the Office of Workforce Training and Development, and the Higher Education Department, all of whom participate on the Collaborative as non-voting members. All together, twenty-one (21) statutory and *ex officio* members of the Collaborative represent the governmental entities and agencies identified above.
- 1.2 All services provided pursuant to this Contract are subject to the New Mexico Procurement Code and 1.4.1 NMAC, unless specifically provided otherwise herein.

### 1.3 Collaborative Values and Principles

- A. The Collaborative's values and principles, described below and as set forth in the original Request for Proposals (RFP)\*, shall be incorporated into the SE's administration, direction, and management of the services provided under this Contract. Services shall be delivered in a manner that is individually (consumer) centered and family-focused, based on principles of an individual's capacity for recovery and resiliency.
1. Services shall increase consumer and family abilities to successfully manage life challenges, including, but not limited to, housing, employment, parenting, and school success;
  2. Services shall utilize consumer and family/caregiver abilities and strengths;
  3. The SE shall ensure consultation with the consumer, his/her family, legal guardian and/or designated representative, caregivers, and other persons critical to the consumer's life and well-being, where appropriate;
  4. Services shall be based on evidence of effectiveness and be consumer and family/caregiver-driven or operated, taking into account the individual consumer's and family's preferences;
  5. Services shall be delivered in a culturally competent, responsive and respectful manner via the most appropriate, least restrictive means;
  6. Services shall be timely, coordinated, accessible, accountable, and of high quality;
  7. Services shall be evaluated with system performance and consumer- and family-friendly outcomes, and the SE shall ensure a mechanism for continuous quality improvement (CQI);
  8. The SE shall ensure that behavioral health wellness promotion, prevention, early intervention, treatment, community support, supported housing, supported employment, supports for families and children, and other activities further recovery and resiliency;
  9. The SE shall demonstrate sensitivity to, and respect for, diversity, including race, age, gender, disability, culture, ethnicity, spirituality, sexual identity, literacy level, criminal history, place of residence and primary language;
  10. The SE shall utilize "person first" and "people who" language;
  11. The SE shall make available the services of peer specialists, consumers, family members or staff to provide individual assistance for consumers with needs for special assistance related to written or verbal communications; and
  12. The SE shall ensure meaningful involvement of consumers, family members, and peer-run organizations at all levels of the decision-making processes concerning operations and oversight of the behavioral health service system.

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\* RFP # 09-630-7903-0001

- 1.4 All services provided pursuant to this Contract shall be subject to the following, which are incorporated herein by reference:
- A. Title XIX and Title XXI of the Social Security Act and the Code of Federal Regulations, Title 42 Parts 430 to end, as revised or otherwise amended;
  - B. All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico, and the Human Services Department, Medical Assistance Division ("HSD/MAD"), concerning Medicaid services;
  - C. The HSD/MAD program eligibility and provider policy manuals, including all updates, revisions, substitutions and replacements;
  - D. The HSD/MAD Policy Manual, including all updates and revisions thereto, or substitutions and replacements thereof, duly adopted in accordance with applicable law. All defined terms used within the Contract shall have the meanings given them in the Policy Manual;
  - E. The HSD/MAD MCO/SCP Systems Manual, including all updates and revisions, submissions and replacements
  - F. All applicable statutes, regulations and rules implemented by the State of New Mexico concerning managed care organizations (MCOs), health maintenance organizations, insurance companies, and fiscal and fiduciary responsibilities applicable under the Insurance Code of New Mexico, NMSA 1978, §§ 59A-1-1 et. seq., and any other applicable laws;
  - G. All applicable statutes, regulations and rules implemented by the Federal Government or the State of New Mexico regarding child welfare, including but not limited to the Child and Family Services Review (CFSR) (see 45 CFR Part 1355), Title IV-B and Title IV-E of the Social Security Act, and the current New Mexico Children's Code;
  - H. The Indian Child Welfare Act (ICWA), 25 USC §1901, et seq. and the Indian Health Care Improvement Act;
  - I. The Adult Protective Services Act, Chapter 27, Section 7 (27-7-14 through 27-7-31);
  - J. The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and implementing regulations;
  - K. For substance abuse services funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the comprehensive Alcohol and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended (42 USC §§290 dd-1, et seq. and the Public Health Service Act 42 USC §§300x, et seq.;
  - L. For mental health services funded by the Community Mental Health Services Block Grant, the Community Mental Health Centers Act (42 USC §§2681, et seq., as amended), the Act (42 USC §§300x, et seq.), and applicable federal regulations;
  - M. The applicable provisions of Titles II and III of the Americans with Disabilities Act of 1990, P.L. 101-336 (42 USC §§12101, et seq.) and Section 504 of the Rehabilitation Act (29 USC §794);

- N. The requirements of the Pro-Children Act of 1994 (20 USC §§6083, et seq.) that prohibits smoking in any portion of any indoor facility used routinely or regularly for the provision of health services to children under the age of 18 funded by federal grants;
  - O. All applicable statutes, regulations and rules related to any federal grant specified in this Contract and any management letters, protocols or procedures relevant to implementation of such grant awards;
  - P. Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act;
  - Q. Any other applicable state or federal statutes and regulations;
  - R. All procedures related to the exchange of data related to consumers, providers, and encounter information between the SE and the Collaborative members as specified within department-specific regulations, manuals, policies and memoranda;
  - S. Any and all provider or eligibility manuals or policy statements, including all updates and revisions thereto, or substitutions and replacements thereof, duly adopted in accordance with applicable law for all member agencies:
    - 1. To the extent these manuals are unclear or inconsistent, the SE shall identify those areas in writing, and the Collaborative will clarify intent, change the content, or otherwise instruct the SE
    - 2. All defined terms used within this Contract shall have the meanings given them in any manual or policy statement
  - T. Any and all consent decrees, legally-binding agreements, federal program improvement plans, and contracts related to behavioral health services entered into by the Collaborative or any member agency;
  - U. The Request for Proposal ("RFP"), all RFP amendments, the SE's Questions and the Collaborative's answers, and the Collaborative's written clarifications;
  - V. The SE's Best and Final Offers; and
  - W. The SE's Proposal (including any and all written materials presented in the oral portion of the procurement) where not inconsistent with this Contract and subsequent amendments to this Contract.
- 1.5 The parties understand and agree that references to specific laws, regulations, dates and other matters of a similar nature to currently existing and known laws, regulations, and dates. The parties understand and agree that such existing laws, rules, regulations and dates may change after execution of this Contract, and that new enactments, adoptions, amendments, substitutions, replacements, successors, or the like shall be given full force and effect and shall govern this Contract in the spirit in which this Contract is made.
- 1.6 The SE has statutory authority to enter into capitated agreements, assume risk and meet applicable requirements and/or standards delineated under state and federal laws and regulations.



- 1.7 The SE possesses the required authorization and expertise to meet the terms of this Contract.
- 1.8 The parties acknowledge the need to work cooperatively to address and resolve problems that may arise in the administration and performance of this Contract. The parties agree to document any amendments in writing prior to implementation of any new contract requirements.
- 1.9 The Collaborative and its member agencies will, in the administration of this Contract, seek input on behavioral health services and related issues from advisory groups, steering committees, stakeholders, and consultants. The Collaborative and its member agencies may seek input from the SE on issues raised by such advisory groups, steering committees, stakeholders, or consultants that may affect the SE's performance of its obligations under this Contract.
- 1.10 The SE shall notify the Collaborative of the SE's (including its subcontractors) potential public relations issues of which the SE becomes aware that could affect the State or this Contract.

NOW THEREFORE, in consideration of the mutual promises contained herein, the Collaborative and the SE agree as follows:

## **ARTICLE 2 – DEFINITIONS**

- 2.1 Terms used throughout this Contract have the following meaning, unless the context clearly indicates otherwise or as may be further defined herein:
  - A. **Abuse**. Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with NMSA 1978, §30-47-1; or (2) provider practices that are inconsistent with sound fiscal, business, medical or service related practices and result in an unnecessary cost to the program, or in reimbursement for services that are not medically, clinically, or psychosocially necessary or that fail to meet professionally recognized standards for behavioral health care. Abuse also includes consumer practices that result in unnecessary cost to the program.
  - B. **Advance Directive**. Written instructions such as an Advance Directive, Mental Health Advance Directive, living will, durable health care power of attorney, durable mental health care power of attorney, or Advance Health Directive, relating to the provision of health care when an adult is incapacitated. [See generally, NMSA 1978, §§27-7A-1 – 27-7A-18, and §§24-7B-1 – 24-7B-16.]
  - C. **Adverse Determination**. A determination by the SE that the behavioral health services furnished, or proposed to be furnished to a consumer, are not medically, clinically or psychosocially necessary or not appropriate.
  - D. **American Society of Addiction Medicine (ASAM)**. An organization of professionals in addiction services that developed, in the early 1990s, a set of criteria and tools to identify the level of care best suited to an individual in need of such services.

- E. **Behavioral Health (BH)**. The umbrella term for mental health and substance abuse. It includes both mental health (MH), including emotional disorders, and substance abuse (SA), including chemical dependency disorders, and it includes co-occurring MH and SA disorders.
- F. **Behavioral Health Planning Council (BHPC)**. A body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico.
- G. **Bobby-approved**. Standards for website accessibility in keeping with ADA and other national standardization criteria.
- H. **Centers for Medicare and Medicaid Services (CMS)**. The federal agency that administers the Medicaid and Medicare programs.
- I. **Claim**. Bill for services submitted to the SE manually or electronically; a line item of service on a bill; or all services for one consumer within a bill.
- J. **Clean Claim**. A manually or electronically submitted claim form a provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information form outside of the SE's System. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical, clinical, or psychosocial necessity. [See, NMAC 8.305.1.7, 8.305.11.9.]
- K. **Clinical Necessity**. The determination made by a behavioral health professional exercising prudent clinical judgment as to whether a behavioral health service would promote normal growth and development and prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a behavioral health condition, injury, or disability for the consumer.
- L. **Collaborative**. The Interagency Behavioral Health Purchasing Collaborative. The Collaborative, established under NMSA 1978, §9-7-6.4, by its statutory member agencies collectively, operates under a Memorandum of Understanding. Wherever the term "Collaborative" is used within this Contract, the Collaborative may delegate that role to a subcommittee of the Collaborative, to the Collaborative CEO, to a CAT, or to a designated staff or group of staff from member agencies, except for those matters specifically required to be a decision of the Collaborative itself (e.g., approving and signing this Contract and any amendments thereto).
- M. **Collaborative Chief Executive Officer (CEO)**. The individual who acts as the primary agent of the Collaborative, directly or through a designee, and directs the Cross-Agency Teams (CATs).
- N. **Collaborative Members or Member Agencies**. The statutory and *ex officio* agency representatives who sit on the Collaborative.
- O. **CoLTS**. The Coordination of Long Term Services program, which is New Mexico's managed long-term care services program for Medicaid recipients in need of long-term care services. The CoLTS MCOs manage primary, acute, and long-term care services in one coordinated and integrated program that includes Medicare services and funding. The State operates CoLTS pursuant to 1915(b) and 1915(c) waivers granted by CMS.

- P. **Consumer.** For purposes of this Contract, a person with a mental health or substance abuse disorder who is receiving, has received, or is eligible to receive behavioral health services through this Contract. References to consumer include the consumer's family, guardian, and/or designated representative as applicable and appropriate.
- Q. **Continuous Quality Improvement (CQI).** A process for improving quality that: (1) assumes opportunities of improvement are unlimited; (2) is consumer-oriented; (3) is data driven; (4) results in implementation of improvements; (5) requires continual measurement of implemented improvements; and (6) requires modification of improvements as indicated. [See, NMAC 8.305.1.7.]
- R. **Covered Services.** Those services funded through the funding source listed in Appendix xxx (Funding Table)<sup>1</sup> of this Contract and any additional funding sources identified during the term of the Contract.
- S. **Critical Incident.** A reportable incident that may include, but is not limited to, abuse, neglect, or exploitation; death; environmental hazards; law enforcement intervention that encompasses the full range of covered services.
- T. **Cross-Agency Team (CAT).** A workgroup consisting of staff from various Collaborative member agencies.
- U. **Cultural Competence.** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. [See, NMAC 8.305.1.7]. For purposes of this Contract, culture includes the deaf and blind communities.
- V. **Date of Receipt (Claims).** The date that the SE (or, if applicable, its claims processing subcontractor, receives a claim, as indicated by its date stamp on the claim.
- W. **Date of Payment (Claims).** The date that the check or other form of payment for a claim is issued by the SE.
- X. **Day or Days.** Calendar day, unless specified otherwise. The first day is included and the last day is excluded. Timeliness or due dates falling on a weekend or State or Federal holiday shall be extended to the first business day after the weekend or holiday.
- Y. **Designated Representative.** A person designated under a valid mental health care treatment advance directive as an individual's authorized agent according to the provisions of the Mental Health Care Treatment Decisions Act (NMSA 1978, §24-7B et seq.) and who has personal knowledge of the respondent and the facts as required in Subsection B of the Act.
- Z. **Encounter.** A covered service or group of covered services delivered by a provider to a consumer during a visit between the consumer and provider.

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<sup>1</sup> The Funding Table for FY09 is available in the Procurement Library.

- AA. **Encounter Data**. Data elements from encounters submitted in fee-for-service claims, or from data submissions ("proxy claims") for services not reimbursable on a fee-for-service basis. Encounter data elements comprise a minimum core data set as prescribed in this Contract (see Article 3.19). [Also, see NMAC 8.305.1.7, 8.305.10.]
- BB. **Fraud**. An intentional deception or misrepresentation by a person or an entity with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law, consistent with NMAC 8.305.13.10. [See, NMAC 8.305.1.7.]
- CC. **HIPAA**. The Health Insurance Portability and Accountability Act of 1996, 42 USC §160, et seq., as amended or modified.
- DD. **IHS Facility**. A hospital, clinic, or pharmacy established and operated by the Federal Indian Health Service.
- EE. **Individual with Special Health Care Needs (ISHCN)**. An individual who has or is at an increased risk for having a chronic mental, developmental, behavioral, neurobiological or emotional condition and who also requires behavioral health and related services of a type or amount beyond that required by persons generally. Individuals with special health care needs have ongoing health conditions, high or complex service utilization, and low to severe functional limitations.
- FF. **Information System (System)**. Any combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.
- GG. **Information System Span and Control (Span of Control)**. Information systems and telecommunications capabilities that the SE itself operates or for which it is otherwise legally responsible according to the Contract. The SE's span of control also includes Systems and telecommunications capabilities outsourced by the SE.
- HH. **Letter of Direction (LD)**. Written instructions, detailed action steps, and guidelines to clarify the implementation of programs funded by new funding sources or changes to programs funded by funding sources identified in Appendix xxx (Funding Table).
- II. **Local Collaborative (LC)**. An advisory body, delineated by either judicial district or tribal grouping and recognized by the Collaborative, that provides input on local and regional behavioral health issues to the Collaborative and the SE.
- JJ. **Managed Care Organization (MCO)**. An organization that contracts with the State of New Mexico to provide a variety of health care services to individuals who are enrolled in Medicaid. It includes Salud!, SCI, and/or CoLTS MCOs.

- KK. **Management Letter.** A document signed by the Co-Chairs of the Collaborative and a representative of the SE authorized to bind the SE that describes a certain task or activity to be pursued or conducted by the SE, the specific approach to that task/activity, the expected result and the schedule to be followed to implement the task or activity. Such letters are not intended to be amendments to this Contract, but more specific directions for completing Contract requirements.
- LL. **Medically Necessary Services.** Clinical and rehabilitative physical, mental or behavioral health services that:
- (1) Are essential to prevent, diagnose or treat medical conditions or are essential to enable the consumer to attain, maintain or regain the consumer's optimal functional capacity;
  - (2) Are delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the consumer;
  - (3) Are provided within professionally accepted standards of practice and national guidelines; and
  - (4) Are required to meet the physical, mental and behavioral health needs of the consumer and are not primarily for the convenience of the consumer, the provider or the SE. [See, NMAC 8.305.1.7.M.]
- MM. **Native American Program.** A program of behavioral health care developed, administered or implemented by an Indian Nation, Tribe or Pueblo located wholly or partially in New Mexico and/or any behavioral health program administered by the federal government and/or an Indian entity organized for the benefit of Native Americans in the area of behavioral health that may include, but not limited to, prevention, intervention, mental health, substance abuse, traditional healing, telehealth, education, training and the delivery of other behavioral health services.
- NN. **Network Provider.** An individual provider, clinic, group, association or facility employed by or contracted with the SE to furnish covered services to consumers under the provisions of this Contract.
- OO. **Non-Network Provider.** An individual provider, clinic, group, association or facility that provides covered services and does not have a contract with the SE.
- PP. **Performance Measures.** A system of operational and tracking indicators specified by the federal government or the Collaborative, including but not limited to, the Governor's Performance & Accountability Measures and the federal National Outcome Measures (NOMS).
- QQ. **System Unavailability.** As measured within the SE's information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

- RR. **Plan of Care (Care Coordination Plan)**. A comprehensive plan that addresses a consumer's need for coordination of treatment and access to services. Components of the plan include assessing the goals, needs, capacities and behavioral health and medical condition of the consumer; addressing the needs and goals of the family (as applicable to the consumer's care); identifying clear goals that can be regularly evaluated along with the intensity of care coordination to ensure that progress is being made; and identifying linkages with multiple providers as needed.
- SS. **Psychosocial Necessity**. Services or products provided to a consumer with the goal of helping that individual develop to his/her fullest capacities through learning and environmental supports and/or reduce the risk of the consumer developing a behavioral health disorder or an increase in the severity of behavioral health symptoms. The consumer need not have a behavioral health diagnosis but rather have a need to improve psychosocial functioning.
- TT. **Region**. The Collaborative-designated area of the State for purposes of SE service provision and Local Collaborative organization. The State is made up of six regions: five geographically delineated regions (see Appendix xxx) and one statewide Native American region.
- UU. **Steering Group**. The working group of the Collaborative, made up of senior management, the chairs of the CATs, and representatives from other related workgroups.
- VV. **Salud!**. The State's managed care program for low-income eligible individuals not included in the State's CoLTS program. The State operates Salud! pursuant to a 1915(b) waiver granted by CMS.
- WW. **SCI**. The State Coverage Insurance, a program to provide certain health care services to low-income, uninsured adults. The State operates SCI pursuant to a HIFA 1115 demonstration waiver granted by CMS.
- XX. **State**. The State of New Mexico, including any entity or agency of the State and including but not limited to the Collaborative and member agencies.
- YY. **Statewide Entity (SE)**. The organization designated to execute the requirements of this Contract.
- ZZ. **Tribal 638 Facility or 638 Provider**. A facility operated by a Native American/Indian tribe and funded by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). [See, 25 CFR §900.]
- AAA. **Tribal Provider or Tribal Facility**. A facility that is operated by a Native American/Alaskan Indian tribe that has not elected designation as a 638 provider.

## ARTICLE 3 – CONTRACTOR RESPONSIBILITIES

### 3.1 COMPLIANCE

The SE shall, to the satisfaction of the Collaborative, comply with:

- A. All provisions set forth in this Contract; and
- B. All applicable provisions of federal and state laws, regulations, waivers, and variances, as may be amended, including the implementation of a compliance plan.

### 3.2 CONTRACT MANAGEMENT

- A. The SE shall employ a qualified individual to serve as the Contract Manager for New Mexico operations. The Contract Manager shall be dedicated to this Contract, hold a senior management position in the SE's organization, and be authorized and empowered to represent the SE on all matters pertaining to the SE's program and specifically this Contract. The Contract Manager shall act as a liaison between the SE, the Collaborative, and member agencies and has responsibilities that include but are not limited to the following:
  - 1. Ensuring the SE's compliance with the terms of this Contract, including securing and coordinating resources necessary for such compliance;
  - 2. Overseeing all activities by the SE and its subcontractors;
  - 3. Receiving and responding to all inquiries and requests by the Collaborative, or any State or Federal agency, in timeframes and formats reasonably acceptable to the parties;
  - 4. Meeting with representatives of the Collaborative and member agencies on a periodic or as-needed basis and resolving issues that arise;
  - 5. Attending and participating in regular meetings with the Collaborative and member agencies and attending and participating in stakeholder meetings;
  - 6. Making best efforts to promptly resolve any issues related to this Contract identified by the Collaborative, member agencies, or the SE; and
  - 7. Working cooperatively with other State of New Mexico contracting partners, including but not limited to: (1) Salud! MCOs; (2) SCI MCOs; (3) CoLTS MCOs; (4) MMIS contractor, which is currently ACS; and (5) other identified contractors as, from time-to-time may be identified by the State.
- B. The SE may not have an employment, consulting or other agreement with a person who has been convicted of crimes specified in Section 1128 of the Social Security Act for the provision of items and services that are significant and material to the SE's obligations under this Contract.
- C. **Compliance.** The SE shall:
  - 1. Designate a compliance officer and a compliance committee that are accountable to senior management;
  - 2. Provide effective training and education for the compliance officer and the SE's employees;

3. Implement effective lines of communication between the compliance officer and the SE's employees;
4. Require enforcement of standards through well-publicized disciplinary guidelines; and
5. Have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to compliance with this Contract.

**D. Delegation.** The SE shall:

1. Not assign, transfer or delegate key management functions such as utilization review/utilization management or care coordination without the explicit written approval of the Collaborative;
2. Oversee and be held accountable for any function and responsibility, including claims submission requirements, that it delegates to any subcontractor;
3. Evaluate the prospective subcontractor's ability to perform the activities to be delegated;
4. Have a written agreement between the SE and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
5. Monitor the subcontractor on an ongoing basis and subject it to review on a periodic basis as agreed upon by the SE and Collaborative; and
6. Ensure that if deficiencies or areas for improvement are identified, corrective action shall be taken by the SE and the subcontractor.

### 3.3 GENERAL REQUIREMENTS

- A. The SE shall ensure that quality behavioral health services, including services funded by Medicaid and various other funding sources (see Appendix xxx – Funding Table), are provided to Medicaid and non-Medicaid consumers; network and out-of-network providers are reimbursed timely and accurately; and services promote prevention, recovery, resilience, and efficient use of available resources.
- B. The SE shall manage and account for all funding by funding source and consumer as specified by Collaborative and its member agencies.
- C. The SE shall identify, track, and report all allowable and non-allowable expenses and service utilization by funding source and consumer.
- D. The SE shall "coordinate," "braid," or "blend" the funding from the funding sources included in this Contract in order to increase flexibility, maximize available resources, and create a single, seamless behavioral health system for New Mexico.
- E. The SE shall develop written policies and procedures that describe how the SE shall comply with the requirements of this Contract, and, unless otherwise directed or approved in writing by the Collaborative, the SE shall administer this Contract in accordance with those policies and procedures.



### 3.4 STAFFING

- A. The SE shall operate a comprehensive Service Center and six (6) Regional Offices (five regional and one Native American) in New Mexico, including a clinical call center.
- B. Except as prior approved by the Collaborative, all administrative functions, including but not limited to care coordination, member services, QM/QI, UM, provider credentialing/recredentialing, provider contracting, and claims adjudication shall be done with decision-making authority in New Mexico.
- C. The SE shall maintain sufficient qualified staff in all of its departments and regional offices necessary to fulfill the requirements of this Contract. This includes but is not limited to functions and services in the following areas: administration, quality management/quality improvement, provider services and provider relations, grievance and appeals, accounting and finance, claims adjudication, information systems, and reporting.
- D. The SE shall submit to the Collaborative the names, resumes and contact information of all key staff. Key staff positions shall include but are not limited to the staff identified below.
- E. The SE shall notify the Collaborative within fifteen (15) days when changes in key staff occur or there are significant changes in staffing. The SE shall consult with and receive the approval of the Collaborative CEO and Collaborative Co-Chairs before any change of Chief Executive Officer (CEO), Chief Medical Officer (CMO)/Medical Director, Chief Financial Officer (CFO), or Chief Information Officer (CIO).
- F. The minimum key staff positions are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person.
  - 1. The SE shall employ a full-time Chief Executive Officer (CEO) who shall be responsible for all New Mexico-based operations, with authority to reallocate staff and resources to ensure Contract compliance.
  - 2. The SE shall employ a full-time Chief Medical Officer/Medical Director dedicated to this Contract who is licensed to practice medicine in New Mexico and is board certified in psychiatry. The CMO/Medical Director shall oversee and be responsible for all clinical activities. The CMO/Medical Director shall have the authority to delegate activities to other psychiatrists or other appropriate licensed providers, but the CMO/Medical Director shall remain responsible for coordination, management, oversight, and reporting of clinical activities.
  - 3. The SE shall employ a full-time Chief Financial Officer (CFO) dedicated to this Contract responsible for accounting and finance operations, including all audit activities.
  - 4. The SE shall employ a full-time Contract Manager dedicated to this Contract (see Article 3.2).

5. The SE shall employ a full-time staff person dedicated to this Contract who shall assist the SE in the transition from the SE's implementation team to regular ongoing operations. This person shall be onsite in New Mexico from the start date of this Contract through at least one hundred and twenty (120) days after the start date of operations.
  6. The SE shall employ a full-time Chief Information Officer (CIO) who shall oversee and be responsible for all SE information systems functions supporting this Contract.
  7. The SE shall employ a full-time staff person dedicated to this Contract who shall oversee and be responsible for provider services and provider relations, including all network management issues.
  8. The SE shall employ a full-time staff person dedicated to this Contract who shall oversee and be responsible for all utilization management activities. This person shall be a physician licensed to practice in New Mexico and board certified in psychiatry.
  9. The SE shall employ a full-time staff person dedicated to this Contract who shall oversee and be responsible for all QM/QI activities.
  10. The SE shall employ a full-time staff person dedicated to this Contract who shall oversee and be responsible for care coordination.
  11. The SE shall employ a full-time staff person dedicated to each region who shall oversee and be responsible for activities in that region, including working with the LCs.
  12. The SE shall employ a full-time staff person dedicated to this Contract who shall work on Native American issues.
- G. The SE is not required to report to the Collaborative changes in staff not identified as key staff in Article 3.4.F above. However, the SE shall provide its staffing plan to the Collaborative for review and approval and shall implement the staffing plan approved by the Collaborative. Upon the request of the Collaborative, the SE shall update the Collaborative regarding staffing, including how actual staffing compares to the staffing plan (e.g., different qualifications and vacant positions).
- H. The Collaborative reserves the right to require the SE to make changes in its staff, subject to applicable laws, regulations and reasonable SE employment policies as uniformly applied to SE's staff, with thirty (30) days notice.
- I. Except as otherwise prior approved by the Collaborative, all SE functions shall be conducted by staff who reside in the State of New Mexico.
- J. The SE shall provide regular and ongoing comprehensive training for SE staff to ensure that they understand the goals of the Collaborative as well as the requirements of the Contract.
1. The SE shall provide an initial orientation and training as well as ongoing training, including training targeted to different types of staff, to ensure compliance with Contract requirements.
  2. The SE shall identify and provide timely, targeted training to SE staff as issues are identified by the SE or the Collaborative.

3. The SE shall develop training plans that specify the training topic, the targeted SE staff, the content of the training, and the training schedule (including dates/times and locations).
4. The SE shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided. Upon request, the SE shall report the results of this evaluation to the Collaborative.
5. The SE shall submit a quarterly training activity report to the Collaborative that provides a summary of each training event.

### 3.5 CONSUMER ELIGIBILITY AND ENROLLMENT

- A. Any individual receiving or eligible to receive behavioral health services from a funding source included in this Contract (see Appendix xxx – Funding Table) is covered by this Contract. There is no formal enrollment process for these individuals. The SE shall provide access to covered services for these individuals ("consumers") in accordance with this Contract.
- B. Consumers may be enrolled in Medicaid (referred to as Medicaid consumers). Medicaid consumers may be eligible for services funded by Medicaid or by other funding sources (referred to as non-Medicaid services).
- C. The SE shall receive and as needed process Medicaid eligibility files as well as consumer-specific data from providers registering consumers for non-Medicaid funding sources.
- D. The SE shall update its consumer eligibility/registration databases within twenty-four (24) hours of receipt of new or refreshed consumer eligibility/registration data.
- E. The SE shall transmit to the appropriate member agency, in the formats and methods specified by that agency, changes to consumer contact information (consumer address, telephone number(s)) and other information as agreed to with the agency.
- F. The SE shall be capable of uniquely identifying a distinct consumer across multiple populations and Systems within its span of control.
- G. The SE shall be able to identify potential duplicate records for a single consumer and resolve any reported duplication such that the consumer eligibility/registration, service utilization, and customer interaction histories of the duplicate records are linked or merged.
- H. The SE shall have a Web-based and phone-based confirmation of consumer eligibility/registration function. The function shall provide consumer eligibility/registration information for a particular consumer for any program/service for which the consumer is eligible. This function shall be available 24 hours a day, 7 days a week, with the exception of scheduled upgrades and maintenance activities.
- I. The SE shall ensure that providers register consumers eligible for non-Medicaid funding sources with the SE. The SE shall develop a registration process, including both a paper-based and electronic process, for collecting relevant information, including but not limited to the consumer's demographic information and the funding source(s) for which the consumer is eligible.

- J. For non-Medicaid consumers and for non-Medicaid services to Medicaid consumers, the SE shall establish and manage a process for eligibility and priority determination. This process shall incorporate the eligibility and priority determination criteria are set forth in the relevant rules and policy manuals of the Collaborative member agencies.
- K. **Disenrollment of Medicaid consumers.** Disenrollment for Medicaid consumers shall only be considered in rare circumstances and may be initiated by a consumer, the SE, or the State.
1. A Medicaid consumer may request to be disenrolled from managed care to fee for service (FFS) behavioral health services "for cause" at any time. The consumer or his/her representative must submit an oral or written request to the State.
  2. The SE may request that a Medicaid consumer be disenrolled from the SE. For disenrollment requests initiated by the SE, the SE shall submit a request in writing to the State and provide any supporting documentation requested by the State. Conditions under which the SE may request disenrollment of a Medicaid consumers from the SE are:
    - a. The SE demonstrates a good faith effort has been made to accommodate the consumer and address the consumer's problems, but those efforts have been unsuccessful;
    - b. The conduct of the consumer does not allow the SE to safely or prudently provide covered services;
    - c. The SE has offered to the member in writing the opportunity to use the grievance process; and
    - d. The SE has received threats or attempts of intimidation from the consumer to the SE, its staff, or its network providers.
  3. The SE shall not request disenrollment of a Medicaid consumer from the SE because of an adverse change in the consumer's health status, or because of the consumer's utilization of covered services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs (except when his/her continued enrollment with the SE seriously impairs the SE's ability to furnish services to either this particular consumer or other consumers).
  4. The effective date of an approved disenrollment shall be no later than the first day of the second month in which the consumer or SE filed the request. If the State fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved. If a Medicaid consumer is dissatisfied with the State's determination denying a request to disenrollment from the SE, access to a Fair Hearing will be provided.
  5. If a Medicaid consumer is hospitalized at the time of disenrollment from the SE, the SE shall be responsible for payment of all covered inpatient psychiatric hospital or psychiatric unit of an acute care hospital costs, including professional services provided from the date of admission to the date of discharge (at the contracted rate).

- a. The discharge date is defined as follows: When a consumer (1) is moved from a psychiatric unit to another unit within the general hospital; (2) is moved from a psychiatric hospital to a non-psychiatric hospital; or (3) leaves a psychiatric hospital or psychiatric unit of a general hospital to a home/community setting. It is not considered a discharge when a consumer is moved from one psychiatric hospital or psychiatric unit of a general hospital to another psychiatric hospital or psychiatric unit of a general hospital, including out-of-state facilities.
- b. If a Medicaid consumer is hospitalized and is disenrolled from the SE due to loss of Medicaid coverage, the SE is only financially liable for the covered hospitalization and associated professional services until such time the consumer is determined to be ineligible for Medicaid. If other (non-Medicaid) funding sources are available to pay for the stay, the SE shall consider those options.

### 3.6 COORDINATION AND COLLABORATION WITH THE COLLABORATIVE

#### A. Coordination and Collaboration with the Collaborative

1. The SE shall coordinate and collaborate with the Collaborative in the implementation of the requirements in this Contract. This includes communicating with, participating in, and collaborating with the Collaborative Steering Group, all CATs, and other cross-agency workgroups/teams or Collaborative subcommittees as requested.
2. Upon request, the SE shall submit its policies and procedures and other deliverables specified by the Collaborative to the Collaborative for review and/or written approval in the format and within the timeframes specified by the Collaborative. The SE shall make any changes requested by the Collaborative to policies and procedures or other deliverables and in the timeframes specified by the Collaborative.
3. The SE shall provide notice to the Collaborative Co-Chairs sixty (60) days prior to making any changes to the behavioral health system. The Collaborative shall have the right to approve or deny the proposed change.
4. The SE shall not make any significant changes to the behavioral health system or programs during the State's Legislative session or for sixty (60) days preceding or following the Legislative session.
5. The SE shall receive approval from the Collaborative prior to providing any data or reports to any person or entity other than the Collaborative.
6. The SE shall coordinate its efforts on behalf of the Collaborative with other public or private behavioral health initiatives underway throughout the state.
7. The SE shall provide regular and ongoing comprehensive training for member agency staff.
  - a. The SE shall confer with each of the specific member agencies and coordinate specific training requirements with each agency.

- b. The SE shall provide timely, targeted training to member agency staff as issues are identified by the SE or the Collaborative or upon request of the Collaborative.
- c. The SE shall develop training plans that specify the training topic, the targeted member agency staff, the content of the training, and the training schedule (including dates/times and locations).
- d. The SE shall provide training regionally whenever possible in order to accommodate member agency staff.
- e. The SE shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided. Upon request the SE shall report the results of this evaluation to the Collaborative.
- f. The SE shall submit a quarterly training activity report to the Collaborative that provides a summary of each training event.

**B. Coordination and Collaboration with the BHPC and Local Collaboratives**

- 1. The BHPC shall serve as the primary statewide advisory body for mental health and substance abuse issues.
  - a. The SE shall work with the BHPC in the development of statewide and regional comprehensive strategic planning activities, prioritizing legislative funding, and similar topics.
  - b. The SE shall seek advice and comment from the BHPC during the planning, implementation, and evaluation of services under this Contract.
  - c. The SE shall make available to the BHPC information, training, technical assistance and data about SE operations or proposed operations.
  - d. The SE shall structure SE committees so that there is opportunity for BHPC representation.
  - e. The SE shall utilize data and information from the BHPC in its operations under the Contract, including making available sufficient public opportunity for input before operations commence or change at the beginning and throughout the Contract.
- 2. The LCs for each of the thirteen (13) geographical areas and for Native American Tribes, Nations, or Pueblos (Appendix xxx), as formally recognized by the Collaborative, shall act as advisors to the SE. The SE shall share information with LCs and consult with the LCs and consider their input on service delivery issues in their geographic or cultural area.
  - a. Upon request, the SE shall work closely with the LC to assist them in recruiting and training providers, consumers, and family members to be fully participating members of the LCs.
  - b. Upon request, the SE shall work with the LCs to build and improve relationships among consumers, family members, providers, advocates, and political entities.

- c. The SE shall, in conjunction with the CATs, participate in a needs assessment of the organizational, developmental, and programmatic requirements of each of the LCs and identify ways the SE will assist in meeting these needs as requested.
- d. The SE shall utilize data provided by the LCs to improve network capacity and to inform service delivery, program development, and quality improvement.
- e. The SE shall provide each LC with regular aggregate and trended service utilization information applicable to consumers from the LC's geographic area and compared to the state as a whole.
- f. 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.
- g. The SE shall provide program evaluation training to LCs to assist in evaluation as requested by the Collaborative.
- h. The SE shall structure SE committees so that there is opportunity for LC representation.
- i. Within each SE Regional Office, the SE shall identify an LC liaison to fully partner with the Local Collaborative CAT to achieve the outcomes identified in the Guidelines for Local Collaboratives. The SE staff in the regional areas shall be knowledgeable of the cultural and linguistic diversity issues within the area in which they serve.
- j. The SE shall provide Regional staff who shall work with LCs to identify available local support groups and provide information on natural community-based informal support mechanisms to consumers and families.
- k. The SE shall meet and consult with the Collaborative regarding the use of LCs to shape overall implementation of the Contract and the provision of covered services in New Mexico.
- l. Upon request, the SE shall meet and consult with LCs to develop service area plans for each of the six regions.
- m. The SE shall provide culturally competent training, technical assistance, capacity building, planning, and logistical resources, for LCs.
- n. The SE shall meet and consult with the LCs to identify service gaps and needs.
- o. Upon request, the SE shall work with particular LCs on demographic or geographic-specific topics.
- p. Upon request, the SE shall work with LCs to develop and provide educational materials for stakeholders in a culturally competent manner and in prevalent languages other than English.

- q. Upon request, the SE's staff (in addition to the LC liaison) shall interact with LCs, including informing and educating LCs regarding relevant aspects of operations affecting local areas.
- 3. The SE shall attend and participate in BHPC and LC meetings regularly.
- 4. The SE, along with the Collaborative and other funding sources, shall provide resources for the development of an electronic communication system accessible to the LCs to facilitate communication and information sharing across and within the system.
- 5. The SE shall establish formal communications and share information at the SE management level related to the LCs.
- 6. The SE shall provide to, and receive information from the BHPC, LCs, and Collaborative members regarding program development and implementation including, but not limited to state, tribal, and federal initiatives (including federal initiatives affecting Tribes, Nations, and Pueblos) being implemented at the local level.
- 7. The SE shall consult with the BHPC and the LCs to identify service gaps and needs, including provider training needs, and ensure intersystem coordination at the local level; and shall utilize the BHPC and the LCs in the decision-making process.
- 8. The SE shall work with the BHPC and the LCs to identify provider, consumer and family concerns, training needs and opportunities. The SE shall report identified concerns and training needs to the Collaborative.
- 9. The SE shall offer assistance and information to the BHPC and the LCs about the types of system interfaces that work in their communities regarding referrals to and from and collaboration among behavioral health providers, adult corrections, adult and juvenile justice, protective services, schools, regarding individual education plans, child welfare, other health and human services agencies, PCPs, etc.

### 3.7 COVERED SERVICES

- A. The SE shall provide all of the programs/services funded by each of the funding sources identified in Appendix xxx (Funding Table) as well as any Letters of Directions. The SE shall provide each program/service in accordance with the requirements of the funding source and the applicable member agency.
- B. The SE shall provide covered services in accordance with the Collaborative's current Comprehensive Behavioral Health Plan.
- C. In the delivery of covered services the SE shall take into account the need for the following:
  - 1. Development and provision of a continuum of school-based behavioral health services in partnership with the DOH Office of School and Adolescent Health (OSAH), the HSD Medicaid School Health Office, the Public Education Department (PED) and CYFD;



2. Development and provision of programs interfacing with other systems such as Aging and Long Term Services, Vocational Rehabilitation, Developmental Disabilities, Child Welfare/Protective Services, Adult and Juvenile Justice, primary health care and workforce development;
  3. Coordination with public and private inpatient and residential behavioral health care facilities;
  4. Coordination with housing, employment and community educational programs necessary for quality community life;
  5. Coordination with local Driving While Intoxicated (DWI) councils, upon request, to identify populations and geographic areas in need of prevention services, and also work with the councils to develop plans with measurable goals and objectives, which will guide them in the implementation of evidence-based prevention programming. The SE will also work with the DWI councils to develop a process for evaluating evidence-based prevention programming;
  6. Coordination with domestic violence service providers;
  7. Development and provision of specialty programs serving persons in corrections, probation and parole and community corrections and adult and juvenile justice and juvenile detention system involvement, including DWI programs, defendants in drug and mental health courts, individuals who are homeless, adult probationers and parolees, and juvenile offenders, and provide care coordination as these populations transition back into the community;
  8. Coordination with those involved in the life of a child or adolescent and family involved in the CYFD PS or JJS systems, including the children, adolescents, and families themselves;
  9. Coordination with disability agencies and organizations providing services to individuals with disabilities to ensure that a system for accessing appropriate and timely services for individuals with special health care needs or disability-related needs is in place; and
  10. Coordination with services and programs identified in this Contract, including but not limited to Articles 3.8, 3.9 and 3.10.
- D. For Medicaid consumer enrolled in an MCO, the SE shall be responsible for all covered services rendered by a behavioral health provider. The Salud! or CoLTS MCO (and the SCI MCO if so agreed by the SE and the MCO; see Article 3.9.F) shall be responsible for behavioral health services provided by the MCO's network provider if the provider is not a behavioral health provider (e.g., PCPs) , even when the primary diagnosis is a behavioral health diagnosis.
1. The SE shall be responsible for services provided in a psychiatric hospital or a psychiatric unit of a general hospital.
  2. The SE shall be responsible for professional services rendered by behavioral health practitioners unless the practitioner is a mid-level or nurse specialist practitioner employed by a non-psychiatric facility and is rendering services included in conjunction with a hospital stay, hospital clinic, or hospital emergency room service.

3. The SE shall be responsible for inpatient and outpatient hospital services rendered by a psychiatrist or psychologist or other independent behavioral health practitioner in independent practice.
4. As provided in Article 3.9.B, the SE shall be responsible for emergency services provided by a psychiatric emergency room. The MCO is responsible for general hospital services, including emergency services, even when the primary diagnosis is a behavioral health diagnosis.
5. The SE shall be responsible for pharmacy services to Medicaid consumers prescribed by a network provider (see Article 3.9.C).
6. The SE shall be responsible for laboratory and radiology costs when they are provided within, and billed by, a psychiatric hospital, a psychiatric unit of a general hospital, or by a psychiatric emergency room. The MCO is responsible for laboratory and radiology costs when a behavioral health provider orders the lab or radiology service and the service is provided by an outside, independent laboratory or radiology facility, including when the service is for a consumer in a psychiatric hospital, psychiatric unit of a general hospital, or a psychiatric emergency room. The SE shall be responsible for payment if a psychiatrist orders lab work but completes that lab work in his/her office/facility and bills for it.

### 3.8 CARE COORDINATION

- A. Care coordination is an administrative function of the SE in which designated SE staff (Care Coordinators) provide coordination services to assist identified consumers and when appropriate their families.
- B. The SE shall ensure that ISHCNs and other special populations are offered and have access to care coordination.
  1. The SE shall develop criteria identifying ISHCNs and other special populations who shall be offered care coordination services. These criteria must be prior approved by the Collaborative.
    - a. Criteria shall include such issues as the need for multiple services and/or systems, past high utilization of behavioral health services, and high risk of needing intensive behavioral health services. Criteria shall also identify consumers who have difficulty navigating the behavioral health system; have multiple and complex needs; are transitioning to higher or lower levels of care; are transitioning from jail or detention facilities; are transitioning from home into foster care or transitioning from foster care to an adoptive home; transitioning from the children's behavioral health services system to the adult behavioral health services system; and/or are transitioning to a new provider.
    - b. Once the criteria are approved by the Collaborative, the SE shall publish, distribute, and utilize the criteria throughout the State. The criteria and intensity levels shall be included in the SE's care coordination policies and procedures.
- C. The goal of care coordination is to ensure that consumers receive needed behavioral health and support services that are coordinated (as appropriate) and are provided without disruption and to ensure continuity of care.

- D. Within the SE, care coordination shall function independently of, but shall be structurally linked to, other SE systems, such as quality management/quality improvement (QM/QI), utilization management (UM) and grievances and appeals.
- E. Activities provided through care coordination at the SE level differ from case management services or Comprehensive Community Support Services (CCSS) provided by providers.
- F. A consumer, his/her parent, legal guardian, or designated representative shall have the right to refuse care coordination. If care coordination is refused, the SE shall have no further obligation to that consumer with respect to care coordination until such time that the consumer, his/her parent, legal guardian or designated representative requests care coordination.
- G. If a consumer is referred to the SE for care coordination by a family member, provider, or state agency, the SE shall contact the consumer or consumer's legal guardian to offer care coordination.
- H. The SE shall provide statewide care coordination by licensed or otherwise qualified professionals. Care Coordinators can be licensed RNs, LPNs, or social workers, or have a bachelor's degree from an accredited college or university in nursing, social work, counseling, special education, or a closely related field and have a minimum of one (1) year's experience in working with individuals with behavioral health conditions; this requirement may be waived by the Collaborative if the SE demonstrates that no persons with these qualifications are available in a specific service area. In this circumstance, the SE shall provide a Care Coordinator with alternative credentials upon approval by the Collaborative.
- I. The SE shall adhere to the following requirements for care coordination, which shall also be included in the SE's care coordination policies and procedures:
  - 1. Proactively identify consumers in the eligible population groups;
  - 2. Ensure access to care coordination for all ISHCNs and other special populations;
  - 3. Provide a designated Care Coordinator to be responsible for coordinating the behavioral and physical health services furnished to each identified consumer and to serve as the SE's single point of contact for that consumer and, when appropriate, the consumer's legal guardian or designated representative;
  - 4. Have care coordination information systems, and provide access to said systems, that facilitate the work of, and promote efficiencies amongst Care Coordinators; and
  - 5. Ensure that each Care Coordinator conducts the following activities:
    - a. Communicate to the consumer and his/her legal guardian or designated representative the Care Coordinator's name and contact information and the role of the Care Coordinator.

- b. Develop a plan of care (care coordination plan) in conjunction with the consumer and legal guardian or designated representative, which is based on an assessment and includes care coordination goals, needs, capacities, and medical and behavioral health condition of the consumer and the needs and goals of the family as applicable to the consumer's care.
- c. Ensure the consumer, and his/her family and/or legal guardian or designated representative as appropriate, is involved in the development and implementation of the plan of care with routine reviews.
- d. Meet face-to-face or telephonically with the consumer and his/her parent, legal guardian and/or designated representative as appropriate to meet the consumer's goals and in accordance with the consumer's plan of care.
- e. Ensure an evaluation process occurs that measures the consumer's response to interventions and revise the plan of care as needed.
- f. Share the plan of care with the consumer's key providers, including behavioral and physical health providers and State agency staff providing behavioral health care and/or case management/monitoring services.
- g. Educate the consumer, the consumer's family and/or caregivers on how to access emergency services and what clinical history to provide when emergency services or inpatient admissions is needed; how to coordinate with the PCP or primary behavioral health provider when the consumer is hospitalized; how to ensure that the emergency room physician has access to the consumers medical and/or behavioral health clinical history; and how to obtain any necessary referrals for inpatient hospital staff providing outpatient or ambulatory surgical procedures.
- h. Coordinate with the designated MCO care coordinator on co-managed cases.
- i. Coordinate care among other applicable member agencies and programs (see Articles 3.9 and 3.10).
- j. Maximize access to non-covered services.
- k. Collaborate with appropriate State agency staff and community agencies in order to facilitate appropriate and timely referrals to non-covered services.
- l. Ensure access to a qualified provider who is responsible for developing and implementing a treatment plan or, when multiple providers are involved, a multidisciplinary service plan to be followed by all providers delivering services for the consumer.
- m. Ensure that physical health as well as behavioral health services are identified in the treatment plan developed by the provider (as appropriate).

- n. Request and review collateral clinical information from providers in order to determine that the treatment plan is in place and services are appropriate and meet the consumer's needs. Assist the provider and consumer in identifying and resolving problems and preventing duplication of services.
- o. Provide resources and information on treatment options and services to the consumer and his/her provider to assist in the development and implementation of the treatment plan.
- p. Coordinate with the consumer's provider(s) to ensure that the treatment plan is implemented and revised as needed.
- q. In the event that a local case manager or community support worker is not available, perform case management functions (as needed) for the consumer.

### 3.9 SPECIAL COORDINATION REQUIREMENTS

#### A. Coordination of Physical and Behavioral Health Services

1. Physical Health Linkage and Referral. The SE shall encourage its providers to make a referral for (a) a physical exam if the consumer has not had a physical exam within twelve (12) months of the date of enrollment and (b) a dental exam if the consumer has not had a dental exam within six (6) months of the date of enrollment.
  - a. The SE shall educate and assist its providers regarding proper procedures for making appropriate referrals for physical health consultations and treatment.
  - b. The SE shall ensure its providers coordinate care with primary care providers (PCP) when appropriate.
  - c. The SE shall educate appropriate physical health providers, including but not limited to PCPs and hospitals, regarding SE covered services.
  - d. The SE shall require its providers to forward to a consumer's PCP or other applicable physical health provider, with the consumer or legal guardian or designated representative's written consent, a written report of the outcome of any referral to the behavioral health provider containing sufficient information to coordinate the consumer's care within seven (7) calendar days after screening and evaluation. The SE shall monitor this process and ensure that providers provide this report.
  - e. The SE shall require its providers, with the written consent of the consumer or his/her legal guardian or designated representative, to provide physical health care providers with access to relevant behavioral health medical records and to make referrals to physical health providers as necessary. The SE shall be responsible for monitoring referrals to physical health providers. In addition, the SE shall require its providers to communicate with physical health providers as appropriate.

2. The SE shall not require consumers to obtain a referral to access covered services.
3. Medicaid Consumers. The SE shall ensure effective coordination with the appropriate physical health systems (MCO or FFS) for Medicaid consumers.
  - a. The SE shall have a Memorandum of Understanding with each Salud! and CoLTS MCO that outlines the actions to be taken by the SE and the MCO to ensure that physical and behavioral health services are provided through a clinically coordinated and collaborative system between the SE and the MCO for Medicaid consumers enrolled with the MCO.
  - b. The SE shall develop and implement protocols with each Salud! and CoLTS MCO governing how care coordination shall be provided for Medicaid consumers eligible for care coordination from both the SE and the MCO. These policies shall address mechanisms for exchanging relevant clinical information between the SE and the MCO care coordination staffs and CMOs/Medical Directors to ensure physical health and behavioral health services are delivered seamlessly.
  - c. The SE shall facilitate access to relevant medical records of mutually served consumers between physical and behavioral health providers subject to applicable law to ensure the maximum benefit of services to the consumer.
  - d. For Medicaid consumers enrolled with a Salud! or CoLTS MCO, the SE or the MCO responsible for the care of that consumer's most acute condition shall take primary lead on care coordination activities, and the SE shall coordinate care with the MCO as needed. Where the SE and MCO disagree on "most acute condition," HSD/MAD staff shall decide and instruct the SE and MCO accordingly.
  - e. The SE shall have a Memorandum of Understanding with HSD that outlines the actions to be taken by the SE and HSD to ensure access to and coordination of physical and behavioral health services for Medicaid consumers who are not enrolled in an MCO.
4. Non-Medicaid Consumers. For non-Medicaid consumers, the SE shall ensure coordination of covered services with appropriate physical health care providers.
5. The SE shall refer non-Medicaid consumers to regional and statewide primary care resources, including the Public Health District Offices, community health centers, indigent care providers, or other physical health care providers as appropriate, when it is determined in the course of screening, assessment, or delivery of behavioral health care services that physical health care services are necessary.

6. The SE shall have a Memorandum of Understanding with DOH that outlines the actions to be taken by the SE and DOH to ensure access to and coordination of physical and behavioral health services for non-Medicaid consumers.

**B. Emergency Services**

1. The SE shall cover emergency and post-stabilization services provided by psychiatric emergency rooms. The SE is not responsible for emergency and post-stabilization services provided in a general hospital. For Medicaid consumers HSD or the MCO is responsible for emergency services provided in a general hospital.
  - a. Emergency services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency condition. An emergency condition exists when a consumer manifests acute symptoms and signs that, by reasonable judgment of a lay person, represent a condition of sufficient severity that the absence of immediate medical and/or behavioral health attention could reasonably result in death, serious impairment of bodily function or major organ, or serious jeopardy to the overall health of the consumer or others.
  - b. Post-stabilization care is defined as covered services related to an emergency behavioral health condition that are provided after the consumer is stabilized in order to maintain the stabilized condition; this care may include improving or resolving the consumer's condition or circumstances.
2. The SE shall not require prior authorization for emergency services regardless of whether they are provided by a network or non-network provider.
3. The SE shall reimburse all emergency services at the Medicaid fee-for-service rate.
4. The SE shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency condition under the prudent layperson standard, turned out to be non-emergency in nature.
5. The SE may not deny payment for treatment obtained when a representative of the SE instructs the consumer to seek emergency services.
6. The SE shall comply with any additional requirements regarding emergency services contained in federal funding requirements from block grants or other sources.
7. If requested by an MCO or a general hospital that is providing emergency services not covered by the SE, the SE shall provide covered services to the consumer.

**C. Pharmacy Services**

1. For Medicaid consumers, the SE shall cover pharmacy services prescribed by network providers operating within their scope of practice.

2. The SE shall work with the Collaborative to develop strategies for meeting the pharmacy needs of non-Medicaid consumers.
3. The SE shall maintain a network of prescriber providers that are appropriately licensed and operating within their scope of practice.
4. For Medicaid consumers the SE shall develop and utilize a preferred drug list (PDL) for psychotropic, anti-depressant, and other behavioral health related medications. This PDL for Medicaid consumers shall be consistent with the common PDL developed by HSD/MAD and must be prior approved by HSD/MAD. For non-Medicaid consumers the SE shall work with the Collaborative to establish an appropriate PDL for state-purchased medications across member agencies.
5. The SE may require additional authorization for medications that are not included on the SE's PDL.
6. Cost shall not be the sole consideration for inclusion or exclusion on the SE's PDL. Furthermore, the SE shall not require failure on more established or less expensive medications on its PDL before authorizing non-PDL medications in the same class. In addition, consumers may not be required to switch medications as a result of a change in the PDL or the prior authorization criteria.
7. The SE is not required to cover all behavioral health-related multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted in instances for which a provider has written a prescription and for which the item is an economical or preferred therapeutic alternative to prescription drug items.
8. The SE's PDL for Medicaid consumers shall:
  - a. Cover behavioral-health related brand name drugs and drug items not on the SE's PDL when determined to be medically or clinically necessary by the SE, where an appropriate alternative drug is not on the SE's PDL, or through a Fair Hearing process; and
  - b. Include on the SE's PDL all behavioral-health related multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one therapeutic ingredient, anti-obesity items, items which are not medically or clinically necessary, and cough, cold, and allergy medications. This requirement does not preclude the SE from requiring authorization prior to dispensing a multi-source generic item.
9. The SE shall ensure that a sufficient number of pharmacy providers are available. The SE shall ensure that pharmacy services meet geographic access standards based on the consumer's county of residence. The access standards for Medicaid consumers are as follows:
  - a. Ninety percent (90%) of urban consumers shall travel no farther than thirty (30) miles;
  - b. Ninety percent (90%) of rural consumers shall travel no farther than forty-five (45) miles; and



- c. Ninety percent (90%) of frontier consumers shall travel no farther than sixty (60) miles.
10. The SE shall ensure that a medically or clinically necessary pharmacy service is provided to Medicaid consumers in a clinically timely manner. The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription telephoned in by a provider shall be filled within ninety (90) minutes.
11. The SE shall coordinate as necessary with the MCOs regarding pharmacy services to Medicaid managed care consumers, including editing claims to assure any authorizations given and claims paid are within the scope of the responsibility of the SE. The SE shall ensure that consumers and network providers are informed when a claim falls outside the scope of the SE's responsibility. Such determination shall be made primarily on the basis of the prescriber and other criteria as may be provided by the State.
12. The SE shall make good faith efforts to subcontract with pharmacy providers that offer Medicare Part D.
13. The SE shall use information provided by HSD indicating Medicaid consumers who are eligible for Medicare Part D. When a consumer is eligible for Medicare Part D, the SE shall not reimburse a provider for any pharmacy service that is included in the coverage of Medicare Part D. The SE shall cover pharmacy services to Medicaid consumers that are excluded by Medicare Part D and over-the-counter items to the extent otherwise required by the Medicaid State Plan (SPA).
14. The SE shall not be required to pay any amount towards a consumer co-payment or a drug item paid by Medicare Part D.

**D. Transportation**

1. The SE shall assist consumers in accessing existing transportation benefits and resources to provide transportation to covered services, including transportation to address a behavioral health issue during non-business hours and transportation related to an emergency.
2. For Medicaid consumers in Salud! or CoLTS, the SE shall establish written protocols with each MCO outlining the process for coordinating transportation services. At a minimum, the protocols shall address the following:
  - a. Contact information and process for arranging transportation services, including assistance from MCO/SE staff in making these arrangements;
  - b. Providing and receiving information regarding consumers, network providers, and covered services;
  - c. Coordination of complex transportation needs;
  - d. Utilization reviews for transportation services and clinical overrides;
  - e. Meetings to resolve consumer and provider issues;

- f. Travel reimbursement for mileage, meals and lodging for the consumer and/or escort(s); and
  - g. Travel reimbursement for families of children in State (CYFD) custody in instances where the families are required to travel to participate in treatment/therapy per the child's treatment and permanency plan.
  - h. Travel reimbursement for foster or pre-adoptive parents caring for children in State (CYFD) custody in instances where travel is required to access service and/or the foster or pre-adoptive parent's participation in treatment/therapy is required per the child's treatment and permanency plan.
3. For Medicaid FFS consumers, the SE shall coordinate with County Income Support Division offices.
  4. The SE shall actively assist Medicaid consumers who are individuals with special health care needs (ISHCN) in arranging transportation to needed services.
  5. The SE shall, when absolutely necessary, pay up front out of CYFD flex funding for transportation costs for non-Medicaid consumers to urgent care where the family is not able to pay up front themselves.
  6. The SE shall assist the Collaborative in preventing reduction of access to existing transportation benefits or resources and increasing coordination of existing transportation benefits and resources, including public transportation.
  7. The SE shall participate in the development of an alternative transportation plan for non-Medicaid consumers.

**E. Supportive Housing**

1. The SE shall participate in Collaborative supportive housing policy and program development, capacity building and other planning activities to assure effective implementation of supportive housing as requested by the Collaborative and articulated in the Collaborative's Long Range Housing Plan and/or other Collaborative policy documents. The SE shall identify an individual to serve as the primary, statewide contact with authority to act on behalf of the SE in these activities.
2. The SE shall participate in local capacity building and implementation activities associated with the implementation of this Long Range Housing Plan. The SE shall designate regional and/or local lead contacts who shall be active participants in any Regional or Local Collaborative or local community capacity building initiative related to supportive housing. The SE shall identify the regional and/or local contact to the Collaborative's Supportive Housing Coordinator. The SE shall assure this role is filled at all times. The regional and/or local contact shall be available on a regularly scheduled basis for implementation activities.
3. The SE shall ensure that the regional and/or local staff are available for briefings and training related to supportive housing to assure the SE has knowledge of local supportive housing development challenges and best

practices, fund sources, provider requirements and general supportive housing principles. It is anticipated the SE must make staff available for these briefings and trainings a minimum of four (4) days annually.

4. The SE shall participate in the ongoing education and promotion of the benefits of supportive housing particularly the benefits of exemplary and best practice models, providing information to providers and stakeholders on the Collaborative's Long Term goals and principles for supportive housing. This includes promotion of the benefits of a cooperative working relationships between providers, Collaborative member agency staff and local housing related organizations (e.g., local and regional Public Housing Authorities, non profit and for profit housing development organizations, Continuums of Care, etc.).
5. The SE shall work closely with the Collaborative's Supportive Housing Leadership Team and Collaborative member agency staff on development and implementation of practice standards, strategies and requirements for the Collaborative's continuum of supportive housing including but not limited to outreach and engagement, referrals and move-in activities, housing sustainability, and related services.
6. The SE shall add supportive housing requirements to provider contracts as requested by the Collaborative, consistent with reimbursement requirements and best practice standards for access to and sustainability of supportive housing. The SE shall track and report supportive housing encounter, performance and outcome data. The SE shall provide assessment and analytical data and special reports as requested by the Collaborative through the Collaborative's Supportive Housing Coordinator.
7. The SE shall ensure that these standards and requirements regarding supportive housing are included in provider agreements and shall monitor compliance with these standards and requirements on a consistent and timely basis.
8. The SE shall report any planned supportive housing activities that may result in consumers having access to housing and related resources that may require an ongoing commitment of the Collaborative to ensure housing is not jeopardized.
9. The SE shall not enter into any actions that would lead to housing resources only being available for a time limited period without written permission of the Collaborative. The SE shall report any planned activities or actions that will potentially interfere with any consumer's or group of consumers' housing stability. This includes changes in policy, contract requirements, contracts or allocations to specific providers.
10. The SE shall have and implement policies and procedures for supportive housing local lead agencies as defined by the Collaborative and its housing partners including but not limited to the Mortgage Finance Agency (MFA), regional and local housing authorities, or other designated housing organizations.

**F. Coordination with SCI MCOs**

Behavioral health services included in the SCI benefit package shall be the responsibility of the SCI MCO unless otherwise agreed to by the SE and the SCI MCO. The SE, the SCI MCO, and HSD shall come to agreement on and put into place all policies and procedures necessary for administering services and coordinating care and benefits to which SCI members may be entitled to through the Collaborative.

**G. Coordination and Collaboration with CYFD, Including Children in CYFD Custody**

1. The SE shall work with CYFD and other member agencies to promote early identification of children who are engaging in delinquent or high-risk factors including exhibiting signs of serious emotional disturbance.
2. The SE shall coordinate services with the CYFD Protective Services (PS), Family Services (FS), and Juvenile Justice Services (JJS) divisions, including discharge planning.
3. The SE shall participate in all FS, PS, and JJS clinical staffing reviews, including the CYFD Behavioral Health Triage process.
4. Upon request, the SE shall participate in the PS Team Decision-Making (TDM) and JJS Multi-Disciplinary Team (MDT) meetings.
5. For requests for authorization of residential treatment center (RTC) services for JJS youth in a detention facility, the SE shall make a decision and notify JJS and the provider of the decision within twenty-four (24) hours of receipt of the request.
6. The SE shall ensure that providers begin discharge planning with CYFD staff within twenty-four (24) hours of a child's admission to an acute behavioral health setting to identify antecedents to the placement and conditions for the child's return to the community, including but not limited to the permanency planning behavioral health needs of the child.
7. The SE shall ensure that children in the custody or supervision of CYFD receive a behavioral health screening within twenty-four (24) hours of a referral to a network provider and receive a behavioral health assessment, medically and clinically necessary covered services, and care coordination as appropriate.
8. The SE shall ensure the consumer's assigned CYFD worker is actively involved in the consumer's care coordination, provided that CYFD informs the SE of who is the assigned CYFD worker.
9. The SE shall promote coordination between juvenile detention facilities and the SE's providers to establish a process to communicate the behavioral health needs of juveniles at intake and discharge and to establish continuity of care between the juvenile detention facility and the SE. The SE shall facilitate that coordination if requested.
  - a. Upon request, the SE shall provide training to juvenile detention facility staff and SE providers regarding service availability, the referral process, and eligibility criteria to promote coordination and access to services upon release.

- b. The SE shall ensure assessment and provide appropriate covered services for all CYFD-referred juveniles, to the extent resources are available, and shall work with the Collaborative to implement criteria to prioritize CYFD-referred juveniles to prevent recidivism to the extent possible.
10. The SE shall work with CYFD to provide care coordination for committed juveniles identified as having high needs as they transition from juvenile correctional facilities (commitment facilities) back into the community.

**H. Coordination and Collaboration with NMCD**

1. The SE shall work with NMCD to establish a process to communicate the behavioral health needs of detainees at intake and discharge and to establish continuity of care for individuals paroled from NMCD prisons or released on probation and under the supervision of NMCD.
2. Upon request, the SE shall provide training to NMCD staff and SE providers regarding service availability, the referral process, and eligibility criteria to promote coordination and access to services upon release.
3. The SE shall ensure assessment and appropriate covered services for all NMCD-referred adults, to the extent resources are available, and shall work with the Collaborative to implement criteria to prioritize NMCD-referred adults to prevent recidivism to the extent possible.
4. The SE shall work with NMCD to provide care coordination of incarcerated individuals identified by the Collaborative as having high needs as these individuals transition back into the community.

**I. Court-Ordered and/or Parole Board-Ordered Treatment**

1. The SE shall require providers to establish and maintain professional relationships with magistrate, municipal, and district judges and with parole board members regarding cases that contain behavioral health elements. The SE shall encourage the development and implementation of the following elements:
  - a. Education of judges and parole board members regarding appropriate referral procedures for covered services, consumer eligibility for covered services, resource availability and clinically appropriate treatment alternatives;
  - b. Review of assessments, court orders and/or conditions of child welfare, probation, or parole that order individuals into covered services to ensure that the level of treatment intervention is medically, clinically, and/or psychosocially appropriate to assessed consumer need and is within the authorized licensed capacity and resource availability of the provider; and
  - c. A process for reviewing with CYFD and/or NMCD cases where care is determined by the SE not to be medically, clinically, and/or psychosocially appropriate and identifying services that are appropriate to the needs of the consumer.

2. The SE shall work with NMCD, CYFD, providers, the Courts and the Adult and Juvenile Parole Boards to educate the criminal justice system on covered services and to facilitate requests for modification to court orders or conditions of parole when clinically indicated.

**J. Children in Tribal Custody or Under Tribal Supervision**

1. The SE shall ensure that children in Tribal custody or under Tribal Supervision receive a behavioral health screening within twenty-four (24) hours of a referral to a network provider and receive a behavioral health assessment, medically and clinically necessary covered services, and care coordination as appropriate.
2. If requested by an Indian Tribe, Nation, or Pueblo located partially or wholly in New Mexico, the SE shall negotiate in good faith to enter into agreements to develop assessment and treatment protocols and procedures to ensure that services are provided to children in Tribal custody or under Tribal supervision who are in need of such services. Should a Tribe, Nation, or Pueblo choose not to enter into such agreements, the SE shall not be liable for providing covered services.

**K. Coordination of Adolescents Transitioning into the Adult System**

1. The SE shall define and identify high-risk youth ages sixteen (16) to twenty-one (21) who are transitioning into the adult system (for example, those who qualify as an ISHCN or are in State custody or supervision) and shall assist them to effectively transition into the adult system.
2. The SE shall ensure coordination with all relevant providers and state agencies currently involved in the consumer's care and with the family, relevant individuals identified by the youth, and the consumer's legal guardian or designated representative, as appropriate.

**L. Coordination Related to Children with IEPs**

The SE shall work with its network providers to coordinate services for children with an individualized education program (IEP).

**M. Coordination Related to Medicaid Eligibility**

1. The SE shall require its providers to identify whether non-Medicaid consumers may be eligible for Medicaid. If a consumer may be eligible for Medicaid, the SE shall assist the provider in helping the consumer make contact with the appropriate agency (e.g., HSD Income Support Division field offices, the Social Security Administration (SSA), or DOH or ALTSD for certain waiver programs) to begin the eligibility process.
2. The SE shall cooperate with HSD's Medicaid outreach efforts, including outreach to non-Medicaid consumers eligible for Medicaid and outreach to Medicaid consumers to maintain Medicaid enrollment.
3. The SE shall ensure that Medicaid consumers placed in a residential facility who are eligible for Medicaid at discharge are enrolled in Medicaid at the time of discharge.

**N. Coordination with Medicaid Waiver and Non-Medicaid Disability Programs.**

1. The SE shall coordinate care as needed with consumers receiving services through Medicaid 1915(c) waiver and non-Medicaid disability programs, including but not limited to New Mexico's 1915(c) Developmental Disabilities waiver, 1915(c) Medically Fragile waiver and 1915(c) HIV/AIDS waiver programs, DOH's State General Fund program for individuals with developmental disabilities, and DOH's Family Infant Toddler (FIT) program.
2. The SE shall coordinate care as needed with the consumer's waiver case manager to ensure that medical information is shared, in compliance with HIPAA and confidentiality requirements, and that medically or clinically necessary services are provided and are not duplicated.

**O. Coordination with ALTSD Programs**

1. The SE shall have and implement policies and procedures governing coordination of covered services with ALTSD's Adult Protective Services (APS), including discharge planning. The SE shall ensure that any APS worker actively involved in a consumer's life is included in care coordination.
2. The SE shall coordinate the delivery of covered services with other Medicaid and non-Medicaid programs administered by ALTSD which may be concurrently serving consumers including, but not limited to, the Traumatic Brain Injury program.

**P. Coordination with HIV/AIDS Treatment Providers**

1. The SE shall participate in meetings and training opportunities with New Mexico Public Health Offices, HIV counseling and testing sites, and the Health Management Alliances (which provide HIV/AIDS treatment services statewide).
2. The SE shall facilitate the referral of consumers to/from the SE and these HIV/AIDS resources.
3. The SE shall encourage its providers to utilize these HIV/AIDS resources as appropriate.

**Q. Disaster Behavioral Health Planning and Response**

The SE shall participate in disaster behavioral health planning and response in collaboration with the Collaborative and the DOH Bureau of Emergency Health Management. The participation of the SE in these activities is intended to ensure that the disaster-related emotional needs of individuals with chronic behavioral health disorders, other special populations, the general public, and emergency responders will be addressed in a systemic and systematic fashion; and services will be responsive and appropriate to the specific needs of the disaster event and recipients of the services.

1. The SE shall participate in planning activities for statewide disaster behavioral health preparedness and response.
2. The SE shall participate in disaster behavioral health training activities to develop a cadre of providers and individuals prepared to respond to behavioral health needs in a disaster event.
3. The SE shall coordinate with the Collaborative to implement behavioral health response activities in the event of a local, state or federally declared disaster. In the event of such as declared disaster, activities shall include participation in identifying individuals to provide psychosocial support services in collaboration with the NMServes Volunteer Registry initiative coordinated by the DOH Bureau of Health Emergency Management.
  - a. In the event of a federally declared disaster, the SE shall coordinate with the Collaborative to locate providers to participate the FEMA- and SAMHSA-funded Immediate and Regular Service Program Crisis Counseling Services grants. The SE shall also serve as a flow-through of funding for these grants. The grants will be managed by HSD.
  - b. The SE, through specific language in its provider agreements, shall require its network providers to participate in disaster behavioral health planning efforts at their local area level. The focus of this activity is to ensure that the needs of their priority populations are addressed in the local emergency plans maintained by Local Emergency Managers. In addition, each provider shall develop and maintain an emergency response protocol that evidences collaboration with emergency management, law enforcement, and other first responder personnel in their counties and local communities.
  - c. The SE, through specific language in its provider agreements, shall require network provider plans to be consistent with the protocol for statewide disaster behavioral health response described in the New Mexico Department of Health Emergency Operations Plan, Psychosocial Annex.

### 3.10 SPECIAL REQUIREMENTS FOR SPECIFIED POPULATIONS

#### A. Requirements for Medicaid Consumers

1. For Medicaid consumer access to second opinions the SE:
  - a. Shall provide Medicaid consumers with the option of receiving a second opinion from another network provider when consumers need additional information regarding recommended treatment or when requested care has been denied by a network provider.
  - b. May select the network provider giving the second opinion in accordance with a method established by the SE to equitably distribute these duties, provided that the provider selected practices in an area that provides expertise appropriate to the consumer's specific treatment or condition.



- c. Shall provide for a second opinion from a qualified network provider, or arrange for the consumer to obtain a second opinion from a non-network provider if there is not another qualified network provider, at no cost to the consumer.
2. If the SE is unable to provide medically necessary covered services to a particular Medicaid consumer through a qualified network provider, the SE shall adequately and timely provide these services to the consumer through a non-network provider, for as long as the SE is unable to provide them through a network provider. The SE shall coordinate with the non-network provider with respect to payment. The SE shall ensure that the cost to the Medicaid consumer is no greater that it would be if the services were furnished through a network provider.

**B. Requirements for Services for Native Americans**

Nothing in this Section shall deny, diminish or result in withholding covered services to eligible Native American Medicaid and non-Medicaid consumers living on and off reservation. Although Native American needs are unique with respect to disparities and sovereignty, the SE shall recognize that services for Native Americans are also integral to all services delivered by the SE.

1. The SE shall recognize Native American Tribes, Nations, and Pueblos as inherently sovereign nations that have a government to government relationship with the State of New Mexico. The SE shall work with the State to carry out the New Mexico Health and Human Services Departments State-Tribal Consultation Protocol to seek, incorporate and utilize input and to support and expand behavioral health services for Native Americans.
2. The SE shall establish partnerships and enhance collaboration with Native American Tribes, Nations, and Pueblos in the design, implementation and modification of service delivery and program evaluation.
3. The SE shall design its organizational structure and provider enrollment process to respect and recognize the unique:
  - a. Government to government relationships between the State and the Native American Tribes, Nations, and Pueblos;
  - b. Indian health care system, which consists of Tribal programs and Tribal organizations, whether operating under Public Law 93-638 agreements (Tribal 638) or not, and the federal Indian Health Service (IHS).
4. The SE shall provide equitable access for Native American consumers, including consumers living off-reservation and in rural/remote tribal reservation areas, to covered services and non-clinical support services including but not limited to transportation, housing, respite, childcare, training opportunities, as well as consumer education on referral options to providers.

5. The SE shall seek and incorporate the views of Native American stakeholders (consumers and family members; BHPC Native American Subcommittee; providers; Region Six LCs; and advocates) in the design, implementation and modification of the behavioral health service delivery system.
6. The SE shall seek and incorporate input from the Tribes, Nations, and Pueblos; Indian Health Service (IHS); Region Six LCs; Native American consumers and family members; advocates for Native Americans; and providers who serve Native Americans to develop, strengthen, and support the behavioral health service delivery systems for Native Americans.
7. The SE shall have and implement policies and procedures ensuring culturally and linguistically appropriate supports and services for Native American consumers.
8. The SE shall promote, maintain and enhance the use of culturally appropriate traditional healing services to Native American consumers. However, the SE shall recognize that some Tribes, Nations and Pueblos may prefer to limit their participation because of cultural beliefs and to keep religious practices safeguarded. Services may include but are not limited to tribally-based community wellness and cultural teachings programs, ceremonies, sweat lodges, Native healers, etc.
9. The SE shall ensure that its staff have knowledge, experience, and training in providing behavioral health services to Native Americans and have experience with and knowledge of New Mexico tribal communities.
10. The SE shall preserve the current reimbursement system for providers serving Native American consumers with the goal of providing specific programs and services for Native Americans.
11. For Medicaid consumers, the SE shall:
  - a. Contract with the Albuquerque Area IHS and Navajo Area IHS, and with Tribal 638 behavioral health providers that meet Medicaid minimum licensing and certification requirements for service delivery within New Mexico.
  - b. Accept a provider employed by the IHS or Tribal 638 facility that holds a current license to practice in the United States or its territories as meeting licensure requirements.
12. For non-Medicaid consumers, the SE shall contract with Tribal and Urban Indian behavioral providers that meet minimum licensing/certification requirements for service delivery within New Mexico.
13. The SE shall develop, maintain and improve linkages with Tribes, the IHS, and the Bureau of Indian Affairs (BIA) in order to ensure appropriate coordination of care for Native American consumers utilizing services from those entities.

14. The SE shall provide technical assistance and training to IHS, Tribal, and Urban Indian behavioral health providers regarding provider enrollment, billing, credentialing standards, covered services, utilization review, prior authorizations, and quality of care. Training shall be conducted following any major program changes or at the Collaborative's request, but no less than two (2) times a year.
15. The SE shall provide support, technical assistance and training to the Region Six LCs.
16. The SE shall provide to Native American consumers comprehensive information of all covered services and providers available through the SE, including Native American providers and services. The SE shall ensure that Native American consumers are provided full information to access the most appropriate, accessible and quality services based on their individual needs and preferences.
17. The SE shall work with public, Tribal and BIA schools and Tribal judges and courts, regarding behavioral health care for Native American consumers and their families.
18. The SE shall provide a quarterly written report to the Collaborative, the co-chairs of the BHPC Native American Subcommittee, and the chair of the Region Six LCs on the planning and progress of the Region Six office and implementing the activities identified above.
19. The SE shall collect, track, and provide data to Native American Tribes, Nations and Pueblos, as well as Region Six LCs, on a regular monthly, quarterly, and annual basis. The SE shall provide assurances that this data shall be appropriately stored, analyzed, and released with any State and tribal approvals required.

**C. Requirements for Individuals with Special Health Care Needs**

1. The SE shall work with the Collaborative to develop new ways of identifying and serving ISHCNs.
2. The SE shall comply with NMAC 8.305.15.
3. With regards to ISHCNs, the SE shall:
  - a. Have and implement policies and procedures to identify ISHCNs that reflects criteria specified by the Collaborative. These policies and procedures shall be prior approved by the Collaborative.
  - b. Ensure that each identified ISCHN is assessed by an appropriate provider and that a treatment plan is developed (as appropriate) in accordance with applicable QM/QI and UM standards.
  - c. Ensure that care coordination is available and offered to all ISHCNs and their parent and/or legal guardian or designated representative.
  - d. Allow consumers to directly access providers as appropriate for the consumer's condition and identified needs.
  - e. Ensure that the appropriate level of transportation is arranged for Medicaid ISHCNs, based on the consumer's clinical condition.

- f. Incorporate into its consumer handbook a description of network providers and programs available to ISHCN.
4. The SE shall work with the Collaborative to develop and track performance measures specific to ISHCNs.

**D. Requirements for Services for People with Both a Developmental Disability and Mental Illness**

The SE shall ensure that consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders, receive covered services in a manner that meets their unique needs. The SE shall ensure that these consumers are offered care coordination services, which shall include coordinating with waiver providers and others who support persons with developmental disabilities and ensuring that these consumers have clinical multi-disciplinary teams. The SE shall provide technical assistance to providers serving this population to ensure the optimal delivery of covered services to consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders.

**3.11 CUSTOMER SERVICES**

**A. Member Services**

The SE shall have a member services function that coordinates communication with consumers (their families, legal guardians, and/or designated representatives). The SE shall have sufficient staff to assist consumers in resolving problems and responding to consumer inquiries.

**B. Consumer Handbook and Provider Directory**

1. The SE shall provide Medicaid consumers a consumer handbook and provider directory within thirty (30) calendar days of the SE being notified by the State of the consumer's enrollment.
2. The SE shall send the consumer handbook and provider directory to non-Medicaid consumers upon request by the consumer or the State.
3. The consumer handbook shall include the following:
  - a. SE demographic information, including the organization's hotline telephone number;
  - b. Consumer rights and responsibilities (see Article 3.11.G);
  - c. Information on covered services;
  - d. Any restrictions on the consumer's freedom of choice among network providers;
  - e. Information regarding care coordination and coordination of care;
  - f. How to obtain emergency services, including:
    - i. The fact that the consumer has a right to use any hospital or other setting for emergency services; and
    - ii. What constitutes emergency condition, emergency services, and post-stabilization services;

- g. Information on accessing covered services, including a discussion of the consumer's rights to self-refer; this shall include the right for a consumer to self-refer to any network provider and a Native American consumer to self-refer to an IHS or 638 provider;
  - h. A list of services for which prior authorization is required and the method of obtaining prior authorization;
  - i. The extent to which, and how, consumers may obtain covered services from non-network providers;
  - j. Information about the SE's grievance and appeals process, including how to file a grievance and/or appeal, timeframes, and the resolution process;
  - k. Information about the complaint and grievance processes available from providers, member agencies, and the Collaborative.
  - l. Information about HSD's fair hearing process (for Medicaid consumers), including right to file a request for an administrative hearing upon notification of the SE's action or following an appeal;
  - m. Information regarding advance directives, including a description of applicable state law;
  - n. Information regarding obtaining a second opinion (for Medicaid consumers);
  - o. Information on cost sharing, if any;
  - p. Additional information specified by the Collaborative; and
  - q. How to obtain, upon request, information on the structure and operation of the SE, physician incentive plans, and any other information specified by the Collaborative.
4. The provider directory shall be accurate and complete and include the following:
    - a. SE addresses and telephone numbers; and
    - b. A listing of behavioral health providers with the name, location(s), phone number, categories of service, and non-English languages spoken.
  5. The consumer handbook and provider directory shall be accessible via the internet (see Article 3.20.K), and the SE's AVRS shall include provider directory inquiry.
  6. The SE's Web-based provider directory and AVRS shall contain accurate and complete information on the provider network, including all of the information listed in Section 4.b above, and shall be searchable by geographic location and service category. The SE shall update the Web-based and AVRS provider directory at least quarterly to reflect additions, deletions, and corrections.
  7. The consumer handbook and provider directory shall be provided as requested by the Collaborative.

8. The consumer handbook and provider directory must be prior approved by the Collaborative.
9. The SE shall notify all Medicaid consumers at least once per year of their right to request and obtain member handbooks and provider directories.
10. The SE shall distribute notification of material changes in the administration of the SE, changes to the SE's provider network, significant changes in applicable state law, and any other information deemed relevant by the Collaborative to consumers 30 days prior to the intended effective date of the change.

**C. Requirements Regarding Written Materials**

1. The consumer handbook, provider directory, and all other educational material shall meet the following requirements:
  - a. Materials shall be prepared in a manner and format that is clear and understandable to an individual who has completed no more than the sixth grade;
  - b. Materials shall be in commonly understood language and avoid professional jargon;
  - c. Materials shall be culturally sensitive;
  - d. If there is a prevalent population of 5% of consumers, as determined by the SE or the Collaborative, materials shall be made available in the language of the identified prevalent population(s); and
  - e. Materials shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency (e.g., large print, Braille, audiotapes/CD, and electronic format).
2. The SE shall notify consumers that written material is available in prevalent languages and alternative formats and how to access the materials in a prevalent language or alternative format.
3. The SE shall ensure that all of its web-based information for consumers is fully accessible according to national disability guidelines (e.g., Bobby-approved).

**D. Oral and Sign Language Interpretation Requirements**

1. The SE shall provide oral and sign language interpretation to consumers free of charge.
2. The SE shall ensure that oral interpretation is available in all non-English languages, not just those languages that are prevalent.
3. The SE shall notify consumers that oral and sign language interpretation is available, that language interpretation is available in any language, and how to access these services.

**E. Behavioral Health Education**

1. The SE shall provide a continuous program of behavioral health education without cost to consumers.
2. Behavioral health education may include but is not limited to education of consumers and family members regarding behavioral health diagnoses and implications, availability of and access to resources for information and services, and coordination with other disability services providers.
3. The behavioral health education program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction.
4. The SE shall work with the Collaborative to develop and implement behavioral health education programs consistent with the values of the Collaborative.

**F. Toll-Free Line**

1. The SE shall maintain a toll-free telephone line for providers, consumers, member agency staff, and other interested parties.
2. The SE may have separate lines/queues for providers, consumers, and/or other interested parties. However, the SE shall ensure that consumers can call the same number for both clinical and non-clinical calls.
3. The SE's call system shall not require a "touch-tone" phone and shall allow for communication with callers whose primary language is not English or who are hearing impaired. The SE's call system shall have TTY services and/or be accessible through the 711 telecommunication system.
4. The SE shall ensure that the line is adequately staffed to respond to non-clinical questions, at a minimum, from 8 A.M. to 5 P.M. Monday through Friday, except for state holidays. The SE shall have an automated system for non-clinical calls received during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave a message. The SE shall ensure that messages are returned the next business day by an appropriate staff person.
5. The SE shall ensure that the line is adequately staffed to respond to clinical calls twenty-four (24) hours a day, three hundred and sixty five (365) days a year by behavioral health professionals who are culturally competent, are trained to screen crisis or emergency calls, and are able to assess the consumer's degree of acuity and need for treatment.
6. Any and all utilization management decisions shall meet the requirements of Article 3.12.J of this Contract.
7. The SE shall ensure that ninety percent (90%) of calls are answered within thirty (30) seconds. The SE shall ensure that the abandon rate for all calls waiting more than thirty (30) seconds shall not exceed 10%.

**G. Consumer Rights and Responsibilities**

1. The SE shall be required to comply with NMAC 8.305.8.15, Member [Consumer] Bill of Rights, and any other member agency's rights' statements.
2. The SE shall have and implement policies and procedures governing consumer rights and responsibilities, which shall include the following:
  - a. Consumers have a right to obtain equitable treatment, respecting and recognizing the consumer's dignity and need for privacy.
  - b. Consumers who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.
  - c. Consumers and their legal guardians have the right to make and have honored an advance directive consistent with state and federal laws.
  - d. Consumers have a right to receive covered services in a non-discriminatory fashion.
  - e. Consumers, their legal guardians and/or designated representatives, have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the consumer's condition and ability to understand.
  - f. Consumers and, as appropriate, their families, legal guardians and/or designated representatives, have a right to participate with providers in decision-making regarding all aspects of their behavioral health care, including development of the course of treatment, acceptable treatments, and the right to refuse treatment.
  - g. Consumers, their legal guardians and/or designated representatives, have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.
  - h. Consumers or their legal guardians or designated representatives have the right to informed consent.
  - i. Consumers, their families, legal guardians and/or designated representatives, have a right to voice grievances about the care provided by the SE and to make use of the SE's grievance process (and the State's fair hearing process for Medicaid consumers) without fear of retaliation.
  - j. Consumers, their families, legal guardians and/or designated representatives, have the right and the means to choose from among available networks providers within the SE's prior authorization requirements.
  - k. Consumers, their legal guardians and/or designated representatives, have the right to request and receive a copy of their medical records in accordance with the applicable federal and state laws and regulations and the right to request that they be amended or corrected as specified in 42 CFR Part 164.



- l. Consumers, their legal guardians and/or designated representatives, have the right to receive information about the SE, covered services, how to access covered services, and the SE's providers.
  - m. Consumers, their legal guardians and/or designated representatives, have the right to be free from harassment by the SE or its network providers in regard to contractual disputes between the SE and providers.
  - n. Consumers have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal or state regulations on the use of restraints and seclusion.
  - o. Consumers, their families, legal guardians, and/or designated representatives, to the extent possible, have a responsibility to provide information that the SE and its providers need in order to care for the consumer.
  - p. Consumers, their families, legal guardians, and/or designated representatives, to the degree possible, have a right and responsibility to participate in understanding their behavioral health problems and developing mutually agreed-upon treatment goals.
  - q. Consumers, their families, legal guardians, and/or designated representatives have a responsibility to follow the plans and instructions for care that they have agreed upon with their providers.
  - r. Consumers, their families, legal guardians, and/or designated representatives, have a responsibility to keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it.
3. The SE shall ensure that each consumer (and/or as appropriate, his/her family, legal guardian and/or designated representative) is free to exercise his/her rights and that the exercise of those rights does not adversely affect the way the way the SE or its network providers treat the consumer (and/or his/her family, legal guardian and/or designated representative).

**H. Consumer Notice of Provider Termination**

The SE shall make a good faith effort to give written notice of termination of a network provider within 15 days after receipt or issuance of termination notice to each consumer that received services four times or more from the provider within the last twelve calendar months.

**I. Advance Directives**

The SE shall have and implement policies and procedures for advance directives. These policies and procedures shall include the following:

1. The SE shall provide adult consumers with written information on advance directive policies. This information shall include a description of applicable state law and regulation; consumer's rights under state law and regulation; the SE's policies respecting the implementation of the right to have an advance directive; and that complaints concerning noncompliance with advance directive requirements may be filed with the State survey and certification agency (currently DOH). This information shall reflect changes in state law and regulation as soon as possible, but no later than ninety (90) calendar days after the effective date of such change.
2. The SE shall honor advance directives within its UM protocols.
3. The SE shall educate its staff regarding advance directives and comply with the SE's policies and procedures and applicable state and federal law and regulations.
4. The SE shall ensure that consumers are offered the opportunity to prepare an advance request and that, upon request, are provided assistance in the process.
5. The SE shall not discriminate against a consumer in the provision of care or in any other manner discriminating against a consumer based on whether the consumer has executed an advance directive.
6. The SE shall ensure that its providers:
  - a. Provide written information to adult consumers concerning their right to formulate advance directives; this information shall include the SE's policies and procedures for advance directives;
  - b. Document in the consumer's medical record whether or not the consumer has executed an advance directive;
  - c. Not discriminate against a consumer in the provision of care or in any other manner discriminating against a consumer based on whether the consumer has executed an advance directive;
  - d. Comply with federal and state law and regulations;
  - e. Educate staff and the community on issues concerning advance directives; and
  - f. Inform consumers that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency, currently DOH.

### 3.12 QUALITY ASSURANCE

#### A. Consumer and Family Advisory Board

1. The SE shall comply with NMAC 8.305.3.11 regarding a Consumer Advisory Board.
2. The SE's Consumer and Family Advisory Board shall keep a written record of all attempts to invite and include consumers in its meetings. The Board roster and minutes shall be made available to the Collaborative upon request.

3. The Consumer and Family Advisory Board shall consist of an equitable representation of consumers in terms of race, gender, special populations, and New Mexico's geographic areas.
4. The SE's Consumer and Family Advisory Board shall interact with the BHPC as directed by the Collaborative.

**B. Consumer and Family Member Involvement and Activities**

1. The SE shall support and help strengthen existing consumer and family networks and community peer advocacy organizations in expanding behavioral health consumer and family member peer advocacy, self-help programs, support networks, and peer-directed services.
2. The SE shall support efforts that involve utilizing consumers and family members in the development and implementation of peer-directed services. The SE shall work with the Collaborative in the development of peer support specialist and family and child support specialist services.
3. The SE shall conduct ongoing training and technical assistance for child, adult and family peers and shall include curricula that is culturally competent and sensitive to the needs of consumers and their families and that help to develop the skills necessary to match goals with services and to advocate for the needs of consumers and their families.
4. The SE shall attend at least two (2) statewide consumer and family member-driven or -hosted meetings per year if scheduled, that focus on consumer and family member or behavioral health service system issues and needs, in order to ensure that concerns are heard and addressed. These meetings shall be of the SE's choosing.
5. The SE shall ensure that consumers and family members, where appropriate, are presented with opportunities to proactively engage and participate in treatment planning and the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer's preferences and wishes.
6. The SE shall have multimedia announcements that identify opportunities that are available for consumers and family members and how consumers and family members may access those opportunities.
7. The SE, in partnership with the Collaborative, shall ensure outreach, recruitment, orientation and training and development of consumer and family member representatives to participate on its QM/QI Committee and shall encourage those representatives to attend the Consumer and Family Engagement (CAFÉ) Leadership Academy and the SE Recovery and Resiliency Department's Community Empowerment Training.
8. The SE shall foster open communication as well as collaborative relationships with State agency consumer/family liaisons. At a minimum, this shall involve established monthly mechanisms for briefing one another with regard to regional coordination of consumer and family member issues and peer advocacy, self-help programs and support networks, and peer-directed services, as well as exploring additional opportunities for coordination of technical assistance and quality improvement.

9. The SE shall ensure that its providers:
  - a. Involve consumers in all aspects of treatment planning, development, and implementation, including making appropriate accommodations to ensure the participation of consumers and family members with cognitive and/or physical disabilities.
  - b. Educate consumers about treatment options so that their ability to make informed choices regarding effective treatment is enhanced.
  - c. Develop mechanisms for consumer and family member involvement in advocacy development and in quality activities that are culturally sensitive.

**C. Quality Management and Quality Improvement (QM/QI) Program**

1. The SE shall base its administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM) including: the recognition that opportunities for improvement are unlimited; that the QI process shall be data driven; requiring continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements; re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and reliance upon consumer and stakeholder input.
2. The SE shall comply with all sections of NMAC 8.305.8, Quality Management.
3. The SE shall comply with NMAC 8.305.8.12, including but not limited to:
  - a. Base the QM/QI program on a model of continuous quality improvement, including, but not limited to the following:
    - i. Demonstrate to the Collaborative that the results of QM/QI projects and reviews are used to improve the quality of service delivery;
    - ii. Take appropriate action and document action to address provider and SE performance problems, as identified;
    - iii. Incorporate sound quality studies, apply statistical analysis to data, and derive meaning from the statistical analysis; and
    - iv. Perform a performance improvement project specific to ISHCN.
  - b. Ensure that the QM/QI program is applied to the entire range of covered services and all major demographic population groups.
  - c. Have an annual QM/QI work plan, prior approved by the Collaborative, that includes, at a minimum the following:
    - i. Immediate objectives for each contract period and long-term objectives for the entire term of this Contract;
    - ii. The scope of the objectives, projects, or activities planned, timeframes and data indicators for tracking performance;

- iii. Performance improvement projects, plans and activities consistent with federal and state laws and regulations, including 42 CFR §438.240; and
    - iv. At least one (1) consumer safety indicator.
  - d. Institute QM/QI policies and procedures that emphasize and promote prevention and care coordination;
  - e. Develop and implement written QM/QI policies and procedures to address the following requirements:
    - i. QM/QI program;
    - ii. QM/QI committee;
    - iii. An annual QM/QI work plan and an annual program evaluation that includes goals, objectives and structure, and that results in continuous quality improvement for consumers;
    - iv. Confidentiality, including a provision that all materials concerning the care and treatment of members shall be made available to the Collaborative;
    - v. Medical records and other records documentation;
    - vi. Protocols for working with school-age consumers;
    - vii. Consumer and network provider satisfaction surveys and other relevant consumer/family surveys;
    - viii. Disease management protocols;
    - ix. Continuity and coordination of services;
    - x. Tracking and trending of consumer and provider grievances for early identification and resolution of systemic issues and potential trends;
    - xi. Care coordination protocols for ISHCN and priority populations that reflect their comprehensive needs and service plan priorities, including coordination and integration of services; and
    - xii. Provide quality oversight of network providers as necessary to ensure quality of services but in no way as a replacement for the licensing and certification oversight otherwise provided by the State.
  - f. Establish a committee to oversee and implement QM/QI activities.
  - g. Have an annual QM/QI evaluation of overall effectiveness to demonstrate improvements in the quality of clinical care and non-clinical services to consumers. The SE shall submit an annual written evaluation that includes, but is not limited to the following:
    - i. A description of on-going and completed QM/QI activities;
    - ii. Trending of measures to assess performance in quality of clinical care and non-clinical services;

- iii. An analysis of whether or not there have been demonstrable improvements in the quality of clinical care and non-clinical services; and
    - iv. Incorporation of findings of overall effectiveness in the development of the following year's plan.
  - h. Designate an SE staff person responsible for compliance with all the QM/QI requirements.
  - i. Be responsible for the QM/QI program and not delegate this responsibility to subcontractors.
4. The SE shall conduct QM/QI activities in accordance with any applicable requirements of member agencies, funding source requirements and/or policies issued by the Collaborative.
  5. The SE's QM/QI program shall include activities that provide continuous monitoring and regular evaluation of clinical services provided, the adequacy of covered services, the provider network, and the SE's administrative operations (including but not limited to member services, grievances and appeals, provider relations, UM, call center, and care coordination). The SE shall ensure that corrective action is implemented as necessary to ensure continuous quality improvement in clinical and non-clinical services.
  6. The SE's QM/QI program shall incorporate findings from external evaluations of the SE (e.g., C/FSP and the EQRO report).
  7. Based on findings from the QM/QI program, including any applicable external evaluations, the SE shall identify opportunities for improvement, initiate targeted quality interventions, and monitor the intervention's effectiveness.
  8. The SE shall submit to the Collaborative a written report whenever a finding indicates a significant system problem or warrants serious corrective action. The report shall include the finding and proposed corrective action.
  9. The SE shall, as directed by the Collaborative, conduct selected quality studies jointly with the MCOs and/or other key entities. No more than two (2) studies per year will be required.
  10. The SE shall conduct an annual provider satisfaction survey and shall incorporate the results of the survey into the SE's QM/QI program.
  11. The SE's QM/QI program shall include ongoing monitoring, tracking, and trending of provider performance, and, as necessary, the SE shall provide training and technical assistance and ensure that appropriate interventions, including corrective actions are implemented (see Articles 3.13.D and E).
  12. The SE shall communicate the results of QM/QI activities and provider reviews with appropriate providers and use this information to improve the performance of the providers, including technical assistance, corrective action plans, and follow-up activities as necessary.

13. The SE's QM/QI program shall include conducting data-driven evaluations of clinical practices to improve quality of care. The SE shall demonstrate how the SE has facilitated improvements.
14. The SE shall ensure that its high-volume providers, as defined by the SE and approved by the Collaborative, have a current QM/QI plan for tracking and improving quality of care, access, appropriateness of care, consumer/family satisfaction, and outcomes. The providers' plans shall describe the roles of provider agency staff, consumers, and family members in development and implementation of the QM/QI plan.
15. The SE shall ensure that its high-volume providers submit their annual QM/QI plan to the SE no later than August 1 each Contract Year and submit an annual QM/QI report that summarizes activities and findings, including opportunities for improvement. The SE shall report to the Collaborative, upon request, the status of provider compliance with this requirement.
16. The SE shall conduct an annual on-site clinical audit of a sample of high-volume providers QM/QI plan performance. This task shall be shared by the SE's QM/QI and Provider Relations departments. The sample shall be determined in collaboration with the Collaborative.
17. In the development, implementation, and evaluation of its QM/QI program the SE shall ensure the exchange of information (as allowable by state and federal law) and input by stakeholders, including but not limited to consumers, family members, advocates, the BHPC, LCs, MCOs, providers, Collaborative staff, and member agency staff.
18. The SE's QM/QI committee shall include, at a minimum, representation from provider agencies, consumers, family members, the BHPC, and the Collaborative.
19. The SE shall share regularly findings of the QM/QI program, including data and analysis of performance measures (see Article 3.12.D), with the Collaborative, the BHPC, LCs, and member agencies.
20. The SE shall, upon request and as specified by the Collaborative, communicate non-confidential QM/QI findings to network providers, consumers, families and others.
21. The SE's QM/QI program shall include leadership by executive clinical staff of the SE, including the Chief Medical Officer/Medical Director, Vice President of Clinical Operations, and Vice President of QM/QI.

**D. Performance Measures**

1. The SE shall measure and track performance measures, report on performance measures at intervals defined by the Collaborative, and incorporate performance measures as part of its QM/QI program.
  - a. Performance measures shall include those required by the federal government or specified by the Collaborative.

- b. The Collaborative will use performance measures to evaluate the SE's clinical and non-clinical performance, ability to improve clinical and non-clinical performance, and to take corrective actions as needed to improve performance.
  - c. The SE shall:
    - i. Collect and manage data necessary to support performance measurement activities, including establishment of the baseline and tracking of change in performance over time;
    - ii. Design sound quality studies, apply statistical analyses to data, and determine the significance of the data collected;
    - iii. Adhere to the timely and accurate collection of data to calculate the SE's performance rate for those performance measures identified by the Collaborative;
    - iv. Identify specific interventions that the SE shall use to improve performance measures;
    - v. Achieve demonstrable improvement in each performance measure during the course of the Contract;
    - vi. Perform subsequent measurement and assessment of the ongoing effectiveness of specific interventions; and
    - vii. Demonstrate to the Collaborative that the results of performance measurement activities are used to improve the quality of service delivery with appropriate providers. When the SE determines that there are provider performance problems, the SE shall take and document appropriate action.
2. Subject to prior approval by the Collaborative, the SE shall calculate baselines for each performance measure. The Collaborative, working with the SE, shall establish annual targets for each performance measure.
  3. The SE shall submit reports of the SE's progress relating to each performance measure.
  4. The SE shall be accountable for the achievement of the performance measure targets identified by the Collaborative. Failure to achieve performance targets may result in sanctions pursuant to Article 8. The Collaborative will identify the performance targets for which sanctions are applicable.
  5. The SE shall participate with the Collaborative and other stakeholders in the ongoing development and use of performance measures.
  6. Over the course of the Contract period, individual performance measures may be deleted, added, or modified as determined by the Collaborative.



7. As specified by the Collaborative, performance measure demographics will include breakout by disability group, specifically Autism Spectrum Disorders (ASD), cognitive disabilities, brain injury, deaf or hard of hearing, blind and visually impaired, and physical disabilities.
8. Performance measures shall include the Governor's Performance & Accountability Measures, which include but are not be limited to the following:
  - a. Percent of individuals committing suicide or reporting suicidal attempts, specifically suicide rates for youth ages 15-19 and 20-24; persons aged 20 years and older; Native Americans, adults over the age of 65; and percent of youth reporting they have considered or attempted suicide;
  - b. Percent of adults with serious mental illness in competitive employment of their choice;
  - c. Percent of children/adolescents with severe emotional disturbances receiving services who are successful in school;
  - d. Percent of individuals with mental illness and/or substance abuse disorders receiving services with decent, safe, affordable housing;
  - e. Percent of people receiving substance abuse treatment who demonstrate improvement on three (3) or more domains on the Addiction Severity Index (ASI);
  - f. Percent of adults presenting with psychiatric issues who are screened for substance abuse; and percentage of adults presenting with substance abuse issues who are screened for psychiatric issues;
  - g. Percent of adults and youth served who have contact or repeat contact with the adult or juvenile justice system or adult corrections;
  - h. Percent of persons receiving substance abuse services who are arrested for DWI or use of illicit substances;
  - i. Percent of individuals discharged from inpatient facilities who receive follow-up services at seven (7) days and thirty (30) days;
  - j. Percent of consumers and families reporting satisfaction with services;
  - k. Number of individuals served annually in substance abuse and mental health programs, by ethnicity, region, age and risk level (high risk);
  - l. Percent and number of ISHCN served by major disability group (ASD, DD, brain injury, deaf and hard of hearing, blind, and physical disabilities)
  - m. Number of individuals served in evidence-based practice programs;

- n. Percent of children with improved functional assessments between admission and discharge in CYFD-funded community-based programs;
- o. Percent of JJS consumers in facilities assessed as having behavioral health needs on intake who receive behavioral health services;
- p. Percent of all payments made to providers within the required timeframes;
- q. Percentage of individuals with co-occurring disorders (COD) receiving services, the percentage of individuals diagnosed with COD who have treatment goals in both the mental health and substance abuse realms, and appropriate discharge planning that considers an individual's future COD service needs;
- r. Percent of expenditures for community-based services operated by consumers/families as a share of total community-based services expenditures;
- s. Percent of individuals in rural and frontier locations with access to an appropriate behavioral health provider within sixty (60), and ninety (90) miles, respectively;
- t. Number of programs/agencies using community health workers, peer specialists and practitioners designed specifically for persons who are Native American or Spanish speaking; and
- u. Prevention performance measures developed by the SE with the approval of the Collaborative.

**E. Consumer Satisfaction Survey and New Mexico Consumer/Family Satisfaction Project**

- 1. The Collaborative conducts an annual adult and child/family consumer satisfaction survey based on the national Mental Health Statistics Improvement Project (MHSIP), hereafter known as the NM Consumer/Family Satisfaction Project (C/FSP). The SE shall cooperate in conducting this survey as requested by the Collaborative.
- 2. The SE may conduct a consumer/family satisfaction survey separate from the C/FSP. Such survey, including the survey instrument and methodology, shall be prior approved by the Collaborative, and the SE shall submit a report to the Collaborative summarizing the methodology and findings, including opportunities for improvement.

**F. Behavioral Health Management**

The SE shall comply with NMAC 8.305.8.12 regarding health management systems.

**G. External Quality Review**

1. The State shall retain the services of an external quality review organization (EQRO) in accordance with §1902(c)(30)(C) of the Social Security Act. The SE shall cooperate fully with the EQRO and demonstrate to that organization the SE's adherence to HSD/MAD's managed care regulations and quality standards as set forth in MAD Policy.
2. The State shall also contract with an EQRO to audit a statistically valid sample of the SE's UM decisions, including authorizations, reductions, terminations and denials. This audit is intended to determine if authorized service levels are appropriate with respect to accepted standards of clinical care. The EQRO shall also audit the SE's QM/QI program and review performance measures and performance improvement projects, based on CMS criteria.
3. The SE shall participate in various other tasks identified by the State that shall enable it to gauge performance in a variety of areas, including care coordination and treatment of special populations.
4. The SE shall utilize technical assistance and guidelines offered by the EQRO, unless otherwise agreed upon by the parties.
5. The EQRO retained by the State shall not be a direct competitor of the SE.

**H. Standards for Access**

1. The SE shall ensure the accessibility and availability of behavioral health providers for each medically, clinically or psychosocially necessary service.
2. The SE shall comply with NMAC 8.305.8.18.
3. The SE shall submit documentation to the Collaborative, as requested, giving assurances that it has the capacity to serve the expected number of consumers in accordance with the Collaborative's access standards. This documentation shall be in a format acceptable to the State.
4. The SE shall provide access to the full array of covered services. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.
5. The SE shall maintain and update as necessary its Service Access Plan, which shall describe the SE's system for consumer access to services. The plan will be reviewed during regular quarterly meetings that include the SE and the Collaborative, and shall be revised as required by the Collaborative.
6. The SE shall ensure that in each region of the State there is an array of covered services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.
  - a. The SE can include out-of-state providers for those consumers who require services not available from in-state providers.

- b. For each child residing in an out-of-state residential facility, the SE shall develop a plan, approved by the Collaborative, to provide medically or clinically necessary and appropriate services in-state.
- 7. The SE shall report to the Collaborative any high-volume network providers (as defined by the SE) that are not accepting new consumers.
- 8. For non-Medicaid consumers and non-Medicaid services to Medicaid consumers, the SE shall use diagnostic criteria and risk factors (see Article 3.5) to prioritize access to covered services.
- 9. The SE shall ensure that the following appointment standards are met:
  - a. For non-urgent, non-emergent behavioral health care, the request-to-appointment time shall be no more than fourteen (14) days, unless the consumer requests a later time.
  - b. For urgent behavioral health care, appointments shall be available within twenty-four (24) hours.
  - c. For crisis services, face-to-face appointments shall be available within two (2) hours.
- 10. The SE shall report to the Collaborative on the compliance of providers in meeting the appointment standards in section 9 above. The methodology and timeframe must be approved by the Collaborative.

**I. Clinical Practice Guidelines and Evidence-Based Practices**

- 1. The SE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of services for acute and chronic behavioral health care conditions.
- 2. The SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of consumers.
- 3. The clinical practice guidelines shall be evidence-based.
- 4. The SE shall involve network providers who are appropriate to the clinical issue, as well as consumers and family members affected by the guidelines, in the development and adoption of clinical practice guidelines.
- 5. The SE shall develop a mechanism for reviewing the guidelines when clinically appropriate, but at least every two (2) years, and updating them as necessary.
- 6. The SE shall distribute the guidelines to the appropriate providers, provide them to the Collaborative upon request, and make them available to consumers, families, and the public upon request.
- 7. The SE shall periodically assess provider performance against at least three guidelines and determine consistency of decision-making based on the clinical practice guidelines.
- 8. The SE's decision-making in UM, consumer education, interpretation of covered services, and other areas shall be consistent with these guidelines.

9. The SE shall implement targeted disease management protocols and procedures for chronic diseases and/or conditions, such as bipolar disorder, depression, and schizophrenia that are appropriate to meet the needs of the varied consumers. These disease management programs shall be prior approved by the Collaborative.
10. The SE, in the delivery of covered services, shall work with the Collaborative to continue and improve the ongoing implementation of evidence-based practices, including promising and best practices for persons with developmental disabilities, mental illness, and autism spectrum disorder and including the identification of evidence-based or promising practices that are culturally appropriate.

**J. Utilization Management (UM)**

The SE shall:

1. Comply with NMAC 8.305.8.13 regarding Standards for Utilization Management. References to "medical necessity" in NMAC 8.305.8.13 shall be read to include clinical and psychosocial necessity as those terms are defined in Article 2 of this Contract. References to "member" in NMAC 8.305.8.13 shall be read as "consumer" (as defined in Article 2 of this Contract) and shall include the consumer's family, legal guardian, and/or designated representative as appropriate. All requirements in NMAC 8.305.8.13 regarding providing notice to providers shall include notice to the consumer and/or consumer's family, legal guardian, and/or designated representative as appropriate.
2. Manage the use of limited resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes. The consumer's treatment plan priorities and prolonged service authorizations applicable for individuals with chronic conditions shall be considered in the decision-making process.
3. Define and submit annually to the Collaborative a written copy of the UM program description, UM plan, and UM evaluation, which shall include but not be limited to:
  - a. A description of the program structure and accountability mechanisms;
  - b. Specific indicators that will be used for periodic performance tracking and trending as well as processes or mechanisms used for assessment and intervention; and
  - c. An evaluation of the overall effectiveness of the UM plan, an overview of the UM activities and the impact of the UM plan on the quality of management and administrative activities. The review and analysis shall be incorporated in the development of the following year's UM plan.

4. Submit to the Collaborative for prior approval a description of all services that will require prior authorization and all UR criteria that will be utilized for prior authorization and other UM decisions. The SE shall submit to the Collaborative for prior approval any changes to the services that must be prior authorized or the UR criteria.
5. Develop and implement policies and procedures for review of utilization decisions to ensure their basis in sound clinical evidence and that they conform to medical, clinical and psychosocial necessity criteria.
6. Develop and implement policies and procedures to issue extended prior authorization for any covered service expected to be required on an on-going basis to exceed six (6) months. These services shall be authorized for an extended period of time and the SE shall provide for a review and periodic update of the course of treatment, as indicated.
7. Ensure the involvement of appropriate, practicing providers in the development of UM procedures.
8. Except as otherwise provided in this Contract (see, e.g., Article 3.9.G), approve or deny covered services for routine/non-urgent and urgent care requests and provide notice within the timeframes stated in NMAC 8.305.8.13. These required timeframes are not to be affected by a "pend" decision. The SE's decision-making timeframes shall accommodate the clinical urgency of the situation and not delay the provision of covered services to consumers for lengthy periods of time.
9. Develop and implement policies and procedures by which UM decisions may be appealed by consumers or their representatives in a timely manner, which shall include all applicable requirements and timeframes for submission based on CMS and State law and regulations.
10. Ensure that, consistent with 42 CFR §§438.6(h) and 422.208 compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services to any consumer.
11. Evaluate network provider satisfaction with the UM process as part of its provider satisfaction survey (see Article 3.13.A).
12. Provide the Collaborative timely access to the SE's UM review documentation for purposes of compliance audits and/or other contract oversight activities.
13. Establish, maintain and monitor a UM system that includes an efficient decision-making process and the application of clear and consistent criteria for admission, continued stay and discharge into each service with criteria appropriate to each consumer population and funding source.
  - a. The SE shall establish and implement a UM system that follows national standards, promotes quality of care, adherence to standards of care, the efficient use of resources, consumer choice, and the identification of service gaps within the service system.

- b. The SE's UM system shall:
    - i. Ensure that consumers receive services based on their current condition and effectiveness of previous treatment;
    - ii. Ensure that services are based on the history of the problem/illness, its context, and desired outcomes;
    - iii. Assist consumers, their families, legal guardians, and/or designated representatives in choosing among providers and available treatments and services; and
    - iv. Emphasize relapse and crisis prevention, not just crisis intervention.
  - c. The SE shall educate its UM staff and network providers in the application of its UM system, clearly articulating the criteria to be used in making UM decisions and describing specific care coordination functions.
  - d. The SE shall develop protocols, procedures and criteria for assessing medical, clinical or psychosocial necessity as appropriate to the consumer and the funding source, making level-of-care determinations, and authorizing services. Such protocols shall incorporate the definition of medical, clinical and psychosocial necessity as defined in Article 2 of this Contract, the ASAM patient placement criteria, member agency service manuals, and other guiding documents.
  - e. The SE shall ensure that all medically, clinically, or psychosocially necessary referrals are arranged and coordinated by either the referring provider or by the SE's care coordination unit.
14. Maintain records (both hard and electronic) that verify its utilization management activities and compliance with UM requirements.
  15. Specify which covered services will and will not require prior authorization and how the SE will conduct initial, concurrent and retrospective reviews. In all circumstances in which services are authorized at a more or less intensive level of care than requested, the SE shall ensure that the level and duration of such services are appropriate.
  16. Not require prior authorization for the following:
    - a. Evaluations performed for children, adolescents or young adults up to age twenty-one (21) preparing to transition out of a twenty-four (24) hour facility, including juvenile correctional facilities or as court-ordered.
    - b. School-based services except to prevent duplicate services or payment for the same service for the same child.
  17. Ensure that services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

18. Not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the consumer's diagnosis, type of illness, or condition.
19. Honor advance directives within its UM protocols.
20. Ensure that consumers have an optimal choice of providers consistent with their treatment needs and available providers.
21. For each level of care, describe the amount and type of choice consumers (their families, legal guardians, and/or designated representatives) will be offered with respect to providers, services, and time and location of providers/services. The SE shall also describe the options available when the SE's initial selection of provider(s) of services proves unsatisfactory to the consumer, family, legal guardian, and/or designated representative.
22. Receive prior approval of the Collaborative before delegating any of the SE's UM functions to subcontractor(s) and remain fully responsible for all UM decisions and quality of care.
23. Ensure that a board certified psychiatrist, to the extent possible certified in both child/adolescent and adult services, has substantial involvement in the design and implementation of the UM program.
24. Upon request, provide UM decision criteria to providers, consumers, their families, and the public.
25. Ensure the consistent use of written policies and procedures regarding UM by all SE staff performing UM functions.
26. Demonstrate that all UM staff have been trained and are competent in working with individuals with co-occurring psychiatric and addictive disorders.
27. Ensure that staff who make UM decisions are Master's degree clinicians or Registered Nurses with a minimum of five (5) years of clinical experience in the mental health and/or substance abuse fields. This includes Master's equivalent Certified Nurse Practitioners and Clinical Nurse Specialists with a psychiatric certification, in addition to other licensed Master's level clinicians, such as LISWs, LPCCs, or psychologists. The SE may also use Licensed Alcohol and Drug Abuse Counselors (LADACs).
28. Ensure that approvals during business hours are made by a New Mexico licensed clinician. Approvals after hours may be authorized by a non-New Mexico licensed clinician but shall be reviewed by a New Mexico licensed clinician on the next business day.
29. Ensure that denials based on lack of medical or clinical necessity are made by a board certified psychiatrist licensed in New Mexico. Denials for children and adolescents shall be made by a child/adolescent psychiatrist. A board certified child/adolescent psychiatrist is preferred, but a board eligible child/adolescent psychiatrist is acceptable.
30. When a request for a service is denied, assist the consumer and his/her provider in finding the appropriate level of care.



31. Clearly document and communicate the reason(s) for UM decisions (approval/denial) to the requesting provider and to the consumer, family, legal guardian, or designated representative. See Article 3.12.K regarding Notice of Action.
32. For concurrent review of inpatient care, make a decision within one (1) business day of obtaining the required information.
33. Make every effort to obtain all relevant information needed to make an authorization determination based on medical, clinical, or psychosocial necessity, depending on the consumer, service type, and fund source.
  - a. The SE shall have a written description identifying the information required to support UM decision-making.
  - b. The SE shall document that relevant information is gathered consistently to support UM decision-making.
  - c. The SE shall inform providers in writing regarding the information requirements for UM decision-making and shall provide this information to consumers and their families upon request.
34. Comply with NMAC 8.305.8.13.I, Evaluate and use of new technology, and ensure that appropriate providers, consumers, family members, advocates, and members of the BHPC and LCs participate in this process. The inclusion of new treatment technology or new uses of existing technology shall be prior approved by the Collaborative.
35. As part of its UM process, establish and implement policies and procedures relative to the closure of case files. The SE shall ensure that its network providers adhere to the SE's policies and procedures for closure of case files, in conformance with member agency requirements.
36. Have information systems that enable the paperless submission of prior authorization and (if applicable) other utilization management-related requests, and when applicable the automated processing of said requests. These systems shall also provide status information on the processing of said requests. These shall be interfaced as needed to care coordination systems to facilitate care coordination and direction to appropriate services.

**K. Notice of Action**

The SE shall notify the requesting network or non-network provider, and give the consumer (and/or his parent, legal guardian and/or designated representative) written notice of any decision by the SE to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice, including language and format, content, and timing, shall meet the requirements set forth in 42 CFR §438.404. See also Article 3.15.D.1 of this Contract.

**L. Critical Incident Management**

1. The SE shall develop and implement a statewide critical incident management system that identifies and tracks critical incidents, corrects case-specific issues, and addresses identified systems' issues that place consumers at risk.

2. The SE shall immediately report to the Collaborative any incident that could place a consumer at immediate risk. The SE shall report all critical incidents that impact health and safety to the Collaborative within 24 hours of notification/becoming aware of the incident.
3. The SE's critical incident management system shall be in accordance with Collaborative and member agency guidelines and incident management protocols and must be prior approved by the Collaborative.
4. Critical incidents include but are not limited to incidents that may have a serious impact on consumers, provider staff, member agencies, or the public, or may bring about adverse publicity.
5. The SE shall track and analyze critical incidents. The SE shall use this information to identify potential and actual quality of care and/or health and safety issues, including both case-specific and systemic issues, and shall implement appropriate interventions.
6. The SE shall ensure that network providers report critical incidents within the timeframes specified by the SE. This shall include both initial reporting of the incident and a follow-up report providing additional detail regarding the incident. For critical incidents that impact health and safety, the maximum timeframe for providers to report the incident shall be 24 hours and the maximum timeframe for providers to submit a follow-up report shall be 48 hours.
7. The SE shall ensure that providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the SE. The SE shall review the provider's report and take corrective action with the provider as necessary.
8. The SE shall provide appropriate training and take corrective action as needed to ensure provider compliance with critical incident requirements.
9. As specified by the Collaborative, the SE shall submit regular reports to the Collaborative regarding critical incidents, including but not limited to suicide; other death; attempted suicide; involuntary hospitalization; detention for protective custody; detention for alleged criminal activity; elopement; and any incident resulting in significant physical harm to a consumer or to others allegedly caused by a consumer.

### **3.13 PROVIDERS**

#### **A. Provider Network Development and Management**

1. The SE shall comply with the requirements in NMAC 8.305.6.9, General Network Requirements, including, but not limited to the following:
  - a. The SE shall establish and maintain a comprehensive network of providers willing and capable of serving consumers.

- b. The SE shall provide all covered services in a timely manner. The SE is solely responsible for the provision of covered services and shall ensure that its network includes providers in sufficient numbers to ensure that all covered services are available in accordance with access standards.
- c. The SE shall contract with the full array of providers necessary to deliver covered services and shall take into consideration the characteristics and behavioral health care needs of consumers. In establishing and maintaining the network of appropriate providers, the SE shall consider the following:
  - i. The numbers of network providers who are not accepting new consumers;
  - ii. The geographic location of providers compared with eligible consumers, considering distance and travel time; and
  - iii. Whether the location provides physical access for consumers, including consumers with disabilities.
- d. The SE shall notify the Collaborative in writing within five (5) business days of unexpected changes to the composition of its provider network that has a significantly negative effect on consumers or on the SE's ability to deliver covered services. The SE shall notify the Collaborative in writing of anticipated material changes in the SE's provider network at least thirty (30) days prior to the change, or as soon as the SE knows of the anticipated change. A notice of change shall contain:
  - i. The nature of the change;
  - ii. How the change affects delivery of or access to covered services; and
  - iii. The SE's plan for maintaining access and the quality of consumer care.
- e. The SE shall develop and implement policies and procedures on provider recruitment and termination. The recruitment policies and procedures shall describe how the SE responds to a change in the network that affects access and its ability to deliver services in a timely manner.
- f. The SE:
  - i. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
  - ii. Shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;

- iii. Shall not decline to include providers in its network without giving the affected providers written notice of the reason for its decision;
  - iv. Shall not be required to contract with providers beyond the number necessary to meet the needs of consumers;
  - v. Shall be allowed to use different reimbursement amounts for different specialties or for different providers within the same specialty so long as a justifiable reason (e.g., access, volume) for doing so exists;
  - vi. Shall not employ or subcontract with providers excluded from participation in federal health care programs;
  - vii. Shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with the SE's responsibility to consumers; and
  - viii. Shall not be required to contract with providers who are ineligible to receive reimbursement under Medicaid fee-for-service.
2. The SE shall maintain complete, accurate, and up-to-date information on all network and out-of-network providers.
- a. This information shall include all of the data elements specified by the Collaborative.
  - b. The SE shall transmit initial and recurring provider files, in a format and method to be mutually agreed upon with the Collaborative. The provider files shall contain new providers, changes to existing providers, and termination of provider status.
  - c. The SE shall assign provider types and specialties to providers in the provider file according to applicable Collaborative criteria and definitions. These criteria and definitions include but are not limited to the use of the provider's licensure/certification, and not the service that the provider is rendering, when coding a particular provider's specialty.
  - d. Where applicable, the SE shall use the NPI to identify providers and send a separate record for each unique combination of NPI, provider type, and ZIP code. Alternatively, the SE shall send the tax ID (FEIN or SSN) for all providers and, for atypical providers, send a separate record for each unique combination of FEIN/SSN, provider type, and ZIP code.
3. The SE shall not discriminate and/or retaliate against providers who file grievances or appeals.
4. The SE shall not limit or interfere with providers' efforts to lobby and/or air opinions and concerns regarding their interactions with the SE or their business interests.
5. The SE shall not prohibit or otherwise restrict a network or non-network provider from advising a consumer who is a patient of the provider about the health status of the consumer or medical care or treatment for the

consumer's condition of disease, regardless of whether the care or treatment is a covered service, if the provider is acting within the lawful scope of practice. This subsection, however, shall not be construed as requiring the SE to provide, reimburse, or provide coverage of any service if the SE:

- a. Objects to the provision of a counseling or referral service on moral or religious grounds, provided that the SE notifies consumers of these objections at the earliest possible time;
  - b. Notifies the Collaborative within ten (10) business days after the effective date of this Contract of its current policies and procedures regarding its objection to providing such counseling or referral services based on moral or religious grounds, or within fifteen (15) calendar days after it adopts a change in policy regarding such counseling or referral services;
  - c. Can demonstrate that the service in question is not included as a covered service required by this Contract; or
  - d. Determines that the recommended service is not medically, clinically, or psychosocially necessary under the SE's policies and procedures, and in accordance with the definition set forth above.
6. The SE shall have and implement policies and procedures regarding any referral processes. The SE referral process shall be effective and efficient and not impede timely access to and receipt of services.
  7. The SE shall make every effort to reduce administrative burdens on providers. The SE shall develop and use consistent and user-friendly clinical and non-clinical forms and procedures, including but not limited to forms and procedures for credentialing/recredentialing, daily operations, assessments, UM, service authorization, billing, and reporting. The SE shall use electronic formats and web-based applications to the extent practical. The SE shall use national standards as the basis for forms and processes where possible.
  8. The SE or a provider may initiate a change of provider when the consumer's (or legal guardian's or designated representative's) behavior toward the provider is such that the provider has made all reasonable efforts to accommodate the consumer or guardian or designated representative and address the consumer or guardian or designated representative problems, but those efforts have been unsuccessful. If the SE initiates such change in provider, the consumer or guardian or designated representative has the right to file a grievance.
  9. The SE shall conduct an annual provider satisfaction survey, the results of which shall be incorporated into the SE's quality management and quality improvement (QM/QI) program. Survey results shall be reported to the Collaborative.
  10. The SE shall establish and maintain a process for addressing provider grievances and appeals (see Article 3.15.J).

11. The SE shall actively solicit input from its network providers in an effort to improve and resolve problem areas related to service delivery and the SE's administrative functions and incorporate this information into the SE's QM/QI program.
12. The SE shall work with consumers, families, providers, disability organizations, and academic institutions to improve provider capacity and expertise.
13. The SE shall work with and support the Collaborative to ensure the availability of basic behavioral health services within each Region, including Comprehensive Community Support Services, outpatient counseling/therapy, and pharmacotherapy services.
14. The SE shall evaluate, on at least an annual basis, the array of network providers and covered services needed in each of the six regions of the State. The SE shall take into account any service needs identified by the Local Collaboratives, the BHPC, or the Collaborative. The SE shall submit a report of its findings to the Collaborative.

**B. Provider Credentialing and Recredentialing**

1. The SE shall have and implement policies and procedures that comply with NMAC 8.305.8.14, Standards for Credentialing and Recredentialing, as well as any other applicable credentialing/recredentialing requirements from member agencies.
2. The SE shall ensure that all network providers meet the credentialing and recredentialing requirements of all applicable Collaborative standards and policies. Requirements and procedures shall apply to both existing as well as new providers.
3. The SE shall use a Collaborative-approved application for network participation. Any changes to the application must be prior approved by the Collaborative.
4. The SE shall designate a credentialing committee or other peer review body to make recommendations regarding credentialing/recredentialing decisions.
5. The SE shall complete the credentialing process within sixty (60) days from receipt of a completed application with all required documentation unless there are extenuating circumstances.
6. The SE shall ensure that credentialing/recredentialing requirements and processes are streamlined and enable providers to move across agencies and settings without unnecessary restrictions, once credentialing has been granted. The SE's credentialing/credentialing requirements shall recognize and promote approaches to services such as consumer- and family-run programs, Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs.
7. The SE shall have a process for receiving input from providers regarding the credentialing and recredentialing process.

8. For independent practitioners, the SE shall:
  - a. Identify the types of practitioners who shall be credentialed/recredentialed. This shall include, at a minimum, all psychiatrists and other licensed independent practitioners.
  - b. Use a Collaborative-approved application form, which includes at a minimum, the items specified in NMAC 8.305.8.14 as well as a history of consumer complaints and their resolution.
  - c. As part of the initial credentialing process, verify, at minimum the items listed in NMAC 8.305.8.14 regarding primary source verification.
  - d. As part of the initial credentialing process, check that the applicant is not on the List of Excluded Individuals & Entities (LEIE). The SE shall not contract with excluded practitioners.
  - e. As part of the initial credentialing process, comply with provider disclosure requirements pursuant to 42 CFR §§455.104 and 105.
  - f. As part of the initial credentialing process, conduct an onsite visit to the offices of potential high-volume behavioral health care practitioners.
    - i. The SE shall determine the method for identifying high-volume behavioral health providers, which shall be prior approved by the Collaborative.
    - ii. The SE shall develop and document a structured review to evaluate the provider's site relative to the performance standards identified by the SE and approved by the Collaborative.
    - iii. The site visit shall include an evaluation of the provider's medical record keeping practices at each site for conformity with the SE's standards.
  - g. Recredential network providers at least every three (3) years.
9. For organizational providers, the SE shall:
  - a. Conduct initial and ongoing assessments of all organizational providers. Organizational providers include but are not limited to residential treatment centers, clinics, including community mental health centers, twenty-four-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals.
  - b. As part of the initial assessment, check that the applicant is not on the List of Excluded Individuals & Entities (LEIE). The SE shall not contract with excluded providers.
  - c. As part of the initial assessment, comply with provider disclosure requirements pursuant to 42 CFR §§455.104 and 105.
  - d. As part of the initial assessment, confirm that the provider is in good standing with state and federal regulatory bodies and has been certified by the appropriate state certification agency, when applicable.

- e. As part of the initial assessment, if accreditation is required by the Collaborative or the SE, confirm that the appropriate accrediting body has accredited the provider or that the provider has a detailed written plan that could reasonably be expected to lead to accreditation within a reasonable period of time. If accreditation is not required, the SE shall conduct an onsite quality assessment.
  - f. At least every three (3) years, confirm that the provider is in good standing with state and federal regulatory bodies and, as applicable, is accredited by the appropriate accrediting body, certified by the state certification agency, and/or meets the SE's standards of participation.
- 10. The SE shall maintain records, that verify its credentialing activities, including primary source verification, and compliance with credentialing/recredentialing requirements.
  - 11. The SE shall credential DOH facilities, as allowed by regulations, and as requested by those agencies, to provide behavioral health services.

**C. Provider Reimbursement**

- 1. The SE shall be responsible for reimbursing network and non-network providers in accordance with the requirements of this Contract (see Article 3.18 and Article 6).
- 2. Except as otherwise provided in this Contract (see Article 6.15), for Medicaid services the SE shall negotiate the reimbursement methodology and rate with providers. The methodology may include but is not limited to fee-for-service, case rates, or subcapitation. If the SE changes an existing reimbursement methodology or rate, it shall take steps to transition the provider to the new methodology/rate and prevent adverse financial consequences to the provider.
- 3. For non-Medicaid services (to both Medicaid and non-Medicaid consumers), the SE shall use the providers and reimbursement methodology and rate specified by the Collaborative.
- 4. Regardless of a provider's reimbursement methodology, the SE shall ensure that it receives required reports and data (e.g., encounter data) from network providers.
- 5. The SE shall develop and implement a plan, approved by the Collaborative, for moving toward a uniform system of service rates across Collaborative funding streams, specifically utilizing the Collaborative common service definitions.
  - a. The plan shall be presented to the Collaborative for approval no later than that the date specified by the Collaborative.
  - b. The SE shall work with Collaborative staff, as appropriate, in the implementation of its plan.
  - c. The SE shall present any substantive changes to its plan to the Collaborative for review and approval prior to making those changes.



- d. The SE shall include in its plan:
  - i. The changes it will need to make to its fiscal and claims payment systems to implement its plan;
  - ii. How it will give providers the support and training that may be necessary in making the transition to the system;
  - iii. How it will minimize impact on providers where more uniformity will result in a lower reimbursement rate for a particular provider, provider type, or geographic area; specifically, how it will phase in rate changes that will likely lower a high-volume or specialty provider's overall revenue by more than ten percent (10%) in any six (6) month period; and
  - iv. How its uniform rate structure will assist access in rural and frontier areas.
- e. The SE shall make progress toward the goals of more uniform rates through the implementation of this plan and shall submit a semi-annual report to the Collaborative on its progress.
- 6. The SE shall evaluate administrative costs at the provider level and, in consultation with the Collaborative, develop a plan to reduce these costs.
- 7. Notwithstanding the SE's right to negotiate rates with individual providers for Medicaid services, the SE shall give the Collaborative at least sixty (60) days notice prior to any proposed changes that would broadly affect provider rates. No proposed changes shall go into effect without giving the Collaborative the right to hold public meetings and otherwise obtain public input related to the proposed changes. Thereafter, the SE shall give the Collaborative notice of the effective date of the proposed changes.

**D. Provider Education, Training and Technical Assistance**

- 1. The SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials to its network providers. The SE shall provide information to providers that will:
  - a. Inform providers of the conditions of participation with the SE;
  - b. Inform providers of their responsibilities to the SE and to consumers;
  - c. Inform providers of how the SE defines high-volume provider and whether or not a provider meets that definition;
  - d. Inform providers of fund-specific policies and procedures (including but not limited to Medicaid), including information on covered services and services specific to the needs of ISHCN and other special populations;
  - e. Inform providers regarding billing requirements and rate structures and amounts;

- f. Inform providers regarding cultural and linguistic competency and how to access educational opportunities for providers and their staff on cultural and linguistic competency;
  - g. Provide information on credentialing and recredentialing, prior authorization, and referral processes, and how to request and obtain a second opinion for Medicaid consumers;
  - h. Inform providers on how to access care coordination services for ISCHNs and other special populations as well as Medicaid services not covered by this contract for Medicaid consumers;
  - i. Inform providers regarding the delivery of the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
  - j. Furnish providers with information on the SE's internal provider grievance process;
  - k. Inform providers about their responsibility to report critical incident information and the mechanism to report such information; and
  - l. Inform providers regarding the delivery of services to children in the custody of the State, including but not limited to issues related to consent, progress reporting, and potential for court testimony.
2. The SE shall contact all network providers in-person or by phone on a regular basis to update high-volume providers on SE initiatives and communicate pertinent information.
  3. The SE shall provide training and technical assistance to network providers to assist in professional development, increase provider knowledge regarding covered services, improve their business and financial practices, and reduce administrative costs.
  4. The SE shall provide initial education and training to providers prior to their delivery of services under this Contract. This education and training shall include but not be limited to: the role of and relationship among the SE, the BHPC, the LCs, and the Collaborative; provider clinical responsibilities such as conducting assessments, developing treatment plans and discharge plans, and fund-specific requirements; provider administrative responsibilities such as registering non-Medicaid consumers, being credentialed/recruited, and complying with service authorization, billing, and reporting requirements.
  5. The SE shall provide regular, ongoing provider education and training throughout the contract period to address clinical issues and improve the service delivery system, including but not limited to assessments, treatment plans, discharge plans, evidence-based practices, models of care, and fund-specific requirements.
  6. The SE shall identify training needs and work with the Collaborative to identify additional training needs and prioritize training needs.
  7. The SE shall develop training plans and materials and conduct training to address issues/topics identified by the Collaborative.

8. The SE shall develop training plans on a regular basis, which must be prior approved by the Collaborative. The training plans shall specify the training topic, the targeted providers, the content of the training, and the training schedule (including dates/times and locations).
9. The SE shall offer training regionally and at different times of the day in order to accommodate providers' schedules.
10. The SE shall provide training in a culturally competent manner.
11. The SE shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided.
12. The SE shall provide technical assistance to network providers as determined necessary by the SE or the Collaborative, including one-on-one meetings with providers. This technical assistance shall be provided in a culturally competent manner.
13. The SE shall submit a quarterly training activity report to the Collaborative. This report shall provide a summary of each training event by title, location(s), number of registrants, number of participants, number and type of CEUs offered, and a summation of the participants' satisfaction surveys. The report shall also include any cancelled event with an explanation of the cancellation.
14. The SE shall report biannually on the effectiveness of the training provided and recommendations for additional training.
15. The SE shall maintain a record of its training and technical assistance activities, which shall be made available to member agencies upon request.
16. The SE shall incorporate its training plans, their implementation, and their evaluation into its QM/QI program.
17. The SE shall comply with NMAC 8.305.6.17.

**E. Provider Agreement and Provider Monitoring**

1. Provider Agreements

- a. The SE shall execute provider agreements (contracts) with each network provider.
- b. The provider agreement shall include the following:
  - i. All applicable provisions from Article 19.
  - ii. Medical record and case file documentation and access requirements consistent with all applicable state and federal requirements;
  - iii. Requirements regarding disaster behavioral health planning and response (see Article 3.9.Q);
  - iv. Requirement that the provider accept all referrals and shall not refuse to provide covered services to a consumer who needs services that are within the provider's scope of clinical expertise;

- v. Requirement that the provider participate in and cooperate with the SE's QM/QI program and all monitoring activities;
  - vi. Reporting requirements, including but not limited to requirements for reporting data, critical incidents, and other information required by the Contract;
  - vii. Requirements regarding fraud and abuse, including reporting of potential fraud or abuse and cooperation with any investigation;
  - viii. Third party liability requirements;
  - ix. Provisions regarding remedial action for provider non-compliance with requirements, including corrective action and sanctions, up to and including contract termination; this shall include but not be limited to sanctions for failure to comply with reporting requirements; and
  - x. Any provisions necessary to ensure that services are provided consistent with the terms and conditions of this Contract.
- c. The SE and the State shall share all provider contracts as requested.

2. Provider Monitoring

- a. The SE shall ensure that its providers are in compliance with both clinical and non-clinical requirements of this Contract and the provider agreement. The SE shall conduct ongoing monitoring of its providers (see also Article 3.12.C). This monitoring shall include regular provider reviews and/or on-site audits to determine provider compliance with clinical and non-clinical requirements. The SE shall provide the Collaborative with copies of provider reviews and/or audit schedules, upon request, so that the Collaborative may participate if it so desires. The SE shall provide training (see Article 3.13.D) and technical assistance and implement corrective action as needed to ensure that providers are in compliance with applicable requirements.
- b. The SE shall ensure that all providers maintain the certification and training necessary to provide the services they offer. The SE shall utilize QM/QI data in conducting provider re-credentialing, re-contracting and/or performance evaluations.
- c. The SE shall have policies and procedures for altering the conditions of the provider's participation with the SE based on issues of quality of care and service. At a minimum, these policies and procedures shall comply with NMAC 8.305.8.14, Imposition of remedies.
- d. The SE shall evaluate the business practices of its providers, provide technical assistance in implementing sound business practices/improving current practices, implement appropriate interventions/corrective action plans, and conduct appropriate follow-up activities.

- e. The SE shall monitor the financial stability of its providers, provide technical assistance in implementing sound financial management strategies, implement appropriate interventions/corrective action plans, and conduct appropriate follow-up activities. The SE shall notify the Collaborative if any provider is having significant financial difficulties.
- f. The SE shall ensure that all providers are in compliance with applicable provisions of the Americans with Disabilities Act, 42 USC §§12101, et seq., ("ADA"), and its regulations. This shall include entrances, restrooms, business offices, therapy locations and all service delivery sites.
- g. The SE shall ensure that all providers have TTY services and/or are accessible through the 711 telecommunication system.
- h. The SE shall ensure that providers submit all data and reports required by the SE and/or the Collaborative. The SE shall generate reports and track provider performance in terms of data and report completion/submission, create profiles illustrating each provider's compliance, and implement corrective action plans with providers to improve accuracy and timeliness and to monitor the impact of the corrective action.
- i. At the request of the Collaborative, the SE shall conduct provider audits, including both desk and onsite audits, to evaluate provider performance.

**F. Telehealth Requirements**

- 1. In providing services under this Contract, the SE shall employ broad-based utilization of statewide access to HIPAA-compliant telehealth service systems including, but not limited to, access to TTYs and 711 Telecommunication Relay Services.
- 2. The SE shall:
  - a. Follow State guidelines for telehealth equipment or connectivity.
  - b. Attend meetings of the Telehealth Commission as requested.
  - c. Follow accepted HIPAA and 42 CFR Part 2 regulations that affect telehealth transmission, including but not limited to staff and provider training, room setup, security of transmission lines, etc. The SE shall have and implement policies and procedures that follow any federal or state security and procedure guidelines.
  - d. Identify, develop, and implement training for accepted telehealth practices.
  - e. Provide to the Collaborative performance measure data specific to telehealth encounters.
  - f. Participate in the needs assessment of the organizational, developmental, and programmatic requirements of telehealth programs.

- g. Report to the Collaborative on the telehealth outcomes of pilot or other telehealth projects.
- h. Ensure that telehealth services meet the following shared values of the New Mexico Telehealth Commission:
  - i. Ensuring competent care with regards to culture and language needs.
  - ii. Networked sites are equally distributed across regions of the state, including Native American sites, for both clinical and educational purposes, with focus on development of regional networks in line with regional breakout of state agencies.
  - iii. Ensuring coordination of telehealth and technical functions at either end of network connection.

### 3.14 CULTURAL COMPETENCY

- A. The SE shall develop, implement, evaluate, and update a Cultural Competency Plan encompassing all types of disability for itself and for all network providers to ensure that consumers and their families, including individuals with disabilities, receive covered services that are culturally and linguistically appropriate to meet their needs.
- B. The SE shall submit its Cultural Competency Plan to the Collaborative on an annual basis for approval.
- C. The SE's Cultural Competency Plan shall describe how the SE shall ensure that covered services are culturally and linguistically appropriate and shall incorporate nationally accepted Cultural Competence standards.
- D. The SE shall develop and implement policies and procedures that implement the Cultural Competency Plan.
- E. The SE shall develop and implement a plan for sign language interpreter, oral interpreter and written translation services to meet the needs of consumers (their families, legal guardians, and/or designated representative) who have a hearing impairment or whose primary language is not English. The SE shall use qualified medical interpreters, if available.
- F. The SE shall identify community advocates, agencies, and providers to assist individuals who have a hearing impairment or are non-English or limited-English speaking and/or that provide other culturally appropriate and competent services, including outreach and referral activities.
- G. The SE shall incorporate cultural competence into assessment, treatment planning, utilization management, its QM/QI program, and discharge planning.
- H. The SE shall identify resources and interventions for high-risk behavioral health conditions found in certain cultural groups.
- I. The SE shall develop and incorporate cultural and linguistic competency requirements into provider agreements and subcontracts.
- J. The SE shall recruit and train a diverse staff and leadership that are representative of the demographic characteristics of consumers.

- K. The SE shall select a staff member with appropriate training and experience to serve as the Director of Diversity Initiatives. The Director shall implement cultural community support system activities as well as evaluation activities. The Director shall also work with the SE's QM/QI Department to monitor, evaluate and address diversity issues within the SE and the delivery system.
- L. The SE shall conduct an initial and annual organizational self-assessments of culturally and linguistically competent-related activities and is encouraged to integrate cultural and linguistic competence-related measures into its QM/QI activities.
- M. The SE shall work with the Collaborative to appoint individuals within each member agency to form a workgroup with the SE to identify and make recommendations regarding systems-wide issues, indicators, goals, and objectives related to the development of a culturally and linguistically competent behavioral health system.
- N. The SE shall submit a quarterly progress report to the Collaborative outlining progress in implementing activities outlined in the SE's Cultural Competency Plan. This report shall identify difficulties and barriers and a plan for remediation of same, as appropriate.
- O. The SE shall participate with the State's efforts to promote the delivery of covered services in a culturally and linguistically competent manner to all consumers, including consumers who have a hearing impairment, consumers with limited English proficiency, consumers who have a speech or language disorders, consumers who have physical disabilities, consumers who have developmental disabilities, consumers who have differential abilities, and consumers who have diverse cultural and ethnic backgrounds.

### 3.15 GRIEVANCE AND APPEALS

#### A. Definitions

For purposes of this Article 3.15, the following definitions shall apply:

**"Appeal"** is a request for review by the SE of an SE Action.

**"Action"** is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner; or the failure of the SE to complete the authorization request in a timely manner as defined in 42 CFR §438.408. An untimely service authorization constitutes a denial and is thus considered an Action.

**"Expedited Resolution of an Appeal"** means an expedited review by the SE of an SE Action.

**"Grievance"** is a consumer's expression of dissatisfaction about any matter or aspect of the SE or its operation other than an SE Action.

**"Notice"** of an SE Action shall contain: (1) the Action the SE has taken or intends to take; (2) the reasons for the Action; (3) the consumer's or the provider's right to file an appeal of the SE's Action through the SE; (4) a Medicaid consumer's right to request an HSD/MAD Fair Hearing and what that process would be; (5) the procedures for exercising the rights specified; (6) the circumstances under

which Expedited Resolution of an appeal is available and how to request it; and (7) a Medicaid consumer's right to have benefits continue pending resolution of the Appeal, how to request the benefits be continued, and the circumstances under which the consumer may be required to pay the costs of these services.

The consumer, legal guardian if the consumer is a minor or is an incapacitated adult, or a representative of the consumer as designated in writing to the SE, or the representative of a deceased consumer's estate, has the right to file a Grievance; an Appeal of an SE Action; or request an HSD/MAD Fair Hearing (for Medicaid consumers), on behalf of the consumer or deceased consumer. A provider acting on behalf of the consumer and with the consumer's written consent may file a Grievance and/or Appeal of an SE Action. An HSD/MAD Fair Hearing may be requested by a Medicaid consumer prior to, concurrent with, subsequent to, or in lieu of a Grievance.

**B. General Requirements for Grievance and Appeals**

The SE shall:

1. Comply with NMAC 8.305.12 and 8.349.2 regarding Grievances and Appeals.
2. Implement written policies and procedures describing how the consumer may register a Grievance or an Appeal with the SE and how the SE resolves the Grievance or Appeal and meet all the requirements in the HSD/MAD Program Manual or other member agency requirements.
3. Provide a copy of its policies and procedures for resolution of a Grievance and/or Appeal to all network providers.
4. Have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.
5. Name a specific individual designated as the SE's consumer Grievance Coordinator with the authority to administer the policies and procedures for resolution of a Grievance and/or Appeal, to review patterns/trends in Grievances and/or Appeals, and to initiate corrective action.
6. Ensure that the individuals who make decisions on Grievance and/or Appeals are not involved in any previous level of review or decision-making. The SE shall also ensure that behavioral health care practitioners with appropriate clinical expertise will make decisions for the following:
  - a. An Appeal of an SE denial that is based on lack of medical, clinical or psychosocial necessity;
  - b. An SE denial that is upheld in an Expedited Resolution; and
  - c. A Grievance or Appeal that involves clinical issues.
7. Ensure that punitive or retaliatory action is not taken against a consumer or provider that files a Grievance and/or Appeal, or against a provider that supports a consumer's Grievance and/or Appeal.



**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 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 its 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:

<b>Claim Type</b>	<b>Claim Form</b>
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<sup>th</sup>) 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



## **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.



1. The SE shall work with Collaborative staff in the development of the Plan.
  2. The Plan shall be due by the end of the first month following any new fiscal/Contract year.
  3. The Plan shall be presented to the Collaborative at a meeting identified by the Collaborative Co-Chairs.
  4. The Plan shall include the priorities for Value Added Services as established by the Collaborative and the SE.
  5. The Plan shall reflect the planned services and projects that will be Value Added Services for that Contract year, as well as the projected level of expenditure for non-entitlement services and each community reinvestment initiative in each quarter of the Contract year;
  6. The Plan shall include how the SE will solicit ideas for community reinvestment and how the SE will establish the criteria by which community reinvestment projects are selected. These criteria shall include, but need not be limited to: project sustainability; coordination with Local Collaboratives and other resources; cost; and how closely the projects would help meet the priorities for community reinvestment set forth by the Collaborative and in the Plan, specifically moving services toward evidence-based practices; meeting performance targets; or moving toward support of consumer recovery and resiliency.
  7. The Plan shall identify the overall annual target expenditure level for Value Added Services by category (community reinvestment and non-entitlement services).
  8. The Plan shall set forth a timeline indicating how much money shall be obligated and spent by what dates by category of Value Added Services (community reinvestment and non-entitlement services).
- G. In addition to, or concurrently with, the development of the Plan, the Value Added Services process shall include:
1. Consideration of input from the BHPC and its subcommittees, LCs and other stakeholders as the planned services and projects are selected by the Collaborative and the SE;
  2. Quarterly accounting by the SE to the Collaborative or its designee of expenditures and accruals in Value Added Services by category (community reinvestment and non-entitlement services) indicating dollar amounts withheld and total obligations and expenditures from each funding source; and
  3. Adjustment of Value Added Services if expenditures and accruals vary materially from original projections. The Collaborative CEO and the SE will mutually agree upon such adjustments, based on criteria set forth in the Value Added Services Plan.

## 6.5 SPECIAL PAYMENT REQUIREMENTS

- A. Behavioral Health Planning Council. The SE shall provide an annual payment of \$5,000 to support the BHPC no later than August 1, 2009 for FY 2010.

- B. Local Collaboratives. The SE shall provide administrative and logistical support for the development and ongoing maintenance of the LCs as identified by Letters of Interest per the Guidelines for Local Collaboratives, including an annual payment of \$3,000 per Local Collaborative no later than August 1, 2009 for FY 2010, or within thirty (30) days of the identification of additional LCs up to a maximum of eighteen (18).
- C. The SE shall work with the Collaborative and LCs, and in coordination with any related capital outlay projects, to develop projects and/or provider contracts to implement any FY10 special appropriations.
- D. Any amounts required by this Contract to be provided to specific providers shall apply for FY10 only and are subject to adequate provider performance.
- E. At any time the SE determines that a specifically named provider is not adequately performing, the SE shall inform the Collaborative CEO and the Collaborative member agency involved, and shall propose a manner in which to improve that provider's performance or switch the funding to another provider. The Collaborative CEO and the funding member agency must approve any change during FY10.

#### 6.6 FUNDING AND APPROVAL

- A. The Parties to this Contract understand and agree that the compensation and payment reimbursement under this Contract is dependent upon federal and state funding and regulatory approvals and such funding and all rates of compensation and payment are to be determined and agreed to on an annual basis. Neither the SE nor the Collaborative can or will guarantee funding or rates of payment or compensation for any year beyond the current year for which the SE and Collaborative have received funding and reached agreement upon rates of compensation and payment.
- B. The Parties further understand that program changes affecting compensation for covered services are likely to occur during the term of this Contract and further agree to the following if such program changes are implemented by the Collaborative during the term of this Contract:
  - 1. In the event that the Collaborative initiates a program change affecting compensation and/or payment reimbursement for any covered services during the term of this Contract, prior to initiating any such change the Collaborative shall provide the SE with as much notice as is possible, generally at least sixty (60) days, given the circumstance of the contemplated change and the effect it will have on compensation and payment reimbursement for any covered service.
  - 2. Upon notice of a proposed program change, the SE may request negotiations for a modification of the Contract concerning changes in compensation and/or payment reimbursement for the program change, as provided in the notice from the Collaborative. Such program changes and any resulting negotiations and modifications shall be limited to the change in compensation and/or payment reimbursement for the program changes, and shall not subject the entire Contract to being reopened.

3. If the SE does not request negotiations for a modification of the Contract concerning a change in compensation and/or payment reimbursement for a program change within thirty (30) business days of the notice from the Collaborative, then the change shall be implemented and become effective under this Contract.
4. The SE shall provide notice to the Collaborative of any service or program changes anticipated by the SE that will have a budgetary impact on any of the member agencies. This notice shall be provided on a timeline that will allow member agencies to adjust their budget requests. The SE shall submit notice of anticipated changes for FY10 to the Collaborative by August 1, 2009.
5. Any renegotiation of rates, amounts, or program change pursuant to this Section shall be memorialized in writing and signed by the SE, the Co-Chairs of the Collaborative, and the funding member agency.

#### **6.7 MID-YEAR FUNDS**

During the Contract year, funds may become available to the Collaborative or one of its member agencies through federal grants, state appropriations, or other sources. The Collaborative reserves the right to add new funding to this Contract for services and activities that broadly fit within the covered services for this Contract via expedited Amendment (Article 36) signed by (1) the agency from whom the funds issue, (2) the two Collaborative Co-chairs, and (3) the SE CEO or designee.

#### **6.8 PROVIDER FEE INCREASES**

In the event that the Collaborative obtains additional funding identified for increased reimbursement to specific providers, the SE shall pass on all such additional funding less applicable taxes following the receipt of the additional funding by the SE from the Collaborative. The SE shall make such payments only to those types of providers identified by the Collaborative in writing and who are network providers. The SE and the Collaborative agree that the SE's obligation under this Section to pass through any additional funding will require at least thirty (30) days prior written notice. The Collaborative and SE agree that no payments will be required to be made pursuant to this Section until the Collaborative has provided written approval of the payment process to be utilized by the SE to ensure that the process will meet the Collaborative's audit requirements. The Collaborative reserves the right to direct payments to providers if the SE fails to comply with the pass-through requirements. The Collaborative and the SE shall develop a mechanism to report outcomes associated with the pass-through of funds.

#### **6.9 EXPENDITURES INCURRED BUT NOT REPORTED (IBNR)**

The SE shall use a reliable and accepted methodology to determine IBNR or claims run-out. The SE shall share with the Collaborative the methodology that it will use no later than August 1, 2009 for FY10. The Collaborative shall review the SE's methodology and reserves the right to require revisions to the methodology in order to achieve a more acceptable and reliable IBNR methodology. The SE shall use the same methodology, as applicable, for all funding streams and in all reports requiring such information. The SE shall submit a quarterly certification attesting, based on best knowledge, information, and belief, that reported IBNR is calculated correctly based on the approved methodology. This certification shall be certified by one of the following: the SE's Chief Executive Officer; the SE's Chief Financial Officer; or a Certified Public Accountant who

has been delegated authority to sign for, and who reports directly to, the SE's CEO or CFO.

**6.10 PAYMENT FOR SERVICES – NON-MEDICAID**

- A. Each member agency providing funds for services under this Contract shall pay the SE one-twelfth (1/12<sup>th</sup>) of the amount indicated in Appendix xxx (Funding Table), each month, no later than the thirtieth (30<sup>th</sup>) day of each month.
- B. By the thirtieth (30<sup>th</sup>) day following the end of each quarter, the SE shall provide the Collaborative with amounts paid by the SE for direct services appropriate to each fund source, including encounter-based data. To the extent the amount spent in that quarter does not equal the amount required to be spent for direct services for any fund source, or the data have not been provided by the SE by the thirtieth (30<sup>th</sup>) day following the end of a quarter, the SE shall provide a plan for meeting that level of expenditure by the end of the following quarter. This plan shall be approved by the Collaborative CEO and the funding member agency.
- C. If the amount expended by the following quarter does not meet the required amount to be expended for direct services, the Collaborative CEO and the funding member agency shall agree on and instruct the SE how to expend the necessary amount for direct services. The SE shall comply with that instruction.
- D. No later than May 31 of the Contract year, the SE shall notify all providers delivering non-Medicaid funded services that all billing for those services delivered during the Contract year must be submitted within thirty (30) days of the end of the Contract year.
- E. Within ninety (90) days of the end of each Contract year, the SE shall ensure that all funds appropriated by the Legislature for the delivery of covered services are paid and/or encumbered for services delivered during the Contract year.
- F. The SE shall refund any and all unexpended or unencumbered funds for direct services and non-direct services to the appropriate member agency by the end of November 2009 for the Contract year ending June 30, 2009. In the event that the SE has unexpended or unencumbered funds that are to be reverted to the state, and the SE has incurred administrative expenses in excess of the applicable administrative expense percentage, the SE may submit documentation of those expenses to the Collaborative CEO for consideration of retention of these fees for that fiscal year.

**6.11 PAYMENT FOR SERVICES – TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**

The SE shall provide a billing invoice due to HSD monthly on the 15<sup>th</sup> day of the month. The final invoice shall be due no later than July 10, 2010.

The SE shall bill 1/12<sup>th</sup> of the full budget each month as reimbursement.

**6.12 PAYMENT FOR SERVICES – GENERAL MEDICAID REQUIREMENTS**

- A. Medicaid consumers shall be held harmless against any liability for debts of the SE that were incurred in providing covered services to Medicaid consumers excluding any Medicaid consumer's liability for co-payments or liability for an overpayment resulting from benefits paid pending the results of a Fair Hearing.

- B. HSD shall compensate the SE for work performed under this Contract for FY10 at the rates shown on Appendix xxx.

**6.13 PAYMENT FOR SERVICES – MEDICAID FEE-FOR-SERVICE (MEDICAID FFS)**

- A. HSD shall pay an administrative fee for each non-managed care-eligible Medicaid consumer (Medicaid FFS consumer). In addition, HSD will reimburse the SE for all claims paid on behalf of Medicaid FFS consumers. The negotiated administrative fee appears in Appendix xxx.
- B. Any changes to the Medicaid FFS administrative fee shall be negotiated and implemented pursuant to Article 36 (Amendments) of this Contract.
- C. HSD shall make payment to the SE of an administrative fee for each Medicaid FFS consumer, plus reimbursement for claims for covered services on behalf of Medicaid FFS consumers. Administrative fees will be paid for consumers determined retroactively eligible. HSD will only pay the administrative fee for the retroactive period that does not exceed two years from the payment date.
- D. The administrative fee shall include payment for activities associated with the Medicaid FFS program. This includes care coordination, utilization management, provider contracting, and network maintenance, grievance and appeals, and claims processing.
- E. The SE shall administer payment of all Medicaid FFS claims and shall pay these at the established Medicaid fee-for-service rate, but the SE shall not be at financial risk for Medicaid FFS claims (see Sections F through H below).
- F. HSD will reimburse the SE for claims paid by the SE to providers for Medicaid FFS consumers upon validation in the Medicaid Management Information System (Omnicaid). At a minimum, the SE shall submit weekly Medicaid FFS encounter/paid claims files to HSD. HSD will adjudicate/validate these claims in Omnicaid and make payment to the SE for all valid claims within twelve (12) business days of processing the claims file.
- G. HSD and the SE shall reconcile all Medicaid FFS payments on a quarterly basis.
- H. The SE shall have up to two (2) years from a claim's first date of service to submit a claim. Claims not submitted within two years of the first date of service are not eligible for reimbursement. Claims may be resubmitted by the SE as many times as necessary within two years from the first date of service.

**6.14 PAYMENT FOR SERVICES – MEDICAID MANAGED CARE**

- A. **Capitation Rates.** HSD will make payments to the SE for the covered services in the Medicaid managed care behavioral health benefit package that are properly delivered to eligible Medicaid managed care consumers in accordance with and subject to all applicable federal and state laws, regulations, rules, billing instructions, bulletins, as amended, and in accordance with the payment and financial provisions in this Article and the Capitation Rates contained in Appendix xxx.
  - 1. The Collaborative shall meet with the SE annually to explain the Capitation Rates offered by the State.
  - 2. The Capitation Rates developed, discussed and negotiated between the Collaborative and the SE are considered confidential.

3. On an annual basis, the Collaborative shall incorporate by amendment the Capitation Rates by Cohort into the Contract as provided on the attached schedule; provided, however, that the Collaborative may, subject to notification to the SE, amend the Capitation Rates by Cohort and/or add additional Cohorts at such other times as may be necessary to reflect changes in federal or state law, including but not limited to those relating to eligibility, covered services, or copayments.
- B. **Financial Risk.** The SE shall assume full financial risk for all medical and administrative expenditures for all Medicaid benefits provided to the applicable Cohort Members State Fiscal Year 2010 and for any and all costs incurred by the SE in excess of the capitation payments.
  - C. **Capitation Rates for Future Contract Years.** The Capitation Rates awarded with the RFP shall be effective for the time period shown on the attached rate sheet. The Collaborative will establish the rate for any and all future years under this Contract based on the experience of year one (1) and other changes, including changes in the Scope of Work, new or amended federal or state laws or regulations, and adequate and sufficient funding.
  - D. **Failure to Agree upon Capitation Rates.** If the SE and the Collaborative fail to agree upon Capitation Rates at any time during the term of this Contract, the SE shall have the option to terminate this Contract or to agree to the final Capitation Rates proposed by the Collaborative within thirty (30) calendar days of receipt of the proposed amendment. If the SE terminates this Contract, the SE shall be obligated to continue to provide Covered Services to consumers, until such time as all consumers are disenrolled from the SE's plan but in no event longer than one hundred eighty (180) days. The Collaborative reserves the right to adjust the contracted Capitation Rate(s) in an actuarially sound manner in order to account for changes in the factors from which those rates were established. The SE shall accept the current Capitation Rates set forth in this Contract, as adjusted by the Collaborative in an actuarially sound manner as necessary to account for changes in eligibility, Benefit Package, adequate and sufficient funding, as payment in full for the Covered Services delivered to Medicaid managed care consumers during a transition.
  - E. **Funding by Cohort.** HSD shall pay the SE, in accordance with this Article by Cohorts for consumers for covered services according to Cohorts set forth in Appendix xxx.
  - F. **Capitation Rate Development**
    1. Actuarial Soundness. In determining Capitation Rates for all Cohorts, as described in this Article, the Collaborative shall calculate actuarially-sound Capitation Rates in accordance with all federal laws and regulations for which the SE provides the Medicaid managed care behavioral health benefit package. Capitation Rates shall be developed in accordance with generally accepted actuarial principles and practices. Capitation Rates must be appropriate for the populations to be covered, the covered services to be furnished, and be certified as meeting the foregoing requirements by actuaries. The actuaries must meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. Accordingly, the Collaborative's offer of all Capitation

Rates referred to in the attached schedule of this Contract is contingent on both certification by the Collaborative's actuary for actuarial soundness and final approval by CMS, prior to becoming effective for payment purposes. In the event such certification of approval is not obtained for any of all Capitation Rates, the Collaborative reserves the right to renegotiate or set these rates. The Collaborative's decision to renegotiate or set the rates under this provision is binding on the SE.

2. FQHCs. In determining the Capitation Rate for each Cohort, the Collaborative shall include for the behavioral health benefit package provided by FQHCs, the amount that would be paid by HSD/MAD for such services on a fee-for-service basis.

**G. Capitation Payment Process and Terms of Services**

1. Timing of Capitation Payments. HSD shall make capitation payments to the SE on the first Friday of the enrollment month for all Medicaid managed care consumers enrolled in that month and for any retroactive enrollments being made.
2. A consumer can change from one Cohort to another due to a change in eligibility and status. Any change in the consumer's eligibility and status will occasion a change in the consumer's Cohort for which the SE is paid. The capitation payment to the SE will be based on the consumer's Cohort on the first day of the given month.
3. The Collaborative may recoup capitation payments paid previously for a consumer if it is determined that the consumer was ineligible during that period or did not receive the services in accordance with their treatment plan and assessed needs, or that the consumer moved out of the State, or expired.
4. Payment Reconciliations. HSD shall have the discretion to recoup capitation payments made by HSD pursuant to the time periods governed by this Contract. In the event of an error that causes payment(s) to the SE to be issued by HSD, HSD shall recoup the full amount of the payment. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30<sup>th</sup>) day following the notice. Any process that automates the recoupment procedures will be discussed in advance by the Collaborative and the SE and documented in writing, prior to implementation of the new process. The SE has the right to dispute any recoupment action in accordance with this Contract. Recoupments may be made for the following circumstances:
  - a. Consumers who die prior to the enrollment month for which payment was made; and
  - b. Consumers whom HSD later determines were not eligible for Medicaid during the enrollment month for which payment was made.
5. Retroactive Payments for Consumers Reinstated
  - a. If a consumer loses eligibility for any reason and is reinstated as eligible by HSD before the end of a six (6) month period, the SE must accept a capitation payment, made retroactively, for that

month of eligibility and assume financial responsibility for all covered services received by the consumer. The SE shall be paid a capitation rate at the appropriate cohort rate for any period of retroactive coverage. Additionally, for any period of retroactive coverage where the SE is responsible for services for which prior authorization and/or utilization management policies were unable to be enforced, payment to providers for covered services shall be made at the lesser of a negotiated rate or the Medicaid fee-for-service rate.

- b. HSD must notify the SE of this retroactive capitation payment by the last day of the month.
- c. If this notification is not made by the last day of the month, the SE may choose to refuse the retroactive capitation payment.

H. **Medicaid Managed Care Surplus.** Subject to the other applicable terms of this Contract: (a) the SE shall provide a detailed accounting of Medicaid managed care direct service dollars not yet expended according to the percentage required for direct service expenditures on or before February 1, 2010 and again on or before April 1, 2010; (b) the Collaborative may at its sole discretion require that the SE prepare a spending plan to bring the expenditure percentage to the appropriate level based on the accounting provided; and (c) the Collaborative retains the right to approve, suggest accounting modifications to, or deny any proposed expenditure class in the SE's spending plan.

#### 6.15 SPECIAL PAYMENT REQUIREMENTS

##### A. **Reimbursement of Federally Qualified Health Centers (FQHCs)**

- 1. FQHCs are reimbursed at one hundred percent (100%) of reasonable cost, as determined by the State or federal government, under a Medicaid fee-for-service or managed care program. The FQHC can waive its right to reasonable cost and elect to receive the rate negotiated with the SE. During the course of the contract negotiations with the SE, the FQHC shall state explicitly that it elects to receive one hundred percent (100%) of reasonable costs or waive this requirement.
- 2. If the FQHC does not waive its right to receive reasonable costs, the SE shall be required to reimburse the FQHC at the Prospective Payment System (PPS) rates. The PPS rate meets the SE's responsibility toward the Collaborative's obligation to reimburse FQHCs at 100% of reasonable costs as determined by the Collaborative's external audit agency.
- 3. The FQHC shall report annually to the Collaborative's audit agent the reimbursement received from the SE. The Collaborative's audit agent will perform a reconciliation annually based upon FQHC revenue and encounters. The Collaborative's audit agent will submit an Accounting Transaction Request (ATR) to HSD to initiate additional funding required to meet the 100% threshold or request recoupment of payments in excess of the 100% threshold.

B. **Compensation for UM Activities.** The SE shall ensure that, consistent with 42 CFR §438.6(h) and §422.08, compensation to individuals or entities that conduct



UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services to any consumer.

**C. Special Circumstances for Pharmacy Reimbursement**

1. The SE may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement. The SE shall comply with the provisions of NMSA 1978, §27-2-16(B).
2. HSD reserves the right to review for reasonableness the SE's formula for pharmacy reimbursement and its reimbursement rates for pharmacy services for Medicaid consumers. Upon review, HSD reserves the right, to require the SE to adjust its formula and rates.

**D. Reimbursement for Emergency Service**

The SE shall reimburse non-network providers of emergency services as follows:

Any provider of emergency services that does not have in effect a contract with the SE that establishes payment amounts for services furnished to a consumer shall accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the consumer received medical assistance under Title XIX of the Social Security Act other than through enrollment in the SE. In a State where rates paid to hospitals under the State Plan are negotiated by contract and not publicly released, the payment amount shall be the average contract rate that would apply under the State Plan for hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

**E. Third Party Liability/Coordination of Benefits**

1. On a periodic basis, the Collaborative shall provide the SE with third party liability (TPL)/coordination of benefits (COB) information for consumers.
2. The SE shall:
  - a. Notify the Collaborative as set forth below when the SE learns that a consumer has TPL (Third Party Liability) for behavioral health or physical health services (when it was not identified on the enrollment roster):
    - i. Within fifteen (15) business days when a consumer is verified as having both Medicare and Medicaid (dual coverage); and
    - ii. Within sixty (60) calendar days when a consumer is verified as having coverage with any other health carrier.
  - b. Provide the Collaborative a quarterly report identifying TPL recoveries made in the previous quarter. The report shall include:
    - i. Relevant consumer demographic data;
    - ii. Services paid for;
    - iii. Amount recovered; and
    - iv. Carrier and coverage information.

- c. Jointly develop with the Collaborative and agree upon a reporting format to carry out the requirements in Sections a and b above. However, if the agreed upon format cannot be developed, the Collaborative retains the right to make a final determination of the reporting format.
- F. Except as otherwise provided in this Contract, in those instances where a duplicate payment is identified either by the SE or the Collaborative, the Collaborative retains the ability to recoup these payments within the time periods allowed by law.
- G. For payments to the SE that are based on data submitted by the SE, the SE shall certify the data pursuant to 42 CFR §438.606. The data that shall be certified includes, but is not limited to, all documents specified by the Collaborative, enrollment information, encounter data, and other information contained in this Contract or the RFP. The certification shall attest, based on best knowledge, information and belief, as to the accuracy, completeness and truthfulness of the documentation and data. The SE shall submit the certification concurrently with the certified data and documents. The data and documents the SE submits to the Collaborative, shall be certified by one of the following: the SE's Chief Executive Officer; the SE's Chief Financial Officer; or an individual who has been delegated authority to sign for, and who reports directly to, the SE's Chief Executive Officer or Chief Financial Officer.

#### **ARTICLE 7 – CONTRACT ADMINISTRATOR**

The Contract Administrator is, and his/her successor shall be, designated by the Collaborative CEO. The State shall notify the SE of any changes in the identity of the Contract Administrator. The Contract Administrator is empowered and authorized as the agent of the Collaborative to represent the Collaborative in all matters related to this Contract except those reserved to other State personnel by this Contract. Notwithstanding the above, the Contract Administrator does not have the authority to amend the terms and conditions of this Contract. All events, problems, concerns or requests affecting this Contract shall be reported by the SE to the Contract Administrator.

#### **ARTICLE 8 – ENFORCEMENT**

- 8.1 The parties acknowledge and agree that efficient operation of the New Mexico behavioral system is enhanced through a cooperative relationship between the parties. The Collaborative and the SE agree to first attempt to resolve any dispute involving the parties' respective performance through good faith informal negotiations. To that end, the Collaborative shall stress communication, notice and corrective action as the preferred method for initiating action related to the SE's performance hereunto; provided that nothing in this Section shall preclude the Collaborative from initiating the sanctions set forth in this Article 8 at the discretion of the Collaborative.

## 8.2 PROCESS

- A. When the Collaborative determines that the SE is not in compliance with any requirement of this Contract, the Collaborative shall notify the SE in writing. The written notice will include the basis and nature of the remedy (corrective action plan or directed corrective action plan) or sanction, as well as any other due process protections the Collaborative elects to provide. Any notice that imposes civil monetary penalties will be signed by the Collaborative Co-Chairs.
- B. Unless otherwise required by law, the level or extent of remedies or sanctions shall be based on the frequency or pattern of conduct, and/or the severity or degree of harm posed to (or incurred by) consumers.
- C. Civil monetary penalties imposed by the Collaborative may, at the option of the Collaborative, be collected by deducting the amount of the civil monetary penalty from any payments due to the SE or by demanding immediate payment by the SE.
- D. Unless otherwise agreed by the parties, notwithstanding any remedy or sanction imposed upon the SE, the SE shall continue to provide all covered service and administrative services required by this Contract.
- E. The SE may dispute a sanction in accordance with Article 15.

## 8.3 ARRAY OF REMEDIES AND SANCTION OPTIONS

In addition to any other administrative, contractual, or legal remedies available to the Collaborative under federal or state law, in the event that the SE fails to comply with this Contract, the Collaborative may impose the following types of remedies and sanctions:

- A. **Corrective Action Plan (CAP).** The Collaborative may require the SE to develop and submit a CAP within the timeframe specified by the Collaborative. If the SE does not effectively implement the CAP within the timeframe specified in the CAP, the Collaborative may impose additional remedies or sanctions.
- B. **Directed Corrective Action Plan (DCAP).** The Collaborative may develop a directed and very specific DCAP that the SE shall implement. If the SE does not effectively implement the DCAP, the Collaborative may impose sanctions.
- C. **Civil Monetary Penalties (CMP).** The Collaborative may impose upon the SE civil monetary penalties to the extent authorized by federal or state law. The Collaborative may impose progressively higher amounts for continuing deficiencies. Civil monetary penalties include the following, which may be imposed alone or in combination:
  - 1. Imposition of a lump sum fee upon the SE for failure to comply with a requirement of this Contract;
  - 2. Imposition of a daily fee upon the SE until the deficiency is corrected;
  - 3. Withhold of payment, as indicated in the written notice to the SE; and/or
  - 4. Calculated lump sum per consumer impacted by the deficiency.
- D. **Suspension of New Enrollment.** The State may suspend new enrollment to the SE.

- E. **Appointment of a State Monitor.** Should the Collaborative be required to appoint a State Monitor to assure the SE's performance, the SE shall bear the reasonable cost of the Collaborative intervention.
- F. **Payment Denials.** The State may deny payment for all consumers or deny payment for new consumers.
- G. **Actual Damages.** The State may assess to the SE actual damages to the Collaborative or consumers resulting from the SE's non-performance of its obligations.
- H. **Liquidated Damages.** The State may pursue liquidated damages in an amount equal to the costs of obtaining alternative behavioral health services to the consumer in the event of the SE's non-performance. The damages shall include the difference in the payments that would have been paid to the SE and the payments the replacement contractor. The State may withhold payment to the SE for liquidated damages until such damages are paid in full.
- I. **Temporary Management**
  - 1. The State may impose temporary management to oversee the operations of the SE upon a finding by the Collaborative that there is continued egregious behavior by the SE, including but not limited to behavior that is described in 42 CFR §438.700, or that is contrary to any requirements of 42 USC §§1396b(m) or 1396u-2; there is substantial risk to consumers' health or safety; or the sanction is necessary to ensure the health of consumers while improvements are made to remedy violations under 42 CFR §438.700 or until there is an orderly termination or reorganization of the SE.
  - 2. The State shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that the SE has repeatedly failed to meet substantive requirements in 42 USC §§1396b(m) or 1396u-2 or 42 CFR 438, Subpart I (Sanctions).
  - 3. The State shall not delay imposition of temporary management to provide a hearing before imposing this sanction.
  - 4. The State shall not terminate temporary management until it determines that the SE can ensure that the sanctioned behavior will not recur.
  - 5. The SE shall pay the costs associated with imposition of temporary management.
  - 6. The State shall grant Medicaid consumers the right to terminate enrollment without cause as described in 42 CFR §438.702 (a) (3), and shall notify the affected consumers of their right to terminate enrollment.
- J. **Termination of Contract.** The Collaborative has the authority to terminate this Contract and enroll consumers with another contractor(s), or provide covered services through other options (e.g., through the Collaborative plan for Medicaid consumers), if the Collaborative determines that the SE has failed to:
  - 1. Carry out the substantive terms of this Contract;
  - 2. Meet all applicable federal requirements, including those listed in Sections 1932, 1903(m), and 1905(t); or

3. Meet all applicable State requirements.

#### 8.4 **PRE-TERMINATION HEARING**

Before terminating this Contract, the Collaborative shall provide the SE a pre-termination hearing within thirty (30) calendar days after written notice, which consist of the following procedures:

- A. The State shall give the SE written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;
- B. After the hearing, the Collaborative shall give the SE written notice of the decision affirming or reversing the proposed-termination of the contract and, for an affirming decision, the effective date of termination;
- C. For an affirming decision, give consumers notice of the termination and information, consistent with their options for receiving covered services following the effective date of termination; and
- D. The pre-termination hearing procedures shall proceed according to Article 10.3 (Dispute Procedures Involving Contract Termination Proceedings).

#### 8.5 **NOTICE TO CMS**

The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in the 42 CFR §438.700. The notice must be given no later than thirty (30) days after the Collaborative imposes or lifts a sanction and must specify the affected contractor, the kind of sanction, and the reason for the Collaborative's decision to impose or lift a sanction.

### **ARTICLE 9 – TERMINATION**

9.1 All terminations shall be effective at the end of a month, unless otherwise specified in this Article.

9.2 This Contract may be terminated under the following circumstances:

- A. By mutual written agreement of the Collaborative, and the SE upon such terms and conditions as they may agree;
- B. By the Collaborative for convenience, upon not less than 180 days written notice to the SE;
- C. By the Collaborative as a sanction pursuant to Article 8;
- D. On the Contract termination date. The SE shall be paid solely for services provided prior to the termination date. The SE is obligated to pay all claims for all dates of service prior to the termination date if such claims are filed within one year after the termination date. In the event of the Contract termination date or if the SE terminates this Contract prior to the Contract termination date, and, if a consumer is in any facility at the time of termination, the SE shall be responsible for payment of all covered inpatient facility, non-State-operated residential facility, and the associated professional services for such inpatient or residential facility from the date of admission to the date of discharge. In the case of residential facility coverage, the SE shall not be responsible for payment for services for any period in excess of thirty (30) days' post-termination. Payment to the SE based upon termination of this Contract is set forth in Article 11.5.

- E. By the Collaborative for cause upon failure of the SE to materially comply with the terms and conditions of this Contract. The Collaborative shall give the SE written notice specifying the SE's failure to comply. The SE shall correct the failure within thirty (30) days or begin in good faith to correct the failure and thereafter proceed diligently to complete or cure the failure. If within thirty (30) days the SE has not initiated or completed corrective action, the Collaborative may serve written notice stating the date of termination and work stoppage arrangements.
- F. By the Collaborative, if required by modification, change, or interpretation in state or federal law or CMS waiver terms, because of court order, or because of insufficient funding from the federal or state government(s), if federal or state appropriations for Medicaid managed care are not obtained, or are withdrawn, reduced, or limited, or if Medicaid managed care expenditures are greater than anticipated such that funds are insufficient to allow for the purchase of services as required by this Contract. The Collaborative's decision as to whether sufficient funds are available shall be accepted by the SE and shall be final. If the Collaborative proposes an amendment to the Contract to unilaterally reduce funding, the SE shall have the option to terminate this Contract or to agree to the reduced funding, within thirty (30) calendar days of receipt of the proposed amendment;
- G. By the Collaborative, in the event of default by the SE, which is defined as the inability of the SE to provide services described in this Contract or the SE's insolvency. With the exception of termination due to insolvency, the SE shall be given thirty (30) calendar days to cure any such default, unless such opportunity would result in immediate harm to consumers or the improper diversion of Medicaid or other public funds;
- H. By the Collaborative, in the event of notification by the Public Regulation Commission or other applicable regulatory body that the certificate of authority under which the SE operates has been revoked, or that it has expired and shall not be renewed;
- I. By the Collaborative, in the event of notification that the owners or managers of the SE, or other entities with substantial contractual relationships with the SE, have been convicted of Medicare or Medicaid fraud or abuse or received certain sanctions as specified in §1128 of the Social Security Act;
- J. By the Collaborative, in the event it determines that the health or welfare of consumers is in jeopardy should the Contract continue. For purposes of this paragraph, termination of the Contract requires a finding by the Collaborative that a substantial number of consumers face the threat of immediate and serious harm;
- K. By the Collaborative in the event a petition for bankruptcy is filed by or against the SE;
- L. By the Collaborative if the SE fails substantially to provide medically or clinically necessary services that are required under this Contract;
- M. By the Collaborative, if the SE discriminates among consumers on the basis of their behavioral health or disability status or requirements for covered services, including expulsion or refusal to reenroll a consumer, except as permitted by this Contract and federal law or regulation, or the SE engages in any practice that

would reasonably be expected to have the effect of denying or discouraging enrollment with the SE by consumers or by consumers whose condition or history indicates a need for substantial future behavioral health services;

- N. By the Collaborative, if the SE intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, the Collaborative, or consumers, potential consumers or providers under the Social Security Act or pursuant to this Contract;
  - O. By the Collaborative, if the SE fails to comply with applicable physician incentive prohibitions of §1903(m)(2)(A)(x) of the Social Security Act;
  - P. By the SE, on at least sixty (60) calendar days prior written notice, in the event the Collaborative fails to pay any amount due the SE hereunder within thirty (30) calendar days of the date such payments are due;
  - Q. By the SE, on at least sixty (60) calendar days prior written notice, in the event that the Collaborative is unable to make future payments of undisputed capitation or other payments due to a lack of a state budget or legislative appropriation;
  - R. By the SE, on sixty (60) days' written notice with cause, or one hundred eighty (180) days' written notice without cause ; and
  - S. By either party, upon ninety (90) calendar days written notice, in the event of a material change in the Medicaid managed care program, regardless of the cause of or reason for such change, if the parties after negotiating in good faith are unable to agree on the terms of an amendment to incorporate such change.
- 9.3 If the Collaborative terminates this Contract pursuant to this Article and unless otherwise specified in this Article, the Collaborative shall provide the SE written notice of such termination at least sixty (60) calendar days prior to the effective date of the termination. If the Collaborative determines a reduction in the scope of work is necessary, it shall notify the SE and proceed to amend this Contract pursuant to its provisions.
- 9.4 By termination pursuant to this Article, no party may nullify obligations already incurred for performance of services prior to the date of notice or, unless specifically stated in the notice, required to be performed through the effective date of termination. Any agreement or notice of termination shall incorporate necessary transition arrangements.

#### **ARTICLE 10 – TERMINATION AGREEMENT**

- 10.1 When the Collaborative has reduced to writing and delivered to the SE a notice of termination, the effective date, and reasons therefore, if any, the Collaborative, in addition to other rights provided in this Contract, may require the SE to transfer, deliver, and/or make readily available to the Collaborative, property in which the Collaborative has a financial interest. Prior to invoking the provisions of this paragraph, the Collaborative shall identify that property in which it has a financial interest, provided that, subject to the Collaborative's recoupment rights herein, property acquired with capitation or other payments made for consumers properly enrolled shall not be considered property in which the Collaborative has a financial interest.
- 10.2 In the event this Contract is terminated by the Collaborative, immediately as of the notice date, the SE shall:
- A. Incur no additional financial obligations for materials, services, or facilities under this Contract, without prior written approval of the Collaborative.

- B. Comply with all directives issued by the Collaborative in the notice of termination as to the performance of work under this Contract.
- C. Terminate all purchase orders or procurements and subcontracts and stop all work to the extent specified in the notice of termination, except as the Collaborative may direct for orderly completion and transition or as required to prevent the SE from being in breach of its existing contractual obligations.
- D. Agree that the Collaborative is not liable for any costs of the SE arising out of termination unless the SE establishes that the Contract was terminated due to the Collaborative's negligence, wrongful act, or breach of the Contract.
- E. Take such action as the Collaborative may reasonably direct, for protection and preservation of all property and all records related to and required by this Contract.
- F. Cooperate fully in the closeout or transition of any activities so as to permit continuity in the administration of the Collaborative programs.
- G. Allow the Collaborative, its agents and representatives full access, upon reasonable notice and during normal business hours, to the SE's facilities and records to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding claims and any consumer records necessary to effectuate the orderly transition of consumers' care.

#### 10.3 **DISPUTE PROCEDURE INVOLVING CONTRACT TERMINATION PROCEEDINGS**

In the event the Collaborative seeks to terminate this Contract with the SE, the SE may appeal the termination directly to the Collaborative Co-Chairs or designee within ten (10) business days of receiving the Collaborative's termination notice and proceed as follows:

- A. The Collaborative Co-Chairs shall acknowledge receipt of the SE's appeal request within three (3) calendar days of the date the appeal request is received;
- B. The Collaborative Co-Chairs will conduct a formal hearing on the termination issues raised by the SE within thirty (30) calendar days after receipt of the written appeal;
- C. The SE, the Collaborative, or its successor, shall be allowed to present evidence in the form of documents and testimony;
- D. The parties to the hearing are the SE, the Collaborative, or its successor;
- E. The hearing shall be recorded by a court reporter paid for equally by the Collaborative and the SE. Copies of transcripts of the hearing shall be paid by the party requesting the copies;
- F. The court reporter shall swear witnesses under oath;
- G. The Collaborative Co-Chairs shall determine which party presents its issues first and shall allow both sides to question each other's witnesses in the order determined by the Co-Chairs;
- H. The Collaborative Co-Chairs may, but are not required to, allow opening statements from the parties before taking evidence;



- I. The Collaborative Co-Chairs may, but are not required to, request written findings of fact, conclusions of law and closing arguments or any combination thereof. The Collaborative Co-Chairs may, but are not required to, allow oral closing argument only;
- J. The Collaborative Co-Chairs shall render a written decision and mail the decision to the SE within sixty (60) calendar days of the date the request for a hearing is received;
- K. The Collaborative, or their successors, and the SE may be represented by counsel or another representative of choice at the hearing. The legal or other representatives shall submit a written request for an appearance with the Collaborative Co-Chairs within fifteen (15) calendar days of the date of the hearing request;
- L. The civil rules of procedure and rules of evidence for the District Courts for the District of New Mexico shall not apply, but the Collaborative Co-Chairs may limit evidence that is redundant or not relevant to the contract termination issues presented for review; and
- M. The Collaborative Co-Chairs' written decision shall be mailed by certified mail, postage prepaid, to the SE. Another copy of the decision shall be sent to the Collaborative CEO.

#### **ARTICLE 11 – RIGHTS UPON TERMINATION OR EXPIRATION**

- 11.1 Upon termination or expiration of this Contract, the SE shall, upon request of the Collaborative, make available to the Collaborative, or to a person authorized by the Collaborative, all records and equipment that are the property of the Collaborative.
- 11.2 Upon termination or expiration, the Collaborative shall pay the SE all amounts due for service through the effective date of such termination. The State may deduct from amounts otherwise payable to the SE monies determined to be due to the Collaborative from the SE. Any amounts in dispute at the time of termination shall be placed by the Collaborative in an interest-bearing escrow account with an escrow agent mutually agreed to by the Collaborative and the SE.
- 11.3 In the event that the Collaborative terminates the Contract for cause in full or in part, the Collaborative may procure services similar to those terminated and the SE shall be liable to the Collaborative for any excess costs for such similar services for any calendar month for which the SE has been paid for providing services to consumers. In addition, the SE shall be liable to the Collaborative for administrative costs incurred by the Collaborative in procuring such similar services. The rights and remedies of the Collaborative provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.
- 11.4 The SE is responsible for any claims from subcontractors or other providers, including emergency service providers, for services provided prior to the termination date. The SE shall promptly notify the Collaborative of any outstanding claims which the Collaborative may owe, or be liable for fee-for-service payment, which are known to the SE prior to termination.
- 11.5 Any payments advanced to the SE for coverage of consumers for periods after the date of termination shall be promptly returned to the Collaborative. For termination of that occurs mid-month, the capitation payments (for Medicaid managed care consumers) for

that month shall be apportioned on a daily basis. The SE shall be entitled to Medicaid capitation payments for the period of time prior to the date of termination, and the Collaborative shall be entitled to a refund for the balance of the month. All terminations shall include a final accounting of capitation payment received and number of Medicaid consumers during the month in which termination is effective. The State shall pay the SE for each consumer continuing to receive services after the effective date of termination as required in Article 9.2.D.

- 11.6 The SE shall ensure the orderly and reasonable transfer of consumer's care in progress, whether or not those consumers are hospitalized or in long-term treatment.
- 11.7 The SE shall be responsible to the Collaborative for liquidated damages arising out of the SE's breach of this Contract.
- 11.8 In the event the Collaborative proves that the SE's course of performance has resulted in reductions in the Collaborative's receipt of federal program funds, as a federal sanction, the SE shall remit to the Collaborative, as liquidated damages, such funds as are necessary to make the Collaborative whole, but only to the extent such damages are caused by the actions of the SE. This provision is subject to Article 15 (Disputes).

#### **ARTICLE 12 – CONTRACT MODIFICATION**

- 12.1 In the event that changes in federal or state statute, regulation, rules, policy, or changes in federal or state appropriation(s) or other circumstances require a change in the way the Collaborative manages the Medicaid program or any other funding covered by this Contract, this Contract shall be subject to substantial modification by amendment. Such election shall be effected by the Collaborative sending written notice to the SE. The Collaborative's decision as to the requirement for change in the scope of the program shall be final and binding.
- 12.2 The amendment(s) shall be implemented by Contract renegotiation in accordance with Article 36 (Amendments). In addition, in the event that approval of the Collaborative's 1915(b) waiver is contingent upon amendment of this Contract, the SE agrees to make any necessary amendments to obtain such waiver approval, provided that the SE shall not be required to agree if the modification is a substantial change to the business arrangement anticipated by the SE in executing this Contract. For the purposes of this Section, failure of the parties to agree upon capitation payment rates to be incorporated by amendment will be deemed a substantial change to the business arrangement anticipated by the parties. Notwithstanding the foregoing, any material change in the cost to the SE of providing the covered services herein that is caused by CMS in granting the waiver or by any other amendment necessary due to statutory, regulatory or programmatic change(s) shall be negotiated and mutually agreed to between the Collaborative and the SE. The results of the negotiations shall be placed in writing in compliance with Article 36 of this Contract.
- 12.3 Minor modifications of the Scope of Work under Article 3 may be accomplished by a Management Letter between the two parties without formal amendment. All other modifications shall be subject to the provisions of this Article and Article 36.

### **ARTICLE 13 – INTELLECTUAL PROPERTY AND COPYRIGHT**

- 13.1 In the event that the SE shall elect to use or incorporate in the materials to be produced any components of a system already existing, the SE shall first notify the Collaborative, who after investigation may direct the SE not to incorporate such components. If the Collaborative fails to object, and after the SE obtains written consent of the party owning the same, and furnishes a copy to the Collaborative, the SE may incorporate such components.
- 13.2 The SE warrants that all materials produced hereunder shall not infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the SE shall indemnify and hold the Collaborative and member agencies harmless from and against any loss, cost, liability, or expense arising out of breach or claimed breach of this warranty.
- 13.3 All materials developed or acquired by the SE under this Contract shall become the property of the Collaborative and shall be delivered to the Collaborative no later than the termination date of this Contract. Nothing developed or produced, in whole or in part, by the SE under this Contract shall be the subject of an application for copyright or other claim of ownership by or on behalf of the SE. Notwithstanding such requirement, if any material of any type used by SE for the performance of this Contract is a derivative of or otherwise uses preexisting SE-owned intellectual property, the SE shall be entitled to its preexisting rights in all such intellectual property.

### **ARTICLE 14 – APPROPRIATIONS**

- 14.1 The performance of this Contract is contingent upon sufficient appropriations or authorizations being made by either the Legislature of New Mexico (the Legislature) or the federal government. If sufficient appropriations and authorizations are not made by either the Legislature or the federal government, this Contract shall be subject to termination or amendment. The Collaborative's decision as to whether sufficient appropriations or authorizations exist shall be accepted by the SE and shall be final and binding. Any changes to the Scope of Work and compensation to the SE affected pursuant to this Article 14.1 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 36 (Amendments) of this Contract and any other applicable state or federal statutes, rules or regulations.
- 14.2 To the extent action by the federal government impacts the amount of funding available for performance under this Contract, the Collaborative has the right to amend the Scope of Work, in its discretion, which shall be effected by the Collaborative sending written notice to the SE. Any changes to the Scope of Work and compensation to the SE affected pursuant to this Article 14.2 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 36 (Amendments) of this Contract and any other applicable state or federal statutes, rules or regulations.

## ARTICLE 15 – DISPUTES

- 15.1 The entire agreement shall consist of: (1) this Contract, including all Appendices and any amendments; (2) the Request for Proposals, the Collaborative's written clarifications to the Request for Proposals, and the SE's responses to RFP questions where not inconsistent with the terms of this Contract or its amendments; (3) The SE's Best and Final Offer; and (4) the SE's additional responses to the Request for Proposals where not inconsistent with the terms of this Contract or its amendments, all of which are incorporated herein or by reference.
- 15.2 In the event of a dispute under this Contract, the various documents shall be referred to for the purpose of clarification or for additional detail in the order of priority and significance, specified below:
- A. Amendments to the Contract in reverse chronological order followed by;
  - B. The Contract, including any management letters, items incorporated by reference, and all Appendices followed by;
  - C. The SE's Best and Final Offer followed by;
  - D. The Request for Proposals, including Appendices thereto and the Collaborative's written responses to written questions and the Collaborative's written clarifications, and the SE's response to the Request for Proposals, including both technical and cost portions of the response (but only those portions of the SE's response including both technical and cost portions of the response that do not conflict with the terms of this Contract and its amendments).
- 15.3 **DISPUTE PROCEDURES FOR OTHER THAN CONTRACT TERMINATION PROCEEDINGS**
- A. Except for termination of this Contract, any dispute concerning sanctions imposed under this Contract shall be reported in writing to the Collaborative within fifteen (15) calendar days of the date the reporting party receives notice of the sanctions. The decision of the Collaborative regarding the dispute shall be delivered to the parties in writing within thirty (30) calendar days of the date the Director receives the written dispute. The decision shall be final and conclusive unless, within fifteen (15) calendar days from the date of the decision, either party files with the Collaborative Co-Chairs a written appeal of the decision of the Collaborative.
  - B. Any other dispute concerning performance of the Contract shall be reported in writing to the Collaborative within thirty (30) calendar days of the date the reporting party knew of the activity or incident giving rise to the dispute. The decision of the Collaborative shall be delivered to the parties in writing within thirty (30) calendar days and shall be final and conclusive unless, within fifteen (15) calendar days from the date of the decision, either party files with the Collaborative Co-Chairs a written appeal of the decision of the Collaborative.
  - C. Failure to file a timely appeal shall be deemed acceptance of the Collaborative's decision and waiver of any further claim.
  - D. In any appeal under this Article, the SE and the Collaborative shall be afforded an opportunity to be heard and to offer evidence and argument in support of their position to the Collaborative Co-Chairs or designee. The appeal is an informal hearing which shall not be recorded or transcribed, and is not subject to formal rules of evidence or procedure.

- E. The Collaborative Co-Chairs shall review the issues and evidence presented and issue a determination in writing within thirty (30) calendar days of the of the informal hearing which shall conclude the administrative process available to the parties. The Collaborative Co-Chairs shall notify the parties of the decision within thirty (30) calendar days of the notice of the appeal, unless otherwise agreed to by the parties in writing or extended by the Collaborative Co-Chairs for good cause.
- F. Pending decision by the Collaborative Co-Chairs, both parties shall proceed diligently with performance of the Contract, in accordance with the Contract.
- G. Failure to initiate or participate in any part of this process shall be deemed waiver of any claim.

#### **ARTICLE 16 – APPLICABLE LAW**

- 16.1 This Contract shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Contract shall be brought before the First Judicial District Court in Santa Fe, New Mexico.
- 16.2 Each party agrees that it shall perform its obligations hereunder in accordance with all applicable federal and state laws, rules and regulations now or hereafter in effect including the Deficit Reduction Act, the Clean Air Act and the federal Water Pollution Act.
- 16.3 If any provision of this Contract is determined to be invalid, unenforceable, illegal or void, the remaining provisions of this Contract shall not be affected, and providing the remainder of the Contract is capable of performance, and does not as so modified materially impact the underlying business arrangement between the parties, the remaining provisions shall be binding upon the parties hereto, and shall be enforceable, as though said invalid, unenforceable, illegal, or void provision were not contained herein.

#### **ARTICLE 17 – STATUS OF SE**

- 17.1 The SE is an independent contractor performing professional services for the Collaborative and is not an employee of the Collaborative or the State of New Mexico. The SE shall not accrue leave, retirement, insurance, bonding, use of State vehicles, or any other benefits afforded to employees of the State of New Mexico as a result of this Contract. The SE acknowledges that all sums received hereunder are reportable by the SE for tax purposes.
- 17.2 The SE shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business. Should the SE default in these or other responsibilities, jeopardizing the SE's ability to perform services, this Contract may be terminated for cause in accordance with Article 9.
- 17.3 The SE shall not purport to bind the Collaborative, member agencies, the State of New Mexico or any of their officers or employees to any obligation not expressly authorized herein unless the Collaborative has expressly given the SE the authority to so do in writing.

## **ARTICLE 18 – ASSIGNMENT**

With the exception of provider agreements or other subcontracts expressly permitted under this Contract, the SE shall not assign, transfer or delegate any rights, obligations, duties or other interest in this Contract or assign any claim for money due or to become due under this Contract except with the prior written consent of the Collaborative.

## **ARTICLE 19 – SUBCONTRACTS**

- 19.1 The SE is solely responsible for fulfillment of this Contract. The Collaborative shall make Contract payments only to the SE.
- 19.2 The SE shall remain solely responsible for performance by any subcontractor, including providers. In the event that any subcontractor is incapable of performing the service contracted for by the SE, the SE shall, upon the Collaborative's request, assume responsibility for providing the services that the subcontractor is incapable of performing. Upon the Collaborative's request, the SE shall provide any covered services directly until the SE identifies and contracts with a provider to provide such services.
- 19.3 The Collaborative may undertake or award other agreements for work related to the tasks described in this Contract or any portion therein if the SE's available time and/or priorities do not allow for such work to be provided by the SE. The SE shall fully cooperate with such other contractors and with the Collaborative in all such cases.
- 19.4 **SUBCONTRACTING REQUIREMENTS**
- A. Except as otherwise provided in this Contract, the SE may subcontract to a qualified individual or organization for the provision of any covered service or for any other required SE function. The SE remains legally responsible for all work performed by any subcontractor.
- B. The SE shall submit to the Collaborative for prior approval boilerplate contract language and/or sample contracts for each types of subcontract/provider agreement. Any changes to contract templates/sample contracts shall be approved by the Collaborative prior to execution by any subcontractor.
- C. The State will review and approve or disapprove all subcontracts and/or any changes to previously approved subcontracts to ensure compliance with requirements set forth in 42 CFR §§434.6 and 438.230 or this Contract.
- D. The SE shall give the Collaborative prior notice with regard to its intent to subcontract certain significant contract requirements as specified herein or in writing by the Collaborative, including, but not limited to, credentialing, utilization review, and claims processing. The State reserves the right to disallow a proposed subcontracting arrangement if the proposed subcontractor has been formally restricted from participating in a federal health care program (e.g., Medicare, Medicaid) for good cause.
- E. The SE shall not contract with an individual provider, an entity, or an entity with an individual who is an officer, director, agent, manager or person with more than five percent (5%) of beneficial ownership of an entity's equity, that has been convicted of crimes specified in Section 1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

- F. The SE shall include a provision in its subcontracts requiring subcontractors to perform criminal background checks for all required individuals providing services under this Contract, as specified in 7.1.9 NMAC, Caregivers Criminal History Screening Requirements.
- G. Pursuant to 42 CFR §§422.08 and 422.210, if the SE operates a physician incentive plan (PIP), it shall provide assurance satisfactory to the Collaborative that the requirements of 42 CFR §422.208 are met.
- H. In its subcontracts, the SE shall ensure that subcontractors agree to hold harmless the Collaborative, member agencies, and the SE's consumers in the event that the SE cannot or shall not pay for services performed by the subcontractor pursuant to the subcontract. The hold harmless provision shall survive the effective termination of the subcontract, regardless of the cause giving rise to termination. A subcontract termination shall be construed to be for the benefit of consumers.
- I. The SE shall have a written document (agreement/contract/subcontract), signed by both parties, that describes the responsibilities of the SE and the subcontractor; the subcontracted activities; the frequency of reporting (if applicable) to the SE; the process by which the SE evaluates the subcontractor; and the remedies, including the revocation of the delegation, available to the SE if the subcontractor does not fulfill its obligations.
- J. The SE shall have and implement policies and procedures to ensure that the subcontractor meets all standards of performance mandated by the Collaborative or member agency. These include, but are not limited to, use of appropriately qualified staff, and application of clinical practice guidelines and utilization management, reporting capability, and ensuring consumers' access to care.
- K. The SE shall have and implement policies and procedures for the oversight of the subcontractor's performance of the delegated functions.
- L. The SE shall have and implement policies and procedures to ensure consistent statewide application of all UM (Utilization Management) criteria when UM is delegated.
- M. Credentialing Requirements: The SE shall have and implement policies and procedures for verifying that the credentials of all its providers and subcontractors meet applicable standards as stated in this Contract.
- N. Review Requirements: The SE shall maintain fully executed originals of all subcontracts, including provider agreements, which shall be accessible to the Collaborative, upon request.
- O. Minimum Requirements: Subcontracts, including subcontracts with providers, shall meet the following requirements:
  - 1. Subcontracts shall be executed in accordance with all applicable federal and state laws, regulations, policies, procedures and rules;
  - 2. Subcontracts shall identify the parties of the subcontract and their legal basis of operation in the State of New Mexico;
  - 3. Subcontracts shall include the procedures and specific criteria for terminating the subcontract;

4. Subcontracts shall identify the services to be performed by the subcontractor and those services performed under any other subcontract(s). Subcontracts shall include provision(s) describing how services provided under the terms of the subcontract are accessed by consumers;
5. Subcontracts shall include the reimbursement rates and risk assumption, if applicable;
6. Subcontracts shall require subcontractors to maintain all records relating to services provided to consumers for a ten (10) year period and shall make all consumer medical records or other service records available for the purpose of quality review conducted by the Collaborative, or their designated agents both during and after the contract period;
7. Subcontracts shall require that consumer information be kept confidential, as defined by federal and state law;
8. Subcontracts shall include a provision that authorized representatives of the Collaborative have reasonable access to the subcontractor's facilities and records for financial and medical audit purposes both during and after the contract period;
9. Subcontracts shall include a provision for the subcontractor to release to the SE any information necessary for the SE to perform any of its obligations and that the SE shall be monitoring the subcontractor's performance on an ongoing basis and subjecting the subcontractor to formal periodic review;
10. Subcontracts shall state that the subcontractor shall accept payment from the SE as payment for any services included in the benefit package, and cannot request payment from the Collaborative for services performed under the subcontract;
11. Subcontracts shall require the subcontractor shall comply with all applicable state and federal statutes, rules, and regulations;
12. Subcontracts shall include provisions for termination for any violation of applicable state or federal statutes, rules, or regulations;
13. Subcontracts may not prohibit a provider or other subcontractor (with the exception of third-party administrators) from entering into a contractual relationship with another contractor;
14. Subcontracts may not include any incentive or disincentive that encourages a provider or other subcontractor not to enter into another contractual relationship;
15. Subcontracts shall not contain any gag order provisions that prohibit or otherwise restrict covered health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act or in contravention of NMSA 1978, §59A-57-1 to 57-11, the Patient Protection Act;
16. Subcontracts for pharmacy providers shall include a payment provision consistent with NMSA 1978, §27-2-16B, unless there is a change in law or regulation;



17. Subcontracts with providers shall contain a provision requiring at least thirty (30) days' notice of any intent to diminish, materially change, or substantially reduce services provided pursuant to the subcontract and shall require continuation of services as is during that thirty (30) days and shall require negotiations with the SE and, to the extent the Collaborative desires, with the Collaborative regarding continuation or transition of said services; and
18. As applicable, the subcontract shall identify the OMB Circular A-133 requirements, including:
  - a. Identifying the Catalog of Federal Domestic Assistance (CFDA number 93.958 for the CMHS Block Grant and CFDA number 93.959 for the SAPT Block Grant) and stating that subcontractor shall conduct an A-133 audit if it meets the \$500,000 of federal funds threshold, and
  - b. Including the language regarding allowable and unallowable cost/activities as specified by this Contract or regulation.

#### **ARTICLE 20 – RELEASE**

- 20.1 Upon final payment of the amounts due under this Contract, unless the SE objects in writing to such payment within 180 calendar days, the SE shall release the Collaborative, its officers and employees and the State of New Mexico from all such payment obligations whatsoever under this Contract. The SE agrees not to purport to bind the State of New Mexico. If the SE timely objects to such payment, such objection shall be addressed in accordance with the Dispute provisions provided for in this Contract.
- 20.2 Payment to the SE by the Collaborative or any member agency shall not constitute final release of the SE. Should audit or inspection of the SE's records or the SE's consumer complaints subsequently reveal outstanding SE liabilities or obligations, the SE shall remain liable to the Collaborative for such obligations. Any payments by the Collaborative to the SE shall be subject to any appropriate recoupment by the Collaborative.
- 20.3 Notice of any post-termination audit or investigation of complaint by the Collaborative shall be provided to the SE, and such audit or investigation shall be initiated in accordance with CMS or other applicable requirements. The State shall notify the SE of any claim or demand within thirty (30) calendar days after completion of the audit or investigation or as otherwise authorized by CMS or applicable regulations. Any payments by the Collaborative to the SE shall be subject to any appropriate recoupment by the Collaborative in accordance with the provisions of Article 6 of this Contract.

#### **ARTICLE 21 – RECORDS AND AUDIT**

##### **21.1 COMPENSATION RECORDS**

After final payment under this Contract or ten (10) years after a pending audit is completed and resolved, whichever is later, the Collaborative or its designee shall have the right to audit billings both before and after payment. The SE shall maintain all necessary records to substantiate the services it rendered under this Contract. These

records shall be subject to inspection by the Collaborative, the Department of Finance and Administration, the State Auditor and/or any authorized State or Federal entity and shall be retained for ten (10) years. Payment under this Contract shall not foreclose the right of the Collaborative to recover excessive or illegal payments as well as interest, attorney fees and costs incurred in such recovery.

#### **21.2 OTHER RECORDS**

In addition, the SE shall retain all consumer medical records, social service records, collected data, and other information subject to the Collaborative, state or federal reporting or monitoring requirements for ten (10) years after the contract is terminated under any provisions of Article 9 of this Contract or ten (10) years after any pending audit is completed and resolved, whichever is later. These records shall be subject to inspection by the Collaborative, the Department of Finance and Administration and/or any authorized State or Federal entity. The Department of Health and Human Services (HHS), the U.S. Comptroller General, or any representatives, shall have access to any books, documents, papers and records of the SE which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions. This right also includes timely and reasonable access to SE's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period but shall last as long as records are retained. Payment under this Contract shall not foreclose the right of the Collaborative to recover excessive or illegal payments and if such excessive or illegal payments are recovered then the Collaborative shall also be entitled to interest, attorney fees and costs incurred in such recovery.

#### **21.3 STANDARDS FOR MEDICAL RECORDS**

- A. The SE shall require medical records to be maintained on paper and/or in electronic format in a manner that is timely, legible, current, and organized, and that permits effective and confidential consumer care and quality review.
- B. The SE shall have and implement medical record confidentiality policies and procedures that implement the requirements of state and federal law and policy and of this Contract. These policies and procedures shall be consistent with confidentiality requirements in 45 CFR parts 160 and 164 for all medical records and any other health and enrollment information that identifies a particular consumer. Medical record contents shall be consistent with the utilization control required in 42 CFR Part 456.
- C. The SE shall establish, and shall require its providers to have, an organized medical record keeping system and standards for the availability of medical records appropriate to the practice site.
- D. The SE shall include provisions in its contracts with providers requiring appropriate access to the medical records of the SE's consumers for purposes of quality reviews to be conducted by the Collaborative, or agents thereof, and requiring that the medical records be available to providers for each clinical encounter.

21.4 The SE shall comply with the Collaborative's reasonable requests for records and documents as necessary to verify that the SE is meeting its obligations under this Contract, or for data reporting legally required of the Collaborative. However, nothing in this Contract shall require the SE to provide the Collaborative with information, records, and/or documents which are protected from disclosure by any law, including, but not

limited to, laws protecting proprietary information as a trade secret, confidentiality laws, and any applicable legal privileges (including but not limited to, attorney/client, physician/patient, quality assurance and peer review), except as may otherwise be required by law or pursuant to a legally adequate release from the affected consumer(s).

- 21.5 The SE shall provide the State of New Mexico, the Collaborative, and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the SE's premises or other places where work under this Contract is performed to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract. The SE shall provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g. assistance from the SE's staff to retrieve and/or copy materials). The State and its authorized agents shall schedule access with the SE in advance within a reasonable period of time except in the case of suspected fraud and abuse. All inspection, monitoring and evaluation shall be performed in such a manner as not to unduly interfere with the work being performed under this Contract.
- 21.6 In the event right of access is requested under this Section, the SE or subcontractor shall upon request provide and make available staff to assist in the audit or inspection effort, and shall provide adequate space on the premises to reasonably accommodate the Collaborative, State, or Federal representatives conducting the audit or inspection effort.
- 21.7 All inspections or audits shall be conducted in a manner as shall not unduly interfere with the performance of the SE's or any subcontractor's activities. The SE shall be given ten (10) business days to respond to any findings of an audit before the Collaborative shall finalize its findings. All information so obtained shall be accorded confidential treatment as provided in applicable law.

**21.8 RETENTION REQUIREMENTS FOR RECORDS**

Financial records, supporting documents, statistical records, and all other records pertinent to this Contract shall be retained for a period of three (3) years from the date of submission of the final expenditure report. The only exceptions are the following:

- A. If any litigation, claim, financial management review or audit is started before the expiration of the three-year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken;
- B. Records for real property and equipment acquired with federal funds shall be retained for three (3) years after final disposition;
- C. When records are transferred to or retained by the HHS awarding agency, the three (3) year retention requirement is not applicable; and
- D. Indirect cost rate proposals, cost allocations plan, etc., as specified in 45 CFR §74.53(g).

**ARTICLE 22 – INDEMNIFICATION**

- 22.1 The SE agrees to indemnify, defend and hold harmless the State of New Mexico, its officers, agents and employees from any and all claims and losses accruing or resulting from any and all SE employees, agents, or subcontractors, in connection with the breach or failure to perform or erroneous or negligent acts or omissions in the performance of

this Contract, and from any and all claims and losses accruing or resulting to any person, association, partnership, entity or corporation who may be injured or damaged by the SE in the performance or failure in performance of this Contract resulting from such acts of omissions. The provisions of this Article 22.1 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, in whole or in part the acts of omissions of the State of New Mexico, the Collaborative, member agencies, or any of its officers, employees or agents.

22.2 The SE shall at all times during the term of this Contract, indemnify and hold harmless the Collaborative against any and all liability, loss, damage, costs or expenses which the Collaborative may sustain, incur or be required to pay (1) by reason of any consumer suffering personal injury, death or property loss or damage of any kind as a result of the erroneous or negligent acts or omissions of the SE either while participating with or receiving care or services from the SE under this Contract, or (2) while on premises owned, leased, or operated by the SE or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the SE or any officer, agent, subcontractor or employee thereof. The provisions of this Section shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, the Collaborative, or any of its officers, employees, or agents. In the event that any action, suit or proceeding related to the services performed by the SE or any officer, agent, employee, servant or subcontractor under this Contract is brought against the SE, the SE shall, as soon as practicable but no later than two (2) business days after it receives notice thereof, notify the legal counsel of the Collaborative and the Risk Management Division of the New Mexico General Services Department by certified mail.

22.3 The SE shall agree to indemnify and hold harmless the Collaborative, the State of New Mexico, its agents, and its employees from any and all claims, lawsuits, administrative proceedings, judgments, losses, or damages, including court costs and attorney fees, or causes of action, caused by reason of the SE's erroneous or negligent acts or omissions, including the following:

- A. Any claims or losses attributable to any persons or firm injured or damaged by erroneous or negligent acts, including without limitation, disregard of federal or state Medicaid regulations or statutes by the SE, its officers, its employees, or subcontractors in the performance of the Contract, regardless of whether the Collaborative knew or should have known of such erroneous or negligent acts; unless the Collaborative or the State, or any of its officers, employees or agents directed in writing to the performance of such acts; and
- B. Any claims or losses attributable to any person or firm injured or damaged by the SE's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Contract in a manner not authorized by the Contract or by federal or state regulations or statutes, regardless of whether the Collaborative knew or should have known of such publication, translation, reproduction, delivery, performance, use, or disposition unless the Collaborative, the State, or any of its officers, employees or agents directed or affirmatively consented in writing to such publication, translation, reproduction, delivery, performance, use or disposition.

The provisions of this Article 22.3 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the Collaborative, the State, or any of its officers, employees, or agents.

- 22.4 The SE, including its subcontractors, agrees that in no event, including but not limited to nonpayment by the SE, insolvency of the SE or breach of this Contract, shall the SE or its subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a consumer or a person (other than the SE) acting on a consumer's behalf for services provided pursuant to this Contract except for any population required to make co-payments under Collaborative policy. In no case shall the Collaborative and/or any consumer be liable for any debts of the SE.
- 22.5 The SE agrees that the above indemnification provisions shall survive the termination of this Contract, regardless of the cause giving rise to termination. This provision is not intended to apply to services provided after this Contract has been terminated.
- 22.6 The State shall notify the SE of any claim, loss, damage, suit or action as soon as the Collaborative reasonably believes that such claim, loss, damage, suit or action may give rise to a right to indemnification under this Article. The failure of the Collaborative, however, to deliver such notice shall not relieve the SE of its obligation to indemnify the Collaborative under this Article. Prior to entering into any settlement for which it may seek indemnification under this Article, the Collaborative shall consult with the SE, but the SE need not approve the settlement. Nothing in this provision shall be interpreted as a waiver of the Collaborative's right to indemnification. The State shall permit the SE, at the SE's option and expense, to assume the defense of such asserted claim(s) using counsel acceptable to the Collaborative and to settle or otherwise dispose of the same, by and with the consent of the Collaborative. Failure to give prompt notice as provided herein shall not relieve the SE of its obligations hereunder, except to the extent that the defense of any claim for loss is prejudiced by such failure to give notice.

#### **ARTICLE 23 – LIABILITY**

- 23.1 The SE shall be wholly at risk for those covered services specified in this Contract and shall administer all other covered services on an administrative services only (ASO) basis as specified in this Contract. No additional payment shall be made by the Collaborative other than that specified in this Contract, nor shall any payment be collected from a consumer, except for co-payments authorized by the Collaborative or State laws or regulations.
- 23.2 The SE is solely responsible for ensuring that it issues no payments for services for which it is not liable under this Contract. The Collaborative shall accept no responsibility for refunding to the SE any such excess payments unless the Collaborative or Collaborative CEO directed such services to be rendered or payment made.
- 23.3 The SE, its successors and assignees shall procure and maintain such insurance and other forms of financial protections as are identified in this Contract.

#### **ARTICLE 24 – EQUAL OPPORTUNITY COMPLIANCE**

The SE agrees to abide by all federal and state laws, rules, regulations and executive orders of the Governor of the State of New Mexico and the President of the United States pertaining to equal opportunity including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. In accordance with all such laws, rules, and regulations,

and executive orders, the SE agrees to ensure that no person in the United States shall, on the grounds of race, color, national origin, sex, sexual preference, age, trans-gender, handicap or religion be excluded from employment with, or participation in, be denied the benefit of, or otherwise be subjected to discrimination under any program or activity performed under this Contract. If the Collaborative finds that the SE is not in compliance with this requirement at any time during the term of this Contract, the Collaborative reserves the right to terminate this Contract pursuant to Article 9 or take such other steps it deems appropriate to correct said problem.

#### **ARTICLE 25 – RIGHTS TO PROPERTY**

All equipment and other property provided or reimbursed to the SE by the Collaborative is the property of the Collaborative and shall be turned over to the Collaborative at the time of termination or expiration of this Contract, unless otherwise agreed to in writing. In addition, in regard to the performance of experimental, developmental or research done by the SE, the Collaborative shall determine the rights of the federal government and the parties to this Contract in any resulting invention.

#### **ARTICLE 26 – ERRONEOUS ISSUANCE OF PAYMENT OR BENEFITS**

In the event of an error which causes payment(s) to the SE to be issued in error, the SE shall reimburse the Collaborative within thirty (30) calendar days of written notice of such error for the full amount of the payment, subject to the provisions of Article 6 of this Contract. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30<sup>th</sup>) day following the notice.

#### **ARTICLE 27 – EXCUSABLE DELAYS**

- 27.1 The SE shall be excused from performance hereunder for any period that it is prevented from performing any services hereunder in whole or in part as a result of an act of nature, war, civil disturbance, epidemic, court order, or other cause beyond its reasonable control, and such nonperformance shall not be a default hereunder or ground for termination of the Contract.
- 27.2 Suspensions under Force Majeure shall require the Party seeking suspension to give notification to the other Party at least five (5) business days before the imposition of the suspension. The receiving Party will be deemed to have agreed to such suspension unless having posted to mail such objection or non-consent within five (5) business days of receipt of request for suspension. The performance of either Party's obligations under the Contract shall be suspended during the period that any circumstances of Force Majeure persists, or for a consecutive period of ninety (90) calendar days, whichever is shorter, and such Party shall be granted an extension of time for performance equal to the period of suspension. For the purposes of this Section, "Force Majeure" means any event or occurrence which is outside of the reasonable control of the Party concerned and which is not attributable to any act or failure to take preventive action by the Party concerned.

- 27.3 The SE shall be excused from performance hereunder during any period for which the federal government or the State of New Mexico has failed to enact a budget or appropriate monies to fund covered services, provided that the SE notifies the Collaborative, in writing, of its intent to suspend performance and the Collaborative is unable to resolve the budget or appropriation deficiencies within forty-five (45) calendar days.
- 27.4 In addition, the SE shall be excused from performance hereunder for insufficient payment by the Collaborative, provided that the SE notifies the Collaborative in writing of its intent to suspend performance and the Collaborative is unable to remedy the monetary shortfall within forty-five (45) calendar days.

### **ARTICLE 28 – MARKETING**

- 28.1 The SE shall have and implement policies and procedures governing the development and distribution of marketing materials for consumers.
- 28.2 The Collaborative shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at consumers (their families, legal guardians, and/or designated representatives) before use.
- A. The SE shall distribute its marketing materials to its entire service area.
- B. The SE shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance, not including public/private partnerships.
- C. The SE shall specify the methods by which it assures the Collaborative that marketing materials are accurate and do not mislead, confuse, or defraud consumers or the Collaborative. Marketing materials will be considered inaccurate, false, or misleading if they contain statements or assertions, written or oral, including but not limited to:
1. Statements that the consumer must enroll with the SE in order to obtain Medicaid services or in order not to lose benefits; or
  2. Statements that the SE is endorsed by CMS, the federal government, the State, or a similar entity.

### **28.3 MINIMUM MARKETING AND OUTREACH REQUIREMENTS**

The marketing and outreach material shall meet the following minimum requirements:

- A. Marketing and/or outreach materials shall meet requirements for all communication with consumers, as set forth in the Medicaid Program Manual; and
- B. All marketing and/or outreach materials produced by the SE describing services to consumers shall state that such services are funded pursuant to a Contract with the State of New Mexico.
- 28.4 **MARKETING AND OUTREACH ACTIVITIES NOT PERMITTED UNDER THIS CONTRACT**

The following marketing and outreach activities are prohibited, regardless of the method of communication (oral, written) or whether the activity is performed by the SE directly, or by its network providers, its subcontractors, or any other party affiliated with the SE:

- A. Asserting or implying that a consumer shall lose Medicaid benefits if he/she does not enroll with the SE or inaccurately depicting the consequences of choosing a different SE;
  - B. Designing a marketing or outreach plan that discourages or encourages SE selection based on health status or risk;
  - C. Initiating an enrollment request on behalf of a consumer;
  - D. Making inaccurate, false, materially misleading or exaggerated statements;
  - E. Asserting or implying that the SE offers unique covered services when another entity provides the same or similar service;
  - F. Using gifts or other incentives to entice people to enroll with the SE;
  - G. Directly or indirectly conducting door-to-door, telephonic or other "Cold Call" marketing. "Cold Call" marketing is defined as any unsolicited personal contact by the SE with a potential consumer for the purpose of marketing. Marketing means any communication from an SE to a consumer who is not enrolled in the SE that can reasonably be interpreted as intended to influence the consumer to enroll in that SE and not to enroll in or to disenroll from, another SE. The SE may send informational material regarding its benefit package to potential consumers; and
  - H. Conducting any other marketing activity prohibited by the Collaborative during the course of this Contract.
- 28.5 The SE shall take reasonable steps to prevent subcontractors and network providers from committing the acts described herein. The SE shall be held liable only if it knew or should have known that its subcontractors or network providers were committing the acts described herein and did not take timely corrective actions. The Collaborative reserves the right to prohibit additional marketing activities at its discretion.
- 28.6 **MARKETING TIMEFRAMES**
- The SE may initiate marketing and outreach activities at any time.
- 28.7 The Collaborative's Marketing Guidelines are incorporated into this Contract by reference. This Contract shall incorporate all revisions to the Guidelines produced during the course of the Contract.
- 28.8 Behavioral Health Education and Outreach Materials may be distributed to the SE's consumers by mail or in connection with exhibits or other organized events, including but not limited to, health fair booths at community events and SE-hosted behavioral health improvement events. Behavioral Health Education means programs, services or promotions that are designed or intended to inform the SE's actual or potential consumers upon request about the issues related to behavioral health lifestyles, situations that affect or influence behavioral health status or methods or modes of behavioral health treatment. Outreach is the means of educating or informing the SE's actual or potential consumers about behavioral health issues. The State shall not approve health education materials. The SE shall work with the Collaborative to develop and implement outreach programs consistent with the policies of the Collaborative and the Comprehensive Behavioral Health Plan and to meet the goals of the Collaborative.



### **ARTICLE 29 – PROHIBITION OF BRIBES, GRATUITIES & KICKBACKS**

- 29.1 Pursuant to Sections 1978, §§13-1-191, 30-24-1 et seq., 30-41-1, and 30-41-3, the receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.
- 29.2 No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Contract. No individual employed by the State of New Mexico shall be admitted to any share or part of the Contract or to any benefit that may arise therefrom.
- 29.3 The Collaborative may, by written notice to the SE, immediately terminate the right of the SE to proceed under the Contract if it is found, after notice and hearing by the Collaborative that gratuities in the form of entertainment, gifts or otherwise were offered or given by the SE or any agent or representative of the SE to any officer or employee of the State of New Mexico with a view toward securing the Contract or securing favorable treatment with respect to the award or amending or making of any determinations with respect to the performing of such Contract. In the event the Contract is terminated as provided in this Section, the State of New Mexico shall be entitled to pursue the same remedies against the SE as it would pursue in the event of a breach of contract by the SE and as a penalty in addition to any other damages to which it may be entitled by law.

### **ARTICLE 30 – LOBBYING**

- 30.1 The SE certifies, in accordance with the Byrd Anti-Lobbying Amendment, to the best of its knowledge and belief, that:
- A. No Federally appropriated funds have been paid or shall be paid, by or on behalf of the SE, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
  - B. If any funds other than federally appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the SE shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
- 30.2 The SE shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.
- 30.3 This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 USC §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than ten thousand dollars (\$10,000) and not more than one hundred thousand dollars (\$100,000) for such failure.

### **ARTICLE 31 – CONFLICT OF INTEREST**

- 31.1 The SE warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Contract, and further warrants that signing of this Contract shall not be creating a violation of the Governmental Conduct Act, NMSA 1978, §10-16-1 et seq. or be at least equal to federal safeguards 41 USC §423.
- 31.2 If during the term of this Contract and any extension thereof, the SE becomes aware of an actual or potential relationship, which may be considered a conflict of interest, the SE shall immediately notify the Contract Administrator in writing. Such notification includes when the SE employs or contracts with a person, on a matter related to this Contract, and that person: (1) is a former State employee who has an obligation to comply with NMSA 1978, §10-16-1 et seq., or (2) is a former employee of the Department of Health or the Children, Youth and Families Department who was substantially and directly involved in the development or enforcement of this Contract.

### **ARTICLE 32 – CONFIDENTIALITY**

- 32.1 Any confidential information, as defined in state or federal law, code, rules or regulations or otherwise applicable by the Code of Ethics, regarding consumers or providers given to or developed by the SE and its subcontractors shall not be made available to any individual or organization by the SE and its subcontractors other than the SE's employees, agents, subcontractors, consultants or advisors without the prior written approval of the Collaborative.
- 32.2 The SE shall (1) notify the Collaborative promptly of any unauthorized possession, use, knowledge, or attempt thereof, of the Collaborative's data files or other confidential information; and (2) promptly furnish the Collaborative full details of the unauthorized possession, use of knowledge or attempt thereof, and assist investigating or preventing the recurrence thereof.
- 32.3 In order to protect the confidentiality of consumer information and records:
- A. The SE shall adopt and implement confidentiality policies and procedures that conform to federal and state laws and regulations.
  - B. The SE shall ensure that an appropriate system is in effect to protect substance abuse consumer records from inappropriate disclosure in accordance with 42 USC §300x-53(b), 45 CFR §96.132(e), and 42 CFR Part 2.
  - C. The SE's contracts with providers shall explicitly state expectations about the confidentiality of consumer information and records.
  - D. The SE shall afford consumers, legal guardians, and/or designated representatives the opportunity to approve or deny the release of identifiable personal information by the SE to a person or agency outside of the SE, except to duly authorized subcontractors, providers or review organizations, or when such release is required by law, State regulation, or quality standards.
    - 1. When release of information is made in response to a court order, the SE shall notify the consumer, legal guardian, and/or designated representative of such action in a timely manner.

2. The SE shall have and implement specific policies and procedures that direct how confidential information gathered or learned during the investigation or resolution of a grievance is maintained, including the confidentiality of the consumer's status as a grievant.
- 32.4 The SE shall comply with the Collaborative's requests for records and documents as necessary to verify the SE is meeting its duties and obligations under this Contract, or for data reporting legally required of the Collaborative. Except as otherwise required by law, the Collaborative may not request from the SE records and documents that go beyond ensuring that the SE is meeting its duties under this Contract, including, where appropriate, records and documents that are protected by any law, including, but not limited to, laws protecting proprietary information as a trade secret, confidentiality laws, and any and all applicable legal privileges (including, but not limited to, attorney/client, physician/patient, and quality assurance and peer review).

### **ARTICLE 33 – COOPERATION REGARDING FRAUD**

- 33.1 The SE shall make an initial report to the Collaborative within five (5) business days when, in the SE's professional judgment, suspicious activities may have occurred. The SE shall then take steps to establish whether or not, in its professional judgment, potential fraud has occurred. The SE shall then make a report to the Collaborative and submit any applicable evidence in support of its findings. If the Collaborative decides to refer the matter to the New Mexico State Medicaid Fraud Control Unit of the Attorney General's Office (MFCU) or another state or federal investigative agency, the Collaborative will notify the SE within five (5) business days of making the referral. The SE shall cooperate fully with any and all requests from the MFCU or other state or federal investigative agency for additional documentation or other types of collaboration in accordance with applicable law.
- 33.2 The SE shall cooperate fully in any investigation by the MFCU or other state or federal agency as well as any subsequent legal action that may result from such investigation. The SE and its subcontractors and network providers shall, upon request, make available to the MFCU or other state or federal agency conducting an investigation any and all administrative, financial and medical records relating to the delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, the MFCU or other state or federal agency shall be allowed to have access during normal business hours to the place of business and all records of the SE and its subcontractors and network providers, except under special circumstances when after hours access shall be allowed. Special circumstances shall be determined by the MFCU or other state or federal agency.
- 33.3 The SE shall disclose to the Collaborative, the MFCU, and any other state or federal agency, full and complete information regarding ownership, significant financial transactions or financial transactions relating to or affecting this Contract or the Medicaid program and persons related to the SE convicted of criminal activity related to Medicaid, Medicare, or the federal Title XX programs.
- 33.4 The SE shall refer any actual or potential conflict of interest to the MFCU. The SE also shall refer to the MFCU any instance where a financial or material benefit is given by any representative, agent or employee of the SE to the Collaborative, or any other party with direct responsibility for this Contract. In addition, the SE shall notify the MFCU if it hires or enters into any business relationship with any person who, within two (2) years

previous to that hiring or contract, was employed by the State in a capacity relating to the Medicaid program or any other party with direct responsibility for this Contract. (See also Article 31.2.)

- 33.5 Any recoupment received from the SE by the Collaborative shall not preclude the MFCU or any other state or federal agency from exercising its right to criminal prosecution, civil prosecution, or any applicable civil penalties, administrative fines or other remedies.
- 33.6 Upon request to the SE, the MFCU or any other state or federal agency shall be provided with copies of all grievances and resolutions affecting consumers.
- 33.7 Should the SE know about or become aware of any investigation being conducted by the MFCU or another state or federal agency, the SE, and its representatives, agents and employees, shall maintain the confidentiality of this information.
- 33.8 The SE shall have in place and enforce policies and procedures to educate Medicaid consumers of the existence of, and role of, the MFCU.
- 33.9 The SE shall have in place and enforce policies and procedures for the detection and deterrence of fraud. These policies and procedures shall include specific requirements governing who within the SE's organization is responsible for these activities, how these activities shall be conducted, and how the SE shall address cases of suspected fraud and abuse. (See also Article 3.17.)
- 33.10 All documents submitted by the SE to the Collaborative, if developed or generated by the SE, or its agents, shall be deemed to be certified by the SE as submitted under penalty of perjury.

#### **ARTICLE 34 – WAIVERS**

- 34.1 No term or provision of this Contract shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing by the party claimed to have waived or consented.
- 34.2 A waiver by any party hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or Contract herein contained.

#### **ARTICLE 35 – NOTICE**

- 35.1 A notice shall be deemed duly given upon delivery, if delivered by hand, or three (3) calendar days after posting if sent by first-class mail, with proper postage affixed. Notice may also be tendered by facsimile transmission, with original to follow by first class mail.
- 35.2 All notices required to be given to Collaborative under this Contract shall be sent to the Collaborative Contract Administrator or his/her designee:

Bill Belzner  
New Mexico Human Services Department  
Behavioral Health Collaborative  
P. O. Box 2348  
Santa Fe, NM 87504-2348  
Phone: 505-476-9295

- 35.3 Any information or notice required to be provided to the Collaborative or to Collaborative member agency staff or CAT leaders shall be copied to the Collaborative CEO. The Collaborative CEO may designate in writing other individuals to receive specific information, reports or plans required to be submitted pursuant to this Contract, but may not designate another individual to receive formal notices required by this Contract.
- 35.4 All notices required to be given to the SE under this Contract shall be sent to:  
Sandra L. Forquer, CEO

### **ARTICLE 36 – AMENDMENTS**

This Contract shall not be altered, changed or amended other than by an instrument in writing executed by the parties to this Contract. Amendments shall become effective and binding when signed by the parties, approved by the Department of Finance and Administration, and written approvals have been obtained from any necessary State and Federal agencies. All necessary approvals shall be attached as exhibits to the Contract.

### **ARTICLE 37 – SUSPENSION, DEBARMENT AND OTHER RESPONSIBILITY MATTERS**

- 37.1 Pursuant to 45 CFR Part 76 and other applicable federal regulations, the SE certifies by signing this Contract, that it and its principals, to the best of its knowledge and belief and except as otherwise disclosed in writing by SE to the Collaborative prior to the execution of this Contract: (1) are not debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any federal department or agency; (2) have not, within a three-year period preceding the effective date of this Contract, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract or subcontract; violation of federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (3) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with, commission of any of the offenses enumerated above in this Article 37.1; (4) have not, within a three-year period preceding the effective date of this Contract, had one or more public agreements or transactions (federal, state or local) terminated for cause or default; and (5) have not been excluded from participation from Medicare, Medicaid, federal health care programs or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 USC §1320a-7 and other applicable federal statutes. The SE may not knowingly have a relationship with the following:
- A. An individual who is an affiliate, as defined in the Federal Acquisition Regulations that is disbarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under

Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- B. For purposes of this Section, an individual who is an affiliate, as defined in the Federal Acquisition Regulation, has a "relationship" if such individual is:
1. A director, officer or partner of the SE;
  2. A person with beneficial ownership of five percent (5%) or more of the SE's equity; or
  3. A person with an employment, consulting or other arrangement regarding the SE's obligations under this Contract.

37.2 The SE's certification in Article 37.1 is a material representation of fact upon which the Collaborative relied when this Contract was entered into by the parties. The SE shall provide immediate written notice to the Contract Administrator, if, at any time during the term of this Contract, the SE learns that its certification in Article 37.1 was erroneous on the effective date of this Contract or has become erroneous by reason of new or changed circumstances. If it is later determined that the SE's certification in Article 37.1 was erroneous on the effective date of this Contract or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to the Collaborative, the Collaborative may terminate the Contract.

37.3 As required by 45 CFR Part 76 or other applicable federal regulations, the SE shall require each proposed first-tier subcontractor whose subcontract will equal or exceed twenty-five thousand dollars (\$25,000), to disclose to the SE, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by any federal department or agency. The SE shall make such disclosures available to the Collaborative when it requests subcontractor approval from the Collaborative pursuant to Article 19.4. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any federal department or agency, the Collaborative may refuse to approve the use of the subcontractor.

### **ARTICLE 38 – NEW MEXICO EMPLOYEES HEALTH COVERAGE**

38.1 If the SE has, had, or anticipates having, six (6) or more employees who work, or who worked, are working, or are expected to work, an average of at least twenty (20) hours per week over a six (6) month period with said six-month period being at any time during the year prior to seeking the contract with the Collaborative of at anytime during the term of this Contract, SE certifies, by signing this Contract, to:

- A. Have in place, and agree to maintain for the term of this Contract, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2008, if the expected annual value in the aggregate of any and all contracts between the SE and the State exceeds one million dollars (\$1,000,000.00); or
- B. Have in place, and agree to maintain for the term of this Contract, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2009, if the expected annual value in the aggregate of any and all contracts between the SE and the Collaborative exceeds Five hundred thousand dollars \$500,000.00; or

- C. Have in place, and agree to maintain for the term of this Contract, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2010, if the expected annual value in the aggregate of any and all contracts between the SE and the Collaborative exceeds Two hundred fifty thousand dollars \$250,000.00.
- 38.2 The SE shall agree to maintain a record of the number of employees who have:
- A. Accepted health insurance;
  - B. (Declined health insurance due to other health insurance coverage already in place; or
  - C. Declined health insurance for other reasons.
- These records are subject to review and audit by the Collaborative or its representative.
- 38.3 The SE shall agree to advise all New Mexico employees in writing of the availability of State publicly financed health coverage programs by providing each employee with, at a minimum, the following web site link for additional information <http://insurenwnewmexico.state.nm.us/>.
- 38.4 For Indefinite Quantity, Indefinite Delivery contracts (price agreements without specific limitations on quantity and providing for an indeterminate number of orders to be placed against it) these requirements shall apply the first day of the second month after the SE reports combined sales (from state and, if applicable, from local public bodies if from a state price agreement) of Two hundred and fifty thousand (\$250,000); Five hundred thousand dollars (\$500,000), or One million dollars (\$1,000,000), depending on the dollar value threshold in effect at that time.
- 38.5 The SE shall agree to include the provisions of this Article in all subcontracts involving entities whose employees reside within that State of New Mexico, including provider agreements, and all other sub-agreements used to fulfill the SE's obligations under this Contract.
- 38.6 The SE agrees to obtain verification of its subcontractors and network providers for compliance with this Article. Failure of any subcontractor or network provider to comply with this Article shall be reported to the Collaborative immediately upon SE's knowledge of such failure and the SE shall advise the non-complying subcontractor or network provider that failure to cure the deficiency can result in immediate termination of the subcontract or provider agreement, or as may be mandated by the Collaborative.

### **ARTICLE 39 – ENTIRE AGREEMENT/MERGER**

This Contract incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Contract. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Contract. Revisions required by CMS, state or federal requirements to the original Contract shall not require an amendment agreed to by both parties.

### **ARTICLE 40 – DUTY TO COOPERATE**

The parties agree that they will cooperate in carrying out the intent and purpose of this Contract. This duty includes specifically, an obligation by the parties to continue

performance of the Contract in the spirit it was written, in the event they identify any possible errors or problems associated with the performance of their respective obligations under this Contract.

#### **ARTICLE 41 – PENALTIES FOR VIOLATION OF LAW**

The Procurement Code, Sections 13-1-28 through 13-1-19, NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities and kickbacks.

#### **ARTICLE 42 – WORKERS COMPENSATION**

The SE agrees to comply with state laws and regulations applicable to workers compensation benefits for its employees. If the SE fails to comply with the Workers Compensation Act and applicable regulations when required to do so, this Contract may be terminated by the Collaborative.

#### **ARTICLE 43 – INVALID TERM OR CONDITION**

If any term or condition of this Contract shall be held invalid or unenforceable, the remainder of this Contract shall not be affected and shall be valid and enforceable.

#### **ARTICLE 44 – ENFORCEMENT OF AGREEMENT**

A party's failure to require strict performance of any provision of this Contract shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Contract shall be effective to waive any other rights.

#### **ARTICLE 45 – AUTHORITY**

If the SE is other than a natural person, the individual(s) signing this Contract on behalf of the SE represents and warrants that he or she has the power and authority to bind the SE, and that no further action, resolution, or approval from the SE is necessary to enter into a binding contract.



IN WITNESS WHEREOF, the parties have executed this Contract as of the date of execution by the State Contracts Officer, below.

STATEWIDE ENTITY

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

Date: \_\_\_\_\_

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

STATE OF NEW MEXICO

Approved as to Form and Legal sufficiency:

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

Date: \_\_\_\_\_

Counsel for the Collaborative

DEPARTMENT OF FINANCE AND ADMINISTRATION

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

Date: \_\_\_\_\_

State Contracts Officer

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

TAXATION AND REVENUE DEPARTMENT

ID Number: \_\_\_\_\_

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

Date: \_\_\_\_\_

IN WITNESS WHEREOF, the following statutory members of the NM Interagency Behavioral Health Purchasing Collaborative have executed this Contract on the behalf of their respective agencies and organizations only to the extent of their statutory authority as members of the Collaborative.

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Cindy Padilla, Secretary  
Aging and Long-Term Services Department

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Date

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Dorian Dodson, Secretary  
Children, Youth and Families Department

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Date

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Joseph R. Williams, Secretary  
Corrections Department

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Date

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Katherine Miller, Secretary  
Department of Finance and Administration

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Date

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Alfredo Vigil, Secretary  
Department of Health

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Date

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Betty Sparrow Doris, Secretary  
Department of Workforce Solutions

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Date

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Gary Giron, Secretary  
Department of Transportation

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Date

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Patrick Putnam, Executive Director  
Developmental Disabilities Planning Council

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Date

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Ralph Vigil, Director  
Division of Vocational Rehabilitation

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Date

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Jim Parker, Executive Director  
Governor's Commission on Disability

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Date

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Bruce Perlman  
Governor's Senior Health Policy Advisor

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Date

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Elizabeth Stefanics, Executive Director  
Health Policy Commission

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Date

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Pamela S. Hyde, Secretary  
Human Services Department

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Date

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Alvin H. Warren, Secretary  
Indian Affairs Department

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Date

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Jay Czar, Executive Director  
Mortgage Finance Authority

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Date

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Veronica Garcia, Secretary  
Public Education Department

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Date

IN WITNESS WHEREOF, the following *ex-officio* members of the NM Interagency Behavioral Health Purchasing Collaborative have acknowledged their support for this Contract:

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Hugh Dangler  
Chief Public Defender  
Ex Officio

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Date

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Julienne Smrcka  
Children's Cabinet  
Ex Officio

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Date

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John Garcia, Secretary  
Department of Veterans Services  
Ex Officio

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Date

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Reed Dassenbrock, Secretary-Designate  
Department of Higher Education  
Ex Officio

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Date