HUMAN SERVICES
DEPARTMENT

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT

MEDICAID MANAGED CARE SERVICES AGREEMENT

BETWEEN

NEW MEXICO HUMAN SERVICE DEPARTMENT

AND

LOVLACE COMMUNITY HEALTH PLAN

PSC: 13-630-8000-0010
Term: July 1, 2012 – December 31, 2013

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STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT

MEDICAID MANAGED CARE SERVICES AGREEMENT FOR SALUD AND SCI

This agreement ("Agreement") between the New Mexico Human Services Department ("HSD") and Lovelace Community Health Plan of Albuquerque, New Mexico ("CONTRACTOR") specifies the terms and conditions under which the CONTRACTOR shall provide Medicaid managed care services for the HSD's Medical Assistance Division ("MAD") and is entered into by and between the parties to be effective on this 1st day of July, 2012.

WHEREAS, the Medicaid managed care system, created in 1995 pursuant to the Public Assistance Act "provide[s] for a statewide, managed care system to provide cost-efficient, preventative, primary and acute care for Medicaid recipients"; and

WHEREAS, HSD has received approval from the federal Centers for Medicare and Medicaid Services ("CMS") of a certain 1915(b) waiver (permissible waiver to Section 1915(b) of the Social Security Act) to provide Medicaid managed care services through the State's program called Salud!; and

WHEREAS, HSD has received approval from CMS of a certain 1115 Demonstration Waivers (permissible waiver under the Social Security Act) to provide State Coverage Insurance (SCI) to eligible individuals from age nineteen (19) to age sixty-five (65); and

WHEREAS, HSD entered into an agreement with the CONTRACTOR, a managed care organization ("MCO"), to provide services to the State's eligible population in the Salud! and SCI programs, PSC No. 09-630-8000-0016 and all amendments, (the "Prior MCO Agreement"); and

WHEREAS, pursuant to its terms the Prior MCO Agreement expires on June 30, 2012; and

WHEREAS, HSD has proposed a new model to provide Salud! and other services to Medicaid eligible recipients through Centennial Care, through a procurement process through which the CONTRACTOR may submit a response and be selected, currently scheduled to be operational on or about January 1, 2014; and

WHEREAS, HSD will be seeking a waiver under section 1115(b) of the Social Security Act (the "1115 waiver") from CMS to provide Medicaid services to eligible individuals in Centennial Care; and

WHEREAS, it is advantageous to HSD, Salud! and SCI recipients, and the CONTRACTOR to continue Salud! and SCI services until such time as Centennial Care has been approved and is fully operational; and

WHEREAS, HSD anticipates that the CONTRACTOR and each other current MCO that provide services to Medicaid eligible recipients will enter into a Transition Agreement that directs the transition of membership and services to Centennial Care contractors; and

WHEREAS, HSD's General Counsel and Chief Financial Officer have made a determination that this Agreement is exempt from the provisions of the New Mexico Procurement Code [13-1-28 NMSA 1978, *et seq.*] under §13-1-98.1 NMSA 1978, for the purpose of creating a network of health care providers to provide services to Medicaid eligible recipients that will or is likely to reduce health care costs, improve quality of care or improve access to care;

IT IS AGREED BETWEEN THE PARTIES:

ARTICLE 1 - INTRODUCTION

1.1 The term day(s) refers to calendar days, unless otherwise specified. Timelines 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.

1.2 The terms "contract" and "agreement" are used interchangeably throughout this Document.

1.3 All services purchased under this Agreement shall be subject to the following provisions for administration of the Medicaid program, which are incorporated herein by reference:

A. The HSD/MAD program eligibility and provider policy manuals, including all updates, revisions, substitutions and replacements;

B. Title XIX and Title XXI of the Social Security Act and Code of Federal Regulations Title 42 Parts 430 to end, as revised from time to time;

C. The Request for Proposal (RFP) that was issued by HSD on or about December 5, 2007, RFP No. 08-630-8000-0006, all RFP Amendments, CONTRACTOR's Questions and HSD/MAD's Answers, and HSD/MAD's written Clarifications;

D. The CONTRACTOR's Best and Final Offer;

E. The CONTRACTOR's Proposal (including any and all written materials presented in the orals portion of the procurement) where not inconsistent with this Agreement and subsequent amendments to this Agreement;

F. All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico ("State"), and HSD/MAD, concerning Medicaid services, managed care organizations (MCOs), health maintenance organizations, 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. 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 Agreement shall have the meanings given them in the Policy Manual;

H. The HSD/MAD MCO/CSP Systems Manual, including all updates and revisions, submissions and replacements;

I. All applicable instruments HSD/MAD may use from time to time to communicate, update and clarify information including but not limited to: letters of direction, guidance memoranda, correspondence, and other communication. These instruments are governed by the provisions of this Agreement in the event of conflict; and

J. All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico, and HSD/MAD concerning the State Children's Health Insurance Program ("SCHIP").

1.4 HSD/MAD is responsible for administering New Mexico's Salud! and State Coverage Insurance (SCI) programs. HSD/MAD shall require that most Medicaid recipients enroll with MCOs. HSD/MAD plans to execute agreements with MCOs that meet the requirements specified under the terms of this Agreement and the RFP.

1.5 HSD/MAD shall award risk-based contracts to the contractors with statutory authority to enter into capitated agreements, assume risk and meet applicable requirements and/or standards delineated under state and federal laws and regulations 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.

1.6 The CONTRACTOR must possess the required authorization and expertise to meet the terms of this Agreement.

1.7 The CONTRACTOR shall be National Committee for Quality Assurance ("NCQA") accredited.

1.8 The parties to this Agreement 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 agreements in writing prior to implementation of any new contract requirements.

1.9 HSD/MAD may, in the administration of this contract, seek input on health care related issues from any advisory group or steering committee. HSD/MAD may seek the input of the CONTRACTOR on issues raised by advisory groups or steering committees that may affect the CONTRACTOR.

1.10 The CONTRACTOR shall make reasonable efforts to notify HSD/MAD of the CONTRACTOR's or its subcontractors' potential public relations issues that could affect HSD/MAD or the Agreement.

Now, therefore, in consideration of the mutual promises contained herein, HSD/MAD and the CONTRACTOR agree as follows:

ARTICLE 2 – SCOPE OF WORK

2.1 MEMBER SERVICES/MEMBER EDUCATION

The CONTRACTOR shall comply with all requirements listed in NMAC 8.305.2.9 and NMAC 8.306.2.9. The CONTRACTOR shall adhere to procedures developed by HSD/MAD, consistent with applicable laws, rules and regulations, governing the following activities: (1) development of information and educational materials; (2) provision of materials explaining the enrollment options and process to potential enrollees/members; and (3) provision of informational presentations to potential enrollees, enrollees/members, member advocates and other interested parties. Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an enrollee of a specific MCO. Enrollee means a Medicaid recipient who is currently enrolled in an MCO in a specific managed care program.

The CONTRACTOR shall employ sufficient staff to coordinate communication with members and perform other Member Service functions as required by this Agreement. There should be sufficient staff to allow members to resolve problems or inquiries.

A. Policies and Procedures

The CONTRACTOR shall have and comply with written policies and procedures regarding the treatment of minors; adults who are in the custody of the State; children and adolescents who are under the jurisdiction of the Children, Youth and Families Department (CYFD); and any individual who is unable to exercise rational judgment or give informed consent, under applicable federal and state laws and regulations. The CONTRACTOR shall maintain and comply with written policies and procedures:

(1) that describe a process to detect, measure, and eliminate operational bias or discrimination against enrolled members by the CONTRACTOR or its subcontractors;

(2) regarding members' and/or legal guardians' right to select a primary care provider ("PCP") and to make decisions regarding needed social services and supports;

(3) that are specifically mandated in the managed care Medicaid regulations to be made available upon request to members and their representatives for review during normal business hours. The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of informational materials for members; and

(4) regarding advanced directives. The CONTRACTOR shall provide adult members with written information on advance directives that includes a description of applicable state and federal law and regulation. The information must 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. The CONTRACTOR shall ensure that:

a. written information is provided to adult members concerning their rights to accept or refuse medical or surgical treatment and to formulate advance directives, and the CONTRACTOR's policies and procedures with respect to the implementation of such rights including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

b. documentation exists in the member's medical record whether or not the member has executed an advanced directive;

c. discrimination against members is prohibited in the provision of care or in any other manner discriminating against a member based on whether the member has executed an advance directive;

d. compliance with requirements of federal and state laws respecting advance directives;

e. members are informed that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency; and

f. education is provided for staff, the provider network, and the community on issues concerning advance directives.

B. Initial Information

Salud! and SCI members shall be educated about their rights, responsibilities, service availability, and administrative roles under the managed care system. Member education is initiated when members become eligible for Salud! or SCI and is augmented by information provided by HSD/MAD and the CONTRACTOR.

C. MCO Enrollment Information

(1) For Salud! members:

Once a member is determined to be a Salud! mandatory member, HSD/MAD provides specific information about services included in the benefit packages, contractors from which the member can choose, and enrollment of the member(s). The CONTRACTOR shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken, as provided by HSD/MAD to the CONTRACTOR at the time of enrollment of each Salud! member.

(2) For SCI members:

An employer chooses the CONTRACTOR in which it wishes to enroll its employees. An individual, not affiliated with an employer enrolling directly into SCI chooses the CONTRACTOR in which he/she wishes to enroll. Information about services that are included in the CONTRACTORs benefit package is provided by the CONTRACTOR.

D. Member Handbook and Provider Directory

The CONTRACTOR shall send a provider directory and member handbook to Salud! and SCI members or potential members who request a copy and when HSD/MAD requests them. The CONTRACTOR may direct a person requesting a member handbook or a provider directory to an Internet site. However, the CONTRACTOR shall meet a specific request for a printed document. The CONTRACTOR shall provide a one-page, two-sided summary of its benefits, which may be distributed by HSD/MAD at its discretion.

(1) The CONTRACTOR is responsible for providing members or potential members, upon request, with a member handbook and provider directory within thirty (30) days of the CONTRACTOR being notified by HSD/MAD of the member's enrollment. The CONTRACTOR must notify all members at least once per year, in a newsletter or other written form of correspondence, of their right to request and obtain this information.

(2) The member handbook shall contain all necessary and mandated information contained in 42 CFR, Section §438.10(f)(6) including:

a. the amount, duration and scope of all benefits, services and goods included in and excluded from coverage in sufficient detail to ensure that members understand the benefits to which they are entitled;

b. procedures for obtaining benefits including services for which prior authorization or a referral is required and the methods for obtaining both;

c. any restrictions on member's freedom of choice among network providers;

d. how to access after-hours, emergency and post stabilization services, to also include:

i. what constitutes an emergency medical condition, emergency services and post stabilization services as per definitions in 42 CFR §438.114(a);

ii. the fact that prior authorization is not required for emergency services;

iii. the process and procedure for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and

iv. the fact that, subject to the provisions of this section, the member has the right to use any hospital or other setting for emergency care;

e. information regarding grievances, appeals and fair hearing procedures and timeframes including all pertinent information provided in 42 CFR §438.400 and § 438.424.

For State fair hearings:

i. the right to hearing;

ii. the method for obtaining a hearing;

iii. the rules that govern representation at the hearing;

iv. that the parties to the fair hearings include the CONTRACTOR as well as the member and his or her representative or the representative of a deceased member's estate; and

v. requirements for continuation of the benefits during the hearing process, including that the member may be responsible for payment of these continued benefits if the ruling is adverse to the member.

For grievances and appeals:

i. the right to file grievances and appeals;

ii. the requirements and timeframes for filing grievances or appeals;

iii. the availability of assistance in the filing process;

iv. the toll-free numbers that the member may use to file a grievance or appeal by phone; and

v. requirements for the continuation of benefits during the appeal process, including that the member may be responsible for payment of these continued benefits if the ruling is adverse to the member.

f. the CONTRACTOR's policy on referral for specialty care and other benefits;

g. the right to access a second opinion from a qualified health care professional within the network, or, if not available within the network, the CONTRACTOR must arrange for the member to receive a second opinion from a qualified health care professional outside of the network, at no cost to the member;

h. the Member's Bill of Rights and Responsibilities;

i. language to clearly explain that a Native American Salud! or SCI member may self refer to an IHS or a 638 Tribal health care facility for services;

j. information regarding the Birthing Options Plan; and

k. additional information that may be available upon request, including the following:

i. information on the structure and operation of the CONTRACTOR; and

ii. physician incentive plans, if applicable.

(3) The Provider Directory shall include:

a. a list of providers, by provider type and specialty, including names, locations, telephone numbers and non-English languages spoken, a means of checking the open/closed panel status, available through the CONTRACTOR and how to access them. Such list, at the option of the CONTRACTOR, may be limited to primary care providers and specialty providers, hospitals and those providers to whom members may self-refer, including, but not limited to, family planning providers, urgent and emergency care providers, Indian Health Services (IHS) and other Native

American providers (including hospitals, outpatient clinics, pharmacies and dental clinics), and Pharmacies; and

b. upon request, the CONTRACTOR shall provide information on the participation status of any provider and the means for obtaining more information about providers who participate in the MCO, including open and closed panel status which must be updated regularly and made available on the internet.

(4) Member handbooks and provider directories shall be written in other than English if, in the CONTRACTOR's or HSD/MAD's determination, there is a prevalent population i.e. five percent (5%) or more of the CONTRACTOR's members who are conversant only in those languages. The CONTRACTOR shall assist HSD/MAD in establishing a methodology for identifying prevalent non-English languages spoken by members and potential members. The CONTRACTOR shall be responsible for notifying potential members upon request and enrolled members on how to access these materials.

(5) Other Requirements:

All Member material shall:

a. 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. 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 and have a process in place for notifying potential members and members of the availability of these alternative formats; and

c. have an oral interpretation available free of charge to potential members or members. Oral interpretations shall be available to all non-English languages, not just those languages the CONTRACTOR and HSD/MAD determine to be prevalent. The CONTRACTOR shall notify potential members and members that oral interpretation is available in any language, that written information is available in prevalent languages and about how to access this information.

E. Healthcare Assessment Questionnaire

The CONTRACTOR shall send a healthcare assessment questionnaire to each new member within thirty (30) calendar days of the enrollment. This questionnaire must include a question regarding the new member's primary language spoken and/or written.

F. Health Education

The CONTRACTOR shall provide a continuous program of health education without cost to members. Such a program may include publications (e.g., brochures, newsletters), media (e.g., films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction.

G. Maintenance of Toll-Free Line

The CONTRACTOR shall maintain one (1) or more toll-free telephone line(s) accessible twenty-four (24) hours a day, seven (7) days a week, to facilitate member access to qualified clinical staff. Members may also leave a voice mail message to obtain the CONTRACTOR's policy information and /or to register grievances with the CONTRACTOR. The phone call shall be returned the next business day by an appropriate CONTRACTOR staff person.

H. Member Services Meetings

The CONTRACTOR shall meet as requested by HSD/MAD staff for member services meetings. Member services meetings are held to plan outreach and enrollment activities and events which will be jointly conducted by the CONTRACTOR and HSD/MAD.

I. Member Notification

(1) The CONTRACTOR shall adopt written policies and procedures to require prompt notification of abnormal results of diagnostic laboratory, diagnostic imaging, and other testing and, if clinically indicated, to notify the member of a scheduled follow-up visit. This shall be documented in the member's record.

(2) When the member's enrollment is terminated due to loss of eligibility, the CONTRACTOR shall provide information to the member about other public programs available though the *Insure New Mexico!/New Mexikids* Solutions Center. This shall be documented in the member's record maintained by the CONTRACTOR.

(3) The CONTRACTOR shall provide affected members and/or legal guardians with written updated information within thirty (30) days of the intended effective date of any material change. In addition, the CONTRACTOR shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of termination notice to each member who received his or her primary care from the terminated provider.

(4) HSD/MAD shall review and approve all notification to members, with the exception of health education materials.

2.2 CONTRACT MANAGEMENT

HSD/MAD shall be responsible for the management and oversight of the Salud! and SCI contracts. The CONTRACTOR shall comply with all requirements set forth in NMAC 8.305.3.10 and NMAC 8.306.3.10. The CONTRACTOR shall comply with all federal and state law in regards to:

A. CONTRACTOR Compliance

The CONTRACTOR must, to the satisfaction of HSD/MAD, comply with:

(1) all provisions set forth in this Agreement; and

(2) all applicable provisions of federal and state laws, regulations, waivers and variances including the implementation of a compliance plan.

B. Provider Incentive Plans

Pursuant to 42 CFR §417.479(a), no specific payment may be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member. If the CONTRACTOR makes payments under a plan covered by 42 CFR §417.479, the CONTRACTOR shall disclose to HSD/MAD the information on physician incentive plans set forth in 42 CFR §417.479(h)(ii)-(iv) at the times required by 42 CFR §434.70(a)(3) to allow HSD/MAD to determine whether the incentive plans meet the requirements of 42 CFR §417.479(d) through ((g). The CONTRACTOR shall provide such data required by 42 CFR §479(h)(1)(iv) for the previous calendar year to HSD/MAD by contract renewal date annually for the course of this Agreement. If the CONTRACTOR makes payments under a plan covered by 42 CFR §417.479, the CONTRACTOR shall provide the information on its

physician incentive plans allowed by 42 CFR §417.479(h)(3) to any Medicaid recipient upon request including:

(1) whether services not furnished by the physician/group are covered by an incentive plan. No further disclosure required if the physician incentive plan does not cover services not furnished by the physician/group;

(2) type of incentive arrangement, e.g., withhold, bonus, capitation;

(3) percent of withhold or bonus (if applicable);

(4) panel size and if members are pooled, the approved method used;

(5) if the physician/group is at substantial financial risk for covered services or for services not performed by the physician/group; the CONTRACTOR must report proof the physician/group has adequate stop loss coverage, including amount and type of stop loss; and

(6) if the CONTRACTOR is required to do a member survey of affected population due to having a physician incentive plan, the survey results must be disclosed to HSD/MAD or, upon request, to members.

C. Organizational Requirements

(1) Organizational structure

The CONTRACTOR shall provide the following information to HSD/MAD and updates, modifications and amendments to HSD/MAD within thirty (30) days of the start of this Agreement and within thirty (30) days of material changes thereto:

(a) current organizational charts;

(b) articles of incorporation, bylaws, partnership agreements or similar documents;

(c) documents describing the CONTRACTOR's relationship to parent affiliated or related business entities; and

(d) the name of any person or corporation that has five percent (5%) or more ownership or controlling interest in the CONTRACTOR's organization.

(2) Policies, procedures and job descriptions

The CONTRACTOR shall establish and maintain written policies, procedures and job descriptions. Substantive modifications or amendments to key positions must be reviewed by HSD/MAD.

The CONTRACTOR shall:

(a) review all policies and procedures at least every two (2) years for compliance and applicability;

(b) distribute to providers all necessary information to meet contract requirements;

(c) have administrative, information and other necessary systems in place to meet contractual requirements;

(d) meet minimum requirements per federal and state law in respect to solvency and performance guarantees; and

(e) have a member services function that coordinates communications with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries.

D. Consumer Advisory Board

(1) The CONTRACTOR shall comply with NMAC 8.305.3.11 and NMAC 8.306.3.11 regarding Organizational Structure and all Consumer Advisory Board requirements and responsibilities.

(2) The CONTRACTOR's Consumer Advisory Board shall keep a written record of all attempts to invite and include its members in its meetings. The Board roster and minutes shall be made available to the State, upon request.

(3) The Consumer Advisory Board shall consist of a fair representation of the CONTRACTOR's members in terms of race, gender, advocates and providers.

(4) The Consumer Advisory Board shall include regional representation of members, advocates and providers. The CONTRACTOR shall host quarterly centralized meetings and two regional meetings each contract year to solicit information regarding access to care, service delivery and other health care delivery issues concerning its members. A separate board shall be

established for Salud! and SCI members unless the SCI enrollment falls below twenty-five hundred (2500) members in which case at least three (3) SCI members must be included in the Salud! Consumer Advisory Board.

E. Administrative Burden

The CONTRACTOR shall:

(1) participate in work groups to consolidate and standardize all provider specific forms (including service authorization forms) across all plans;

(2) spend no more than fifteen percent (15%) of all combined Salud! and SCI revenue, net of premium taxes, adjustments and New Mexico Medical Insurance Pool (NMMIP) assessments, on administrative costs, including administrative expenses for all delegated entities over the life of the Agreement. HSD/MAD reserves the right, in accordance with and subject to the terms of this Agreement, which shall include but not be limited to the terms of Article 11 and the execution of mutually agreed upon amendment in accordance with Article 34, to reduce or increase the maximum allowable percentage for administrative expenses over the course of this Agreement. Administrative costs shall be no more than fifteen percent (15%) over the life of this Agreement. Revenue includes, but is not limited to, all capitations net of premium tax, adjustments and NMMIP assessments or other payments from HSD/MAD; all collections and recoveries; and, all interest earned exclusively on the CONTRACTOR's segregated Medicaid reserve accounts required to be maintained by the CONTRACTOR under this Agreement.

(3) have net profit/margins of no more than three percent (3%) of revenue generated in the aggregate for all programs, not including the Premium Assistance programs, covered under this Agreement. Excess profit margins shall be expended on service-related programs as designated by HSD/MAD or recommended by the CONTRACTOR and approved by HSD/MAD; and

(4) use current technology when reasonably available to minimize administrative burdens for subcontracted and provider staff.

(5) Notwithstanding anything in this Agreement to the contrary, HSD/MAD agrees that all calculations to determine whether the maximum net profit/margin threshold has been met (or exceeded) shall be based over the entire term of the Agreement, not including

Premium Assistance Program. HSD/MAD also agrees that because the maximum percentage specified may be different from year to year, all calculations to determine compliance with the maximum percentage may be performed on a weighted average basis.

F. Contract Enforcement

HSD/MAD shall enforce contractual and state and federal regulatory requirements specified in this Agreement. Refer to Article 7 – Enforcement for specific details.

G. CONTRACTOR's Incentive Requirements

HSD/MAD may provide incentives to the CONTRACTOR that receives exceptional grading during the procurement process and for ongoing performance under the Agreement for quality assurance standards, performance indicators, enrollment processing, fiscal solvency, access standards, encounter data submission, reporting requirements, Third Party Liability and/or other collections and marketing plan requirements as determined by HSD/MAD by automatically assigning a greater number of those members that do not select a Contractor to the CONTRACTOR determined by HSD/MAD to warrant greater assignments of such Salud! recipients.

2.3 MANAGED CARE ELIGIBILITY

The CONTRACTOR shall comply with all requirements of NMAC 8.305.4 and NMAC 8.306.4.

A. Eligibility – Salud!

(1) HSD/MAD shall determine eligibility for enrollment in the Salud! program. All Medicaid eligible members are required to participate in the Salud! managed care program except for the following:

a. dual eligible members e.g., Medicaid/Medicare eligible;

b. institutionalized members e.g. those residing for greater than thirty (30) days in nursing facilities;

c. members residing in intermediate care facilities for the mentally retarded;

d. members participating in the Health Insurance Premium Program (HIPP);

e. children and adolescents in out-of-state foster care or adoption placement;

f. Native Americans who have the option to voluntarily enroll with the CONTRACTOR;

g. clients eligible for Medicaid category 029, family planning services only;

h. members who will be transitioning to the Coordinated Long Term Services (CoLTS) including the following:

i. members receiving adult Personal Care Option (PCO) services;

ii. members approved for the CoLTS C Home and Community-Based Waiver, categories of eligibility 091, 093 and 094; and

iii. members approved for the Mi Via Home and Community-Based Waiver, including but not limited to, category of eligibility 091, 092, 093, and 094; and

i. adults ages nineteen (19) through sixty-four (64) eligible for Category 062, 063 and 064, State Coverage Insurance.

B. Special Situations – Salud!

(1) Newborn Enrollment

Medicaid eligible newborns of Salud! eligible enrolled mothers are eligible for a period of twelve (12) months starting with the month of birth. When a child is born to a mother enrolled with a Salud! CONTRACTOR, hospitals, other providers, or the CONTRACTOR shall complete a Notification of Birth, MAD Form 313. This process shall be completed by the hospital, other provider, or the CONTRACTOR prior to or at the time of discharge in order to ensure that the newborn shall be enrolled with the same Salud! CONTRACTOR as the mother. HSD/MAD shall be responsible to ensure that the newborn is immediately enrolled in Medicaid upon receipt of the MAD Form 313. Parents or legal guardians may, however, choose a different CONTRACTOR for the newborn as early as the second month of life. In this case, the mother's CONTRACTOR will only be entitled to capitation for the

newborn's birth month. The CONTRACTOR is responsible under the terms of this Agreement for care of a newborn born to a Salud! enrolled mother, whose eligibility is determined through daily rosters provided by HSD/MAD or by the CONTRACTOR's required follow-up of the MAD 313 form. The CONTRACTOR is not responsible for care of a child hospitalized during enrollment until discharge except for Medicaid enrolled newborns born to CONTRACTOR enrolled mothers.

(2) Hospitalized Members

Salud! MCO and Medicaid Fee-for-Service (FFS) Members:

If an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the originating MCO or Fee-For Service ("FFS") shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico Department of Health. The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud!

Salud! MCO and CoLTS MCO Members:

For members transitioning to or from CoLTS, the originating CONTRACTOR shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud!.

For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE.

Salud! MCO and Centennial Care MCO Members:

For members transitioning to a Centennial Care MCO, the CONTRACTOR shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to Centennial Care. Services provided at a free-standing psychiatric hospital or within a psychiatric unity

of an acute-care hospital are the responsibility of the SE and/or the Centennial Care MCO.

(3) Native Americans

Native Americans can choose to participate in Salud! or remain in Fee For Service Medicaid (exempt). Native Americans who choose to be in Salud! are subject to the same lock-in provisions as other Salud! members.

(4) Salud! Members Receiving Hospice Services

Salud! Members who have elected and are receiving hospice services prior to enrollment in managed care shall be exempt from enrolling with a contractor unless they revoke their hospice election.

(5) Salud! Members Placed in Nursing Facilities

If a member is placed in a nursing facility for what is expected to be a long-term or permanent placement, the CONTRACTOR remains responsible for the member until the member is disenrolled from Salud! and enrolled into the CoLTS program at the time their nursing facility determination (the approved abstract) is entered into the Medicaid Management Information System ("MMIS") system.

(6) Parents of Dependent Children under 100% Federal Poverty Level (FPL)

Parents of dependent children under 100% FPL currently enrolled in SCI (COE 062, 063 or 064) may be transitioned into Salud! at any time during the term of this Agreement. If transitioned into Salud!, these members will be placed into the CONTRACTOR's appropriate existing cohort.

(7) Presumptive Eligible Children and Pregnant Women

HSD/MAD may enroll presumptive eligibles (children and pregnant women for whom federal guidelines allow a presumption of eligibility prior to a complete Medicaid application process) into Salud! for the two-month period of their eligibility. The CONTRACTOR shall perform aggressive outreach to these members so that before the end of their presumptive eligibility period, they have applied for regular Medicaid and, as applicable, been approved for ongoing regular Medicaid eligibility.

C. Eligibility – SCI

(1) All SCI eligible members must participate in the SCI managed care program.

(2) Employer Application Process

The CONTRACTOR shall review employer group applications to verify the employer meets the CONTRACTOR's participating employer criteria, which must not include medical underwriting. If the employer meets all applicable requirements, the CONTRACTOR shall accept enrollment of SCI members upon establishment of their eligibility by HSD/MAD and provide the employer with notification of acceptance of the group.

(3) Eligibility for Employer Groups

For employer groups, which are accepted by the employer-designated CONTRACTOR, employees will be notified and asked to send application forms to the appropriate HSD/MAD eligibility office. HSD/MAD or its agent shall determine eligibility for the SCI program. If an individual is determined eligible for SCI, he or she will receive notification from HSD/MAD. HSD/MAD will also notify CONTRACTOR of the eligibility status. The CONTRACTOR shall enroll SCI members upon receipt of the appropriate premium.

(4) Individual Application Process

Individuals must apply for the SCI program with HSD/MAD or its agent. An eligibility determination will be made by the 45th day after the date of application. The CONTRACTOR shall accept enrollment of SCI members upon establishment of their eligibility by HSD/MAD and receipt of the appropriate premium.

(5) Eligibility for Individuals

HSD/MAD or its agent shall determine eligibility for the SCI program. If an individual is determined eligible for SCI, he or she will receive notification from HSD/MAD. HSD/MAD will also notify CONTRACTOR of eligibility status. An individual determined to be eligible for SCI will remain eligible, in the designated income grouping, for a period of twelve (12) continuous months, regardless of changes in income. The calculated premiums, copayments and cost-sharing maximum

amounts will remain in effect for the benefit year following the eligibility determination.

D. Special Situations - SCI

(1) Newborn enrollment

SCI enrolled mothers may apply for Medicaid for their newborn. If Medicaid eligible, the newborn is enrolled into Salud! during the next applicable enrollment cycle.

(2) Hospitalized Members

Individuals who are hospitalized in a general acute care or rehabilitation hospital at the time when initially determined eligible for SCI may enroll with the CONTRACTOR. However, the CONTRACTOR shall not be responsible for such member's costs until the discharge from the hospital. Enrollees shall receive notification of this limitation to coverage as part of the HSD's eligibility process.

2.4 ENROLLMENT IN MANAGED CARE

The CONTRACTOR shall comply with all requirements noted in NMAC 8.305.5 and NMAC 8.306.5.

A. Enrollment Requirements

As required by 42 C.F.R. §434.25, the CONTRACTOR shall accept eligible individuals, in the order in which they apply and:

(1) without restriction, and pursuant to waiver authority, unless authorized by the CMS Regional Administrator;

(2) up to the limits established pursuant to the Agreement;

(3) all enrollments shall be voluntary, and the CONTRACTOR shall not discriminate against eligible individuals on the basis of health status, need for health services, disability, race, color, national origin or sexual orientation and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin; and

(4) the CONTRACTOR shall assume responsibility for all covered medical conditions of each member inclusive of pre-existing conditions as of the effective date of enrollment.

B. Maximum Medicaid Enrollment

HSD/MAD and the CONTRACTOR may mutually agree in writing to establish a maximum Medicaid enrollment level for Medicaid beneficiaries:

(1) The maximum Salud! enrollment also may be established by HSD/MAD on a statewide or county-by-county basis based on the capacity of the CONTRACTOR's provider network, or to ensure that the CONTRACTOR has the capacity to provide statewide Medicaid services to its enrollment or at HSD/MAD's reasonable discretion. Subsequent to the establishment of this limit, if the CONTRACTOR wishes to change its maximum enrollment level, the CONTRACTOR shall notify HSD/MAD in writing ninety (90) calendar days prior to the desired effective date of the change. All requests for changing maximum enrollment levels must be approved by HSD/MAD before implementation. Should a maximum enrollment level be reduced to below the actual enrollment level, HSD/MAD may disenroll members to establish compliance with the new limit.

(2) The maximum SCI enrollment may be established by HSD/MAD in compliance with terms established in the State's Section 1115 CHIPRA Demonstration Waiver for parents and the Section 1115 Medicaid Demonstration Waiver for childless adults and based on available funds to the State. Maximum enrollment may also be established by HSD/MAD on a statewide or county-by-county basis based on the capacity of the CONTRACTOR's provider network and resources or to ensure that the CONTRACTOR has the capacity for statewide enrollment. If the CONTRACTOR wishes to change its maximum enrollment level, the CONTRACTOR shall notify HSD/MAD in writing ninety (90) days prior to the desired effective date of the change. All requests for changing maximum enrollment levels must be approved by HSD/MAD before implementation. Should a maximum enrollment level be reduced to below the actual enrollment level, HSD/MAD may disenroll members to establish compliance with the new limit.

(3) Adjustment of Automated Assignment Formula. HSD/MAD may selectively assign Salud! members who have not selected a CONTRACTOR.

C. Salud! Enrollment

(1) Minimum Selection Period

A new member shall have at a minimum sixteen (16) calendar days from the date of eligibility to select a contractor from the provided information. The new member can select anytime during this selection period..

(2) Begin Date of Enrollment

Enrollment generally shall begin the first day of the first full month following selection or assignment to a contractor.

(3) Member Switch and Loss of Medicaid Eligibility

A current contractor member has the opportunity to change contractors during the first ninety (90) days of a twelve (12)-month period. HSD/MAD shall notify the contractor's members of their opportunity to select a new contractor. A member is limited to one ninety-day (90) switch period per contractor. After exercising the switching rights, and returning to a previously selected contractor, the member shall remain with the contractor until his/her twelve (12) month lock-in period expires before being permitted to switch contractors.

If a member loses Medicaid eligibility for a period of six (6) months or less, he/she will be automatically reenrolled with the former. If the member misses the annual disenrollment opportunity during this six (6) month time, he/she may request to be assigned to another contractor.

(4) HSD/MAD Exemptions

HSD/MAD shall grant exemptions to mandatory Salud! enrollment based upon criteria established by HSD/MAD. A member or his or her representative, parent, or legal guardian shall submit such requests in writing to HSD/MAD, including a description of the special circumstances justifying an exemption. Requests are evaluated by HSD/MAD clinical staff and forwarded to the HSD/MAD Medical Director or his/her designee for final determination.

D. SCI Enrollment

(1) Minimum Selection Period

a. Individuals, not affiliated with an employer, choose a contractor at the time an SCI application is submitted to the Income Support Division (ISD) office. A new member must complete enrollment with this contractor within ninety (90) days of receiving an eligibility letter from ISD. If enrollment is not completed, including payment of any required premium, the enrollee will be considered to have voluntarily dropped the SCI coverage and will have to wait for six (6) months before reapplying.

b. Employer groups choose a contractor at the time an SCI application is submitted to the ISD office. An employer group has a specified timeframe determined by the contractor and HSD/MAD in which to complete enrollment and premium payment with the contractor after all employees have received their letters of eligibility. Failure of the employer to complete the enrollment process within this time period will deem the employer to have voluntarily dropped insurance coverage and the employer will be ineligible to enroll with a contractor for a twelve (12) month period; however, the individual employees are eligible to enroll immediately as individuals and will not be considered to have voluntarily dropped health insurance coverage.

(2) Member Switch Enrollment

a. An individual member not enrolled with an employer group may request to be disenrolled from a contractor for an HSD/MAD approved cause at any time and without cause upon recertification.

b. Members of an employer group must remain with their employer-designated contractor. Members may only switch to another contractor during the employer enrollment period if the employer contracts with another contractor, or if the member changes employers. An employee enrolled in SCI as an individual whose employer is offering SCI employer-sponsored insurance for the first time will be able to participate in SCI under the employer group coverage and will not be subject to the six-month lock-out for disenrolling from individual SCI coverage in order to participate in the employer plan. The employer has the option to switch contractors every twelve (12) months.

E. SCI Enrollment Process

(1) Potential Enrollee File

HSD/MAD shall send the CONTRACTOR a weekly Potential Enrollee File. This file shall contain all individuals from the past week who became eligible to enroll in SCI for the first time or who completed recertification of their twelve (12) month eligibility period. The CONTRACTOR shall use the information on the Potential Enrollee File to contact individuals and initiate the enrollment process.

(2) Reverse Roster and Reverse Roster Error Files

The CONTRACTOR shall track eligible members who are to be enrolled or terminated each month and report this information to HSD/MAD via the monthly Reverse Roster. HSD/MAD will edit this File and send a Reverse Roster Error File back to the CONTRACTOR if indicated.

(3) Enrollment Roster File and Capitation

A monthly Enrollment Roster is produced from successful reverse roster entry information to inform the CONTRACTOR of all current and updated enrollees and terminations.

(4) Begin Date of Enrollment

Enrollment generally shall begin the first day of the first full month following selection of a contrator and receipt of applicable premium. If a premium payment is required by the CONTRACTOR and is not received by the CONTRACTOR by the 25th day of the month, the enrollment begins on the first day of the second full month after CONTRACTOR receipt of premium payment.

(5) The CONTRACTOR will be required to report employment status of all members for tracking purposes, as directed by HSD/MAD, to ensure that appropriate reporting is achieved.

F. Disenrollment – CONTRACTOR Initiated for Salud! Members

Member disenrollment shall only be considered in rare circumstances. The CONTRACTOR may request that a particular member be disenrolled. Disenrollment requests shall be submitted in writing to HSD/MAD. The

request and supporting documentation shall meet requirements specified by HSD/MAD. If the disenrollment request is granted, the CONTRACTOR retains responsibility for the member's care until such time as the member is enrolled with a new CONTRACTOR and is responsible for transitioning the member. If a request for disenrollment is approved, the member shall not be re-enrolled with the CONTRACTOR for a period of time to be determined by HSD/MAD. Conditions that may permit lockout or disenrollment are:

(1) the CONTRACTOR demonstrates that it has made a good faith effort to accommodate the member's health care or other medically necessary covered needs, but such efforts have been unsuccessful;

(2) the conduct of the member is such that it is not feasible, safe or prudent to provide medical care subject to the terms of the contract;

(3) the CONTRACTOR has offered to the member in writing and other means, reasonably calculated to apprise the member of the opportunity to utilize the grievance procedures;

(4) the CONTRACTOR shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the CONTRACTOR seriously impairs the CONTRACTOR's ability to furnish services to either this particular member or other members). The CONTRACTOR shall provide adequate documentation that the CONTRACTOR's request for termination is proper; or

(5) the CONTRACTOR has received threats or attempts of intimidation from the member to the CONTRACTOR, providers or its own staff.

G. Disenrollment – CONTRACTOR Initiated for SCI Members

For individual SCI members, other than for non-payment of premiums or copayments, member disenrollment follows the same process in place for Salud! members and is an option at any time for cause. If a member is part of an employer group and the employer terminates the contract with the CONTRACTOR, HSD/MAD may allow the member to enroll with a different CONTRACTOR but the member will then be responsible for the employer's premium share, if required.

H. Disenrollment – Initiated by Salud! Member

A member who is required to participate in managed care may request to be disenrolled from the CONTRACTOR "for cause" at any time, even during the lock-in period as set forth in Section 2.4(C)(3). The member must submit a written request to HSD/MAD for approval. HSD/MAD must respond no later than the first day of the second month following the month in which the member files the request or else the request is automatically approved. The Salud! member will have access to the HSD Fair Hearing process if he or she is dissatisfied with the determination denying the request to transfer plans or disenroll.

The following are causes for disenrollment:

(1) the member moves out of the CONTRACTOR's service area;

(2) the CONTRACTOR does not, because of moral or religious objections, cover the service the member seeks;

(3) the member needs related services (for example, a caesarian section and a tubal ligation) to be performed at the same time, there is no network provider able to do this and another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(4) other reasons, including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

I. Disenrollment – Initiated by SCI Member

An SCI member who is not enrolled through an employer group may request to be disenrolled from the CONTRACTOR "for cause" at any time, even during a lock-in period. This request shall be submitted in writing to HSD/MAD for review. HSD/MAD shall complete the review and send a written decision to the member and the CONTRACTOR in a timely manner.

J. Mass Transfer Process

The CONTRACTOR shall have HSD/MAD approved mass transfer process policies and procedures in place, which include the mass transfer of members upon sixty (60) days written notice by HSD/MAD.

K. Outreach: Outreach is the means of educating or informing the CONTRACTOR's actual or potential members about health issues.

The CONTRACTOR shall:

(1) support outreach efforts for Medical Assistance Division programs including participation in agreed upon coordinated efforts with HSD/MAD;

(2) provide a detailed marketing plan including a budget that identifies specific line item allocations for SCI and Salud! outreach;

(3) submit these plans for approval by HSD/MAD within thirty (30) days of the date of this Agreement and by July 31 of each contract year; and

(4) provide quarterly reports regarding specific SCI and Salud! outreach efforts, funds expended and outcomes including number of contacts, to HSD/MAD.

L. Marketing

(1) For the purposes of this Agreement, the term marketing means any communication from a contractor to a potential Medicaid member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the potential member to enroll with that particular contractor's Medicaid product, or either to not enroll or to disenroll from another Contractor's Medicaid product.

(2) The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of marketing materials for members.

(3) Marketing materials shall be any materials produced in any medium by or on behalf of the CONTRACTOR that can reasonably be interpreted as intended to market to potential members.

(4) HSD/MAD shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at members before use.

a. The CONTRACTOR shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance, not including public/private partnerships.

b. The CONTRACTOR shall specify the methods by which the entity assures HSD/MAD that marketing materials are accurate and do not mislead, confuse, or defraud the members or HSD/MAD. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

i. the member must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits; or

ii. the CONTRACTOR is endorsed by CMS, the federal or state government, or similar entity.

(5) 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 Salud! and SCI members, as set forth in NMAC 8.305.5.13 and 8.306.5.14; and

b. all marketing and/or outreach materials produced by the CONTRACTOR under the Agreement shall state that such services are funded pursuant to an Agreement with the State of New Mexico.

(6) Marketing and outreach activities not permitted under this Agreement

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

a. asserting or implying that a member shall lose Medicaid benefits if he/she does not enroll with the CONTRACTOR or inaccurately depicting the consequences of choosing a different contractor;

b. designing a marketing or outreach plan which discourages or encourages contractor selection based on health status or risk;

c. initiating an enrollment request on behalf of a Medicaid recipient except under circumstances in which the CONTRACTOR, its representative, network provider or subcontractor may perform presumptive eligibility screening and/or Medicaid on site application assistance as an agent of the State;

d. making inaccurate, false, materially misleading or exaggerated statements;

e. asserting or implying that the CONTRACTOR offers unique covered services when another contractor provides the same or similar service;

f. including the use of gifts such as diapers, toasters, infant formula, or other incentives to entice people to join a specific health plan;

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 CONTRACTOR with a potential member for the purpose of marketing. Marketing means any communication from a contractor to a Medicaid member who is not enrolled in that entity that can reasonably be interpreted as intended to influence the member to enroll in that particular contractor's Medicaid product or not to enroll in or to disenroll from another contractor's Medicaid product. The CONTRACTOR may send informational material regarding its benefit package to potential members; and

h. conducting any other marketing activity prohibited by HSD/MAD during the term of this Agreement.

(7) The CONTRACTOR shall take reasonable steps to prevent subcontractors and participating providers from committing the acts described herein; the CONTRACTOR shall be held liable only if it knew or should have known that its subcontractors or participating providers were committing the act described herein and did not take timely corrective actions. HSD/MAD reserves the right to prohibit additional marketing activities at its discretion.

M. Marketing Time Frames

The CONTRACTOR may initiate marketing and outreach activities at any time.

N. Health Education

Health Education materials may be distributed to the CONTRACTOR's members by mail or to the general public in connection with exhibits or other organized events, including but not limited to, health fair booths at community events and health plan hosted health improvement events. Health Education means programs, services or promotions that are designed or intended to inform the CONTRACTOR's actual or potential members upon request about the issues related to healthy lifestyles, situations that affect or influence health status or methods or modes of medical treatment. HSD/MAD does not require approval of health education materials.

2.5 PROVIDER NETWORKS

A. General Requirements

The CONTRACTOR shall comply with all requirements listed in NMAC 8.305.6 and NMAC 8.306.6. In all contracts with health care professionals, the CONTRACTOR must comply with the requirements specified in 42 CFR part §438.214 which include selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination, and must have policies and procedures that reflect these requirements. The CONTRACTOR shall:

(1) establish and maintain a comprehensive network of providers capable of serving all members who enroll with the CONTRACTOR. This network shall be the same for the Salud! and SCI populations, taking into account benefit plans, populations covered and other differences between the Salud! and SCI programs;

(2) pursuant to Section 1932(b)(7) of the Social Security Act, not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment;

(3) 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;

(4) upon declining to include individual or groups of providers in its network, give the affected providers written notice of the reason for its decision;

(5) not be required to contract with providers beyond the number necessary to meet the needs of its members;

(6) be allowed to use different reimbursement amounts for different specialties or for different practitioners in the same specialty;

(7) be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to members; and

(8) not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or SCHIP sanctions, except for emergency services.

B. Required Policies and Procedures

The CONTRACTOR shall:

(1) maintain written policies and procedures on provider recruitment and termination of provider participation with the CONTRACTOR. HSD/MAD shall have the right to review these policies and procedures upon demand. The recruitment policies and procedures shall describe how the CONTRACTOR responds to a change in the network that affects access and its ability to deliver services in a timely manner;

(2) require that each provider either billing or rendering services to Medicaid members has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act;

(3) annually develop and implement a training plan to educate providers and their staff on Salud! and SCI requirements and the CONTRACTOR's processes and procedures. The plan shall be submitted to HSD/MAD for review and approval on or before August 1st of each year. This training plan shall include, but is not limited to:

(a) Prior authorization process;

(b) Claims/Encounter data submission;

(c) How to access ancillary providers;

(d) Members rights and responsibilities;

(e) Quality Improvement program/Quality Improvement initiatives;

(f) Provider and member appeals and grievances;

(g) Recoupment of funds processes and procedures; and

(h) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requirements, including Preventative Healthcare Guidelines;

(4) consider, in establishing and maintaining the network of appropriate providers, its:

a. anticipated enrollment;

b. expected utilization of services, taking into consideration the characteristics and health care needs of specific Salud! and SCI populations represented in the CONTRACTOR's population;

c. numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;

d. numbers of network providers who are not accepting new Salud! or SCI patients; and

e. geographic location of providers and Salud! and SCI members, considering distance, travel time, the means of transportation ordinarily used by Salud! and SCI members; and whether the location provides physical access for Salud! and SCI members with disabilities;

(5) ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee-For-Service, if the provider serves only Salud! and SCI enrollees. The CONTRACTOR shall:

a. establish mechanisms such as notices or training materials to ensure that network providers comply with the timely access requirements;

b. monitor regularly to determine compliance; and

c. take corrective action if there is a failure to comply;

(6) require that network providers are conducting abuse registry screenings in accordance with the Employee Abuse Registry Act, NMSA 1978, §§27-7A-1 *et seq.* and §§7.1.12 and 8.11.6.1 NMAC;

(7) provide to members and providers clear instructions on how to access services, including those that require prior approval and referral;

(8) meet all availability, time and distance standards for Salud! and SCI members set by HSD/MAD and have a system to track and report this date; and

(9) provide access to out of network providers if the CONTRACTOR is unable to provide necessary medical services covered under this Agreement in an adequate and timely manner to a member and continue to authorize these services for as long as the CONTRACTOR is unable to provide these services through network providers. Out of network providers must coordinate with the CONTRACTOR with respect to payment. The CONTRACTOR must ensure that cost to the member is no greater than it would be if the services were provided within the network.

C. General Information Submitted to HSD/MAD

The CONTRACTOR shall maintain an accurate list of all active PCPs, specialists, hospitals, and other providers participating or affiliated with the CONTRACTOR. The CONTRACTOR shall submit the list to HSD/MAD on a quarterly basis and include a clear delineation of all additions and terminations that have occurred the prior quarter. The CONTRACTOR's contracts with providers must include language stating that the CONTRACTOR's providers will report any changes in their capacity to take new Medicaid members or serve current members. This list shall be provided to HSD/MAD specifically as follows, and no less frequently than:

(1) at the time the CONTRACTOR enters into a contract with HSD/MAD; or

(2) at any time there has been a significant change (as defined by HSD/MAD) in the CONTRACTOR's operations that would affect adequate capacity and services, changes in services, benefits,

geographic area or payments, or enrollment of a new population in the CONTRACTOR's organization.

D. The Primary Care Provider (PCP)

(1) The PCP shall be a medical provider participating with the CONTRACTOR who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of the member's care. The CONTRACTOR shall distribute information to the network providers that explains the Medicaid-specific policies and procedures relating to PCP responsibilities. The CONTRACTOR is prohibited from excluding providers as primary care providers based on the proportion of high-risk patients in their caseloads. The CONTRACTOR shall:

a. ensure that each member has an ongoing source of primary care appropriate to his or her needs and that such source of primary care is a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;

b. coordinate the services the CONTRACTOR furnishes to the member with the services the member receives from any other Contractor;

c. share with other Contractors serving the member the results of its identification and assessment of any member with special health care needs so that these activities need not be duplicated; and

d. ensure that, in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

(2) The CONTRACTOR may designate the following types of providers as PCPs, as appropriate:

a. medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, gynecology and pediatrics;

b. certified nurse practitioners, certified nurse midwives and physician assistants;

c. specialists, on an individualized basis, for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness or disabilities;

d. primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include certified mid-level practitioners who, at the member's request, may serve as the point of first contact; in both instances, the CONTRACTOR shall organize its team to ensure continuity of care to members and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician (medical students, interns and residents may not serve as "lead physician"); or

e. other providers that meet the credentialing requirements for PCPs.

E. Primary Care Responsibilities

The CONTRACTOR shall ensure that the following primary care responsibilities are met by the PCP, or in another manner:

(1) the PCP shall provide twenty-four (24)-hour, seven (7)-day-a-week access;

(2) the PCP shall ensure coordination and continuity of care with providers who participate with the CONTRACTOR network and with providers outside the CONTRACTOR network according to the CONTRACTOR policy; and

(3) the PCP shall ensure that the member receives appropriate prevention services for the member's age group.

F. Selection or Assignment to a PCP

The CONTRACTOR shall maintain and comply with written policies and procedures governing the process of member selection of a PCP and requests for change.

(1) Initial Enrollment. At the time of enrollment, the CONTRACTOR shall ensure that each member has the freedom to choose a PCP within a reasonable distance from the member's place of residence.

The process whereby a CONTRACTOR assigns members to PCPs shall include at least the following features:

a. for SCI members, the initial enrollment application shall include a space to indicate a desired PCP selection. The CONTRACTOR shall provide the member with the means for changing a PCP within five (5) business days of processing the enrollment file if an initial PCP selection was made but the PCP was unavailable;

b. for Salud! members, the CONTRACTOR shall provide the means for selecting a PCP within five (5) business days of processing the enrollment file;

c. the CONTRACTOR shall offer freedom of choice to members in making a PCP selection;

d. if a member does not select a PCP within a reasonable period of enrollment, the CONTRACTOR shall make the assignment and notify the member in writing of his/her PCP's name, location, and office telephone number, while providing the member with an opportunity to select a different PCP if the member is dissatisfied with the assignment; and

e. the CONTRACTOR shall assign a PCP based on factors such as member age, residence, and if known, current provider relationships.

(2) Subsequent Change in PCP Initiated by Member. Members may initiate a PCP change at any time, for any reason. The request can be made in writing or by telephone. If a request is made by the 20th of a month it becomes effective as of the first of the following month. If a request is made after the 20th of the month, the change becomes effective the first day of the second month following the request.

(3) Subsequent Change in PCP Initiated by the CONTRACTOR. The CONTRACTOR may initiate a PCP change for a member under the following circumstances:

a. the member and the CONTRACTOR agree that assignment to a different PCP in the CONTRACTOR's provider network is in the member's best interest, based on the member's medical condition;

b. a member's PCP ceases to participate in the CONTRACTOR's network;

c. a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member;

d. a member has initiated legal actions against the PCP; or

e. the PCP is suspended for potential quality or fraud and abuse issues.

(4) In instances where a PCP has been terminated, the CONTRACTOR shall allow affected members to select a PCP or make an assignment within fifteen (15) days of the termination effective date.

(5) PCP Lock-In. HSD/MAD shall allow the CONTRACTOR to require that a member see a certain PCP when the CONTRACTOR has identified a continuing utilization of unnecessary services (a "PCP lock-in"). Prior to placing the member on PCP lock-in, the CONTRACTOR shall inform the member of the intent to lock-in, including the reasons for imposing the PCP lock-in. The CONTRACTOR's grievance procedure shall be made available to any member being designated for PCP lock-in. The PCP lock-in shall be reviewed and documented by the CONTRACTOR and reported to HSD/MAD every quarter. The member shall be removed from PCP lock-in when the CONTRACTOR has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable. HSD/MAD shall be notified of all lock-in removals.

(6) Pharmacy Lock-In. HSD/MAD shall allow the CONTRACTOR to require that a member see a certain Pharmacy provider when member compliance or drug seeking behavior is suspected (a "Pharmacy lock-in"). Prior to placing the member on Pharmacy lock-in, the CONTRACTOR shall inform the member and/or his/her representative of the intent to lock-in. The CONTRACTOR's grievance procedure shall be made available to the member being designated for Pharmacy lock-in. The Pharmacy lock-in shall be reviewed and documented by the CONTRACTOR and reported to HSD/MAD every quarter. The member shall be removed from Pharmacy lock-in when the CONTRACTOR has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the

problems is judged to be improbable. HSD/MAD shall be notified of all lock-in removals.

G. CONTRACTOR Responsibility for PCP Services

The CONTRACTOR shall retain responsibility for monitoring PCP activities to ensure compliance with the CONTRACTOR and HSD/MAD policies. The CONTRACTOR shall educate PCPs about special populations and their service needs. The CONTRACTOR shall ensure that PCPs successfully identify and refer patients to specialty providers as medically necessary.

H. Access to Services

The CONTRACTOR shall demonstrate that its network is sufficient to meet the health care needs of all enrolled members. The CONTRACTOR shall within two (2) business days, notify HSD/MAD of any material changes to the CONTRACTOR's network which adversely affect~~ing~~ access to care.

(1) The CONTRACTOR shall have written policies and procedures describing how members and providers receive access to services and information including prior authorization and referral requirements for various types of medical and surgical treatments, emergency room services and behavioral health services. The policies and procedures shall be made available in an accessible format upon request, to HSD/MAD, network providers and members.

(2) Provider to member ratios

a. The CONTRACTOR shall ensure that member caseload of any PCP does not exceed 1,500 members of the CONTRACTOR. Exception to this limit may be made with the consent of HSD/MAD.

b. HSD/MAD shall not establish specific specialist to member ratios. The CONTRACTOR must ensure that members have adequate access to specialty providers.

I. Specialty Providers

The CONTRACTOR shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of CONTRACTOR Salud! and SCI members shall be met within the CONTRACTOR network of providers. The CONTRACTOR shall also

have a system to refer members to providers who are not affiliated with the CONTRACTOR's network if providers with the necessary qualifications or certifications do not participate in the network. The CONTRACTOR must coordinate for payment to these out-of-network providers. The CONTRACTOR must ensure that cost to the members is no greater than it would be if services were provided by in network providers.

J. Publicly Supported Providers

(1) Federally Qualified Health Centers

a. Federally Qualified Health Centers (FQHCs) are federally funded Community Health Centers, Migrant Health Centers and Health Care for the Homeless Projects that receive grants under Sections 329, 330 and 340 of the US Public Health Services Act. The current Federal statute, Section 1902(a)(13)(E) of the Social Security Act, specifies that States shall guarantee access to FQHCs and Rural Health Centers (RHCs) under Medicaid managed care programs; therefore, the CONTRACTOR shall provide access to FQHCs and RHCs to the extent that access is required under Federal law.

b. The CONTRACTOR shall contract with as many FQHCs and RHCs as necessary to permit beneficiaries access to participating FQHCs and RHCs without having to travel a significant distance. At least one FQHC shall specialize in provider health care for the homeless in Bernalillo County. At least one FQHC shall be an urban Indian FQHC in Bernalillo County.

c. The CONTRACTOR shall contract with FQHCs and RHCs in accordance with the thirty (30) minute travel time standards for routinely used delivery sites. A CONTRACTOR with an FQHC or RHC on its panel that has no capacity to accept new members shall not satisfy these requirements unless there are no other FQHCs or RHCs in the area.

d. The CONTRACTOR shall offer FQHCs and RHCs terms and conditions, including reimbursement, that are at least equal to those offered to other providers of comparable services.

e. If the CONTRACTOR cannot satisfy the standard for

FQHC and RHC access at any time while the CONTRACTOR holds a Medicaid contract, the CONTRACTOR shall allow its members to seek care from non-contracting FQHCs and RHCs and shall reimburse these providers at the Medicaid fee schedule.

(2) Local Department of Health Offices

a. The CONTRACTOR must contract with public health providers for services as described in NMAC 8.305.6.15 and those defined as public health services under the Public Health Act, NMSA 1978, §§ 24-1-1 et. seq.

b. The CONTRACTOR must contract with local and district public health offices for family planning services.

c. The CONTRACTOR may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal care or prenatal case management.

d. The CONTRACTOR may require PCPs to contract with the Vaccines for Children (VFC) program administered by the Department of Health for its Salud! members.

(3) Children's Medical Services

For Salud! members, the CONTRACTOR shall contract with Children's Medical Services to administer outreach clinics at sites throughout the State. The clinics offer pediatric sub-specialty services in local communities, which include cleft palate, neurology, endocrine, asthma and pulmonary.

K. Shared Responsibility Between the CONTRACTOR and Public Health Offices

The CONTRACTOR shall coordinate with the public health offices regarding the following services:

(1) sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations;

(2) HIV prevention counseling, testing, and early intervention;

(3) Tuberculosis screening, diagnosis, and treatment;

(4) disease outbreak prevention and management, including reporting according to state law requirements, responding to epidemiology requests for information, and coordination with epidemiology investigations and studies;

(5) referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants, and Children (WIC);

(6) health education services for individuals and families with a particular focus on injury prevention including car seat use, domestic violence, and lifestyle issues, including tobacco use, exercise, nutrition, and substance use;

(7) development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education; and

(8) participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as DWI councils, maternal and child health councils, tobacco coalitions, safety counsel, safe kids and others.

L. School-Based Providers

The CONTRACTOR shall contract with the School Based Health Centers programs to provide primary care services for its Salud! members.

M. Indian Health Service (IHS) and Tribal Health Centers

(1) The CONTRACTOR shall allow members who are Native American to seek care from any IHS or a provider in a Tribal Health Program as defined in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), whether or not the provider participates in the CONTRACTOR'S provider network.

(2) The CONTRACTOR shall not prevent members who are IHS beneficiaries from seeking care from IHS, Tribal and Urban Indian Providers, or from network providers due to their status as Native Americans.

(3) The CONTRACTOR shall track IHS and 638 Tribal facilities utilization and expenditures by members. With certain exceptions, such as pharmacy, inpatient physician services, case management and ambulatory surgical center services which are paid at the fee schedule rate established by HSD/MAD, the CONTRACTOR shall

reimburse IHS and Tribal 638 facilities at the IHS all inclusive rate for inpatient and outpatient services as published annually in the federal register by the Office of Management and Budget (OMB).

(4) The CONTRACTOR shall track and report quarterly to HSD/MAD reimbursement and utilization data related to IHS and Tribal 638 facilities.

N. Family Planning Services and Providers

(1) Federal law prohibits restricting access to family planning services for Medicaid recipients. The CONTRACTOR shall implement written policies and procedures defining how Salud! and SCI members are educated about their right to family planning services, freedom of choice, and methods of accessing such services.

(2) The CONTRACTOR shall give each member, including adolescents, the opportunity to use his or her own primary care provider or go to any family planning center for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist. Clinics and providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CONTRACTOR for all family planning services which are covered benefits, regardless of whether they are participating or non-participating providers for Salud! and SCI. Unless otherwise negotiated, the CONTRACTOR shall reimburse providers of family planning services at the Medicaid rate.

(3) Non-participating providers are responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. The CONTRACTOR is not responsible for the confidentiality of medical records maintained by non-participating providers.

(4) Family planning services are defined as the following:

a. health education and counseling necessary to make informed choices and understand contraceptive methods;

b. limited history and physical examination;

c. laboratory tests if medically indicated as part of the decision making process for choice of contraceptive methods;

d. diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated;

e. screening, testing and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment;

f. follow-up care for complications associated with contraceptive methods issued by the family planning provider;

g. provision and payment of contraceptive pills and Plan B;

h. provision of devices/supplies;

i. tubal ligations;

j. vasectomies; and

k. pregnancy testing and counseling.

(5) If a non-participating provider of family planning services to a Salud! or SCI member detects a problem outside of the scope of services listed above, the provider should refer the member back to the CONTRACTOR. The CONTRACTOR is not under any HSD/MAD-initiated obligation to reimburse non-participating family planning providers for non-emergent services outside the scope of these defined services.

O Provider-Preventable Conditions (PPCs) Including Health Care-Acquired Conditions (HACs)

In accordance with Section 2702 of the Patient Protection and Affordable Care Act (P.L. 111-148)(the "ACA"), the CONTRACTOR must have mechanisms in place to preclude payment to providers for PPCs. The CONTRACTOR shall require provider self-reporting through claims systems. The CONTRACTOR will track the PPC data and report to HSD/MAD via the encounter file. PPCs including HACs apply to the Medicaid inpatient hospital settings and are defined as the full list of Medicare's HACs. To ensure member access to care, any reductions in payment to providers must be limited to the added costs resulting from the PPC. The CONTRACTOR must use existing claims systems as the

platform for provider self-reporting and report to HSD/MAD via the encounter data.

P Enhanced Payments for Primary Care Services

In accordance with Section 1202 of the ACA, the CONTRACTOR must have mechanisms in place to reimburse certain evaluation and management (E&M) services and immunization administration services furnished in calendar years 2013 by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent (100%) of the payment rate that applies to such services under Medicare Part B, as directed by CMS. The CONTRACTOR must establish payment rates for these primary care services for 2013 as to be consistent with the equivalent Fee-for-Service (FFS) Medicare Part B rate. The CONTRACTOR will submit to HSD/MAD this data for enhanced payments for primary care services via encounter data.

2.6 BENEFIT/SERVICES PACKAGE

A. General Requirements

The CONTRACTOR shall be required to provide a comprehensive coordinated and fully integrated system of health care services. The CONTRACTOR does not have the option of deleting benefits from the Medicaid defined benefit package or the State Coverage Insurance benefit and shall be responsible for ensuring to HSD/MAD that the services offered under his Agreement are provided in an amount, duration and scope that is in accordance with the requirements of applicable law. Access to Medicaid benefits must be available for physical health services directly by the CONTRACTOR's network. The CONTRACTOR shall comply with all requirements stipulated in NMAC 8.305.7 and NMAC 8.306.7.

B. Salud! Behavioral Health Services Responsibilities

Behavioral health services provided by the CONTRACTOR'S network providers will be covered by the CONTRACTOR even when the primary diagnosis is a behavioral health diagnosis. All prescriptions for drugs written by the CONTRACTOR's providers shall be paid for by the CONTRACTOR including drugs used to treat behavioral health conditions. Facility costs, including emergency room costs, will be covered by the CONTRACTOR when billed on an acute care/general hospital facility claim form, including behavioral health services provided by hospital staff.

C. Laboratory and Radiology Services

This Section is Not Applicable to SCI

Laboratory and radiology services costs shall be the responsibility of the CONTRACTOR when a Behavioral Health provider orders lab or radiology work that is performed by an outside, independent laboratory or radiology facility, including those lab and radiology services provided for persons within a psychiatric unit, a freestanding psychiatric hospital or the UNM Psychiatric emergency room.

Lab and radiology services shall be the responsibility of the Statewide Entity for Behavioral Health Services (the "SE") when they are provided within and billed by a free standing psychiatric hospital, a PPS exempt unit of a general acute care hospital or UNM Psychiatric ER. In the event that a psychiatrist orders lab work but completes that lab work in their office/facility and bills for it, the SE is responsible for the payment.

D. Anti-Gag Requirement

The CONTRACTOR shall not prohibit or otherwise restrict a covered health care professional, if the professional is acting within the lawful scope of practice, from advising or advocating for a member who is a patient of the professional for:

(1) the member's health status, medical care or treatment for the individual's condition of disease including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided for under the contract;

(2) any information the member needs in order to decide among relevant treatment options;

(3) the risks, benefits and consequences of treatment or non-treatment; or

(4) the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

This subsection, however, shall not be construed as requiring the CONTRACTOR to provide, reimburse, or provide coverage of any service if the CONTRACTOR:

(1) objects to the provision of a counseling or referral service on moral or religious grounds, provided that the CONTRACTOR notifies members of these objections at the earliest possible time, optimally during the enrollment process whether the service in question is covered or not; or

(2) in the manner and through written policies and procedures, the CONTRACTOR makes available information on its policies regarding such service to prospective members before or during enrollment and to members within thirty (30) days after the date the CONTRACTOR adopts a change in policy regarding such a counseling or referral service; or

(3) notifies HSD/MAD within ten (10) business days after the effective date of this Agreement of its current policies and procedures regarding CONTRACTOR's objection to providing such counseling or referral services based on moral or religious grounds, or within fifteen (15) calendar days after CONTRACTOR adopts a change in policy regarding such counseling or referral services; or

(4) can demonstrate that the service in question is not included in the covered benefit package required by this Agreement; or

(5) determines that the recommended service is not medically necessary as defined by the State Plan in effect with CMS as of the time the service is delivered, under the CONTRACTOR's policies and procedures, and in accordance with the definition set forth in Section 2.6(B) below.

E. Emergency and Post-Stabilization Services

The benefit package includes emergency and post-stabilization care services. Emergency services are covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and which are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the following definition of emergency as set forth in NMAC 8.305.1.7 and NMAC 8.306.1.7. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions or serious dysfunction of any bodily organ or part. The CONTRACTOR shall not

limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Post-stabilization care services are covered services related to an emergency condition that are provided after a patient is stabilized in order to maintain the stabilized condition or to improve or resolve the patient's condition, such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during discharge or post-discharge of the patient or transfer of the patient to another facility.

F. Birthing Option Program

The CONTRACTOR must participate in HSD/MAD's Birthing Option Program, as operated at the time of execution of this Agreement or as directed by HSD/MAD during the term of this Agreement.

G. Coordination of Benefits

There are specific services that have been excluded from the benefit package. HSD/MAD expects the CONTRACTOR to coordinate member services in an integrated service delivery system, even though members may be receiving some of their services from the SE, other contractors, or in the Fee-For-Service system. This will require careful identification and coordination by the CONTRACTOR to prevent fragmentation and/or duplication of services for these members.

H. SCI Only Requirements

(1) Annual Limits on Out of Pocket Expenditures

Out of pocket charges for all members will be limited to five percent (5%) of the maximum countable family income per benefit year. The CONTRACTOR must have a system in place to comply with verification of member out of pocket maximums per NMAC 8.262.600.9.

(2) All pharmacy claims, regardless of prescriber but excluding Salud! Behavioral Health specialty providers, will be paid by the CONTRACTOR.

(3) Limitations on Coverage

The benefit package is limited to one hundred thousand dollars ($100,000) in benefits payable per member per benefit year. The State may adjust the $100,000 maximum per benefit year; however, the maximum per benefit year cannot be decreased more than five percent (5%) in a single year and the maximum per

benefit year cannot be adjusted to an amount less than $100,000. The State will notify CMS sixty (60) days prior to any requested change in the maximum benefit per year. Inpatient hospitalization coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation includes home health services and inpatient physical rehabilitation. Behavioral health inpatient hospitalization coverage is also limited to twenty-five (25) days per benefit year.

(4) Tracking Benefits

The CONTRACTOR shall track benefits provided to each member. The CONTRACTOR shall maintain a claims tracking method to identify members who reach the fifty thousand dollar ($50,000.00) benefit year claims payment threshold and/or the twenty (20) day hospital benefit year limit in order to coordinate with HSD/MAD in instituting appropriate measures to ensure members continue to receive care through the CONTRACTOR or through some other identifiable program if either the claims and/or hospital maximum are reached. The CONTRACTOR shall assist the SCI members in transitioning into other state sponsored insurance programs or other insurance programs.

(5) Behavioral Health Benefits

Behavioral health and substance abuse services included in the SCI benefit package remain the responsibility of the CONTRACTOR. The CONTRACTOR, the SE 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 Interagency Behavioral Health Purchasing Collaborative.

(6) Services through the University of New Mexico (UNM) Health Sciences Center for the UNM/SCI Program.

If the CONTRACTOR is willing and has been chosen to work with UNM by HSD/MAD, it will contract directly with UNM to provide the SCI physical health benefit package through the UNM health care delivery system. The CONTRACTOR and UNM shall come to agreement on and put into place all policies and procedures necessary for administering services and coordinating care and benefits so the SCI members have appropriate access to these services. HSD/MAD shall have final approval of these policies and procedures.

I. Benefit Package

The complete Benefit package including copayments and premium requirements and limitations on services are documented in Exhibit 1 for Salud! and Exhibit 2 for SCI.

2.7 QUALITY ASSURANCE

The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.8 and NMAC 8.306.8. The requirements include, but are not limited to, the following:

A. Accreditation

The CONTRACTOR shall be accredited by the National Committee for Quality Assurance (NCQA).

B. External Quality Review (EQRO)

(1) HSD/MAD shall retain the services of an EQRO in accordance with the Social Security Act, §1902(c)(30)(C), and the CONTRACTOR shall cooperate fully with that organization and prove to that organization the CONTRACTOR's adherence to HSD/MAD's managed care regulations and quality standards as set forth in federal regulation and MAD Policy.

(2) HSD/MAD shall also contract with an EQRO to audit a statistically valid sample of the CONTRACTOR's Salud! and SCI 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.

(3) The EQRO shall also audit the CONTRACTOR's Performance Improvement Projects, Performance Measure Program, and the CONTRACTOR's performance against quality standards based on CMS criteria. The CONTRACTOR shall cooperate fully with the EQRO.

(4) The CONTRACTOR shall participate in various other tasks and projects identified by HSD/MAD to gauge performance in a variety of areas, including care coordination and treatment of special populations.

(5) The CONTRACTOR shall utilize technical assistance and guidelines offered by the EQRO, unless otherwise agreed upon by the parties.

(6) The EQRO retained by HSD/MAD shall not be a competitor of the CONTRACTOR.

C. Standards for Quality Management and Quality Improvement ("QM/QI")

The CONTRACTOR shall comply with NMAC 8.305.8.12 and NMAC 8.306.8.12. The CONTRACTOR shall:

(1) establish QM/QI programs based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria; recognize that opportunities for improvement are unlimited; that the QI process shall be data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements; requiring re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and, shall rely on member and provider input;

(2) have a QM/QI annual program description that includes goals, objectives, structure, policies and procedures and authorities that shall result in continuous quality improvement;

(3) have an annual QM/QI work plan that includes immediate objectives for each contract period and long-term objectives for the entire term of this Agreement. The QM/QI work plan shall contain the scope, objectives, planned activities, timeframes and data indicators for tracking performance and other relevant information;

(4) implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD/MAD; have a PIPs work plan and activities that must be consistent with the federal/state laws, regulations and Quality Assessment and Performance Improvement Program requirements for PIPs and Performance Measurement programs pursuant to 42 CFR §438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" at http://www.cms.hhs.gov/MedicaidManagCare/;

(5) demonstrate active processes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;

(6) demonstrate that the results of QM/QI projects and reviews are incorporated in the QM/QI program;

(7) submit an annual QM/QI written evaluation that includes, but is not limited to:

a. a description of ongoing and completed QI activities;

b. measures which are trended to assess performance;

c. findings which incorporate prior year plan information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;

d. development of future plans must be based on the incorporation of previous year findings of overall effectiveness; and

e. incorporating annual HEDIS results in the following year's plan as applicable to HSD/MAD specific program;

(8) ensure that the QM/QI program is applied to the entire range of covered services provided through the CONTRACTOR to key populations to include relevant diagnoses, care settings, and demographics;

(9) have the ability to design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis;

(10) have access to, and the ability to collect, manage and report to HSD/MAD data necessary to support the QI activities;

(11) review outcome data at least quarterly for performance improvement, recommendations and interventions;

(12) have a mechanism in place to detect under and over utilization of services;

(13) provide mechanisms for monitoring, addressing and correcting any evidence of cost-shifting practices by network providers including information on pharmaceutical cost-shifting of behavioral health medications that are currently being prescribed by PCPs;

(14) have written policies and procedures for continuity and coordination of care as they relate to the delivery of physical health

services and coordinating care for Individuals with Special Health Care Needs (ISHCN) with CoLTS, the Single Statewide Entity (SE) and/or other state agencies/departments;

(15) develop and implement a quality initiative within the QM/QI plan related to the identification and care provided specific to ISHCN members;

(16) collaborate with HSD/MAD and other Contractors to develop QI-related material for various public forums that are intended to be easily understandable to the lay person and, when possible, written at a sixth grade reading level;

(17) establish a committee to oversee and implement all policies and procedures;

(18) designate an individual within the company responsible for compliance with all of the QM/QI requirements; and

(19) ensure that the ultimate responsibility for QM/QI is with the CONTRACTOR and shall not be delegated to subcontractors.

D. Member Satisfaction Survey

As part of the QI Program for the Salud! and SCI populations, the CONTRACTOR shall conduct at least one (1) annual survey of member satisfaction for each program which shall assess member satisfaction with the quality, availability, and accessibility of care. The survey shall provide a statistically valid sample of CONTRACTOR's members who must have at least six (6) months of continuous enrollment, including members who have requested to change their PCPs. The member survey shall address member receipt of educational materials and the members' use and usability of the provided education materials. The survey shall address the satisfaction of ISHCN by including at least one (1) question related to ISHCN's ability to participate in their treatment plan and goals. The CONTRACTOR shall follow all federal and state confidentiality laws and regulations in conducting this Member Satisfaction Survey. HSD/MAD agrees that use by the CONTRACTOR of the CAHPS Survey will be deemed to meet all of the requirements of this Section. The CONTRACTOR shall:

(1) establish policies and procedures for conducting relevant member surveys and, if the member is a minor or unable to act on his/her behalf, to survey the member's parent, guardian or legal representative as permitted under applicable privacy laws;

(2) use the most recent version of the CAHPS Adult and Child Survey Instruments, including the Children with Chronic Conditions (CCC) to assess member satisfaction as part of the HEDIS requirements and report the results of the CAHPS survey to HSD/MAD. The CONTRACTOR shall utilize the annual CAHPS results in the CONTRACTOR's internal QI Program by using areas of decreased satisfaction as areas for targeted improvement;

(3) work with NCQA, if applicable, to obtain approval to use additional survey questions in addition to the CAHPS that are relevant to the Salud! and SCI population;

(4) disseminate results of the Member Satisfaction Survey to providers, HSD/MAD and members and families/caregivers as appropriate;

(5) demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall Member Satisfaction Survey results; and

(6) be obligated to perform survey as described for SCI membership once CONTRACTOR's SCI membership reaches an enrollment threshold of 2500 members. CONTRACTOR shall perform survey within twelve (12) months of reaching the enrollment threshold.

E. Provider Satisfaction Survey

The CONTRACTOR shall conduct at least one (1) annual Provider Satisfaction Survey that covers Salud! and SCI providers and follows NCQA guidelines. Results will be provided to HSD/MAD. The survey must be reported to HSD/MAD by specific program and take into consideration each program's benefits and limitations.

F. Practice Guidelines

The CONTRACTOR shall:

(1) adopt practice guidelines that meet the following requirements:

a. are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

b. consider the needs of the members;

c. are adopted in consultation with contracting health care professionals; and

d. are reviewed and updated every two years;

(2) disseminate the guidelines to all affected providers and, upon request, to members and potential enrollees; and

(3) ensure that decisions for utilization management, member education, coverage of services, and other applicable areas are consistent with the guidelines.

G. Pay for Performance – General Expectations and Directed Initiatives

(1) The purpose of the Pay for Performance (P4P) program is to promote initiatives that support HSD/MAD's commitment to improving health, achieving superior clinical outcomes and reducing administrative burdens to increase clinical care time.

(2) The CONTRACTOR, with input from HSD/MAD, shall develop a P4P model for its Salud! and SCI provider population based on three (3) categories of measurements: Quality of Care, Access to Care and Satisfaction with Physician or Provider.

(3) The CONTRACTOR shall establish and provide for HSD/MAD approval, minimum requirements for provider participation, establish measures that can be compared to national data and evaluate progress towards attaining the established target for the measure.

(4) The CONTRACTOR shall, in collaboration with HSD/MAD, develop and implement a P4P program to effectively and efficiently manage the health care of its members by providing incentives for provider performance. The CONTRACTOR shall work with HSD/MAD on the creation of P4P initiatives in designated outcome areas. The CONTRACTOR shall determine the basis for the implementation of interventions, and the evaluation and measurement of the specified initiative, including:

a. development of baseline measurements;

b. on-going measurement of outcomes using clearly stated and accepted methodology;

c. establishment of new or related goals, based on performance; and

d. establishment of common methodology and measurement criteria for HSD/MAD required initiatives.

(5) For Salud! and SCI, the CONTRACTOR shall appropriate twenty-five percent (25%) of the withheld funds from the Challenge Fund (as described in Section 27.5(J)(1)) for the P4P program. No other amounts will be required to be funded by the CONTRACTOR for the P4P program.

(6) The funds appropriated for the P4P program may be released for use by the CONTRACTOR only after HSD/MAD has approved in writing, the CONTRACTOR's P4P initiatives, interventions, evaluation and measurement based on HSD/MAD's model. Funds paid out to providers from the P4P appropriation shall be counted as direct expenses and payment made to non-providers may be considered administrative or direct, at the discretion of HSD/MAD.

(7) P4P funds may be allocated to P4P activities throughout the contract year. The CONTRACTOR shall submit a report detailing all expenditures to HSD/MAD on a quarterly basis until all funds are disbursed. The funds appropriated for the P4P program must be disbursed by the end of September following the end of the contract year or incurred by the end of the contract year.

(8) Patient Centered Medical Home Initiatives (PCMH)

The CONTRACTOR shall establish a P4P initiative for its Salud! and SCI provider population based on the Patient Centered Medical Home or Medical Home model.

The CONTRACTOR shall continue to meet with the New Mexico Medical Society, HSD/MAD, the other MCOs, Primary Care Providers and other stakeholders to determine the methods under which PCMH/MH programs can be most effectively implemented in New Mexico to meet the needs and goals of the Salud! and SCI programs. In meeting to discuss PCMH/MH programs, the CONTRACTOR understands that HSD/MAD desires that the following principles, to the extent reasonable and consistent with the stakeholder meetings, be incorporated in the final program:

a. The CONTRACTOR shall work with contracted Primary Care Providers to implement PCMH/MH programs. The programs will incorporate the following principles:

i. Every patient shall have a personal physician;

ii. Care shall be provided by a physician-directed team that collectively cares for the patient;

iii. Personal physician is responsible for providing all patients' needs, or arranging and coordinating services to be provided by others;

iv. Care shall be coordinated and/or integrated across all aspects of healthcare; and

v. Quality and safety are its hallmarks:

1. Compassionate, patient centered care;

2. Evidence-based medicine and clinical decision supports;

3. Participation in continuous quality improvement and voluntary performance measurement;

4. Patients actively participate in decision-making and provide feedback;

5. Information technology is utilized to support care delivery;

6. Practices participate in voluntary recognition process;

7. Enhanced Access (expanded hours, open scheduling and alternative communication models); and

8. Payment which appropriately recognizes the added value of PCMH (Fee for Service, Care Management Fee and Pay for Performance).

b. The CONTRACTOR shall encourage development of a PCMH/MH program:

i. through the implementation of seed money whereby the CONTRACTOR awards a limited amount of funds following submission and evaluation by

CONTRACTOR of proposals received by the CONTRACTOR from providers or groups describing how such funds would be expended to develop, or otherwise work toward, the creation of a PCMH/MH program, or

ii. through the use of specific Memorandums of Understanding (MOU) or contract amendments with providers whereby the CONTRACTOR and the provider agree upon the terms and conditions under which the provider will be compensated for worked performed in connection with, or toward, the establishment of a PCMH/MH program.

c. The CONTRACTOR shall encourage and support the efforts of Primary Care providers and groups to apply for and obtain NCQA recognition for Patient Centered Medical Homes (PCMH"). Support may include providing direct consultative services as well as financial subsidies. If the CONTRACTOR elects to utilize an MOU approach, it shall include the following as key components of such program:

i. The CONTRACTOR shall incorporate elements of the Three Tiered Reimbursement Model (Fee for Service, Care Management Fee, and Pay for Performance) to reimburse Primary Care Providers or Groups that have attained NCQA recognition for PCMH. The proposed reimbursement methodology does not need to be identical for different providers, given potential differences in patient demographics, illness burden, and practice patterns. The proposed reimbursement for each provider or group should be developed as a Memorandum of Understanding (MOU) or contract amendment that both the CONTRACTOR and provider first agree to and then submit to HSD/MAD for review and approval.

ii. The additional payments specified above are intended to provide the CONTRACTOR's Primary Care Providers and Groups incentives to pursue PCMH implementation and are intended to be disbursed to such providers to facilitate such implementation and provide three tiered reimbursement. Any payments from the CONTRACTOR for such providers for this

initiative shall be considered direct service expenses as defined in Section 2.12.R of this Agreement.

iii. The MOU must contain provisions for targeted outcomes that will be measured and followed by the CONTRACTOR for each provider or group. They may include, but are not limited to: immunization rates, diabetes care, asthma care, maternity and child care, patient satisfaction, inpatient utilization, emergency department utilization, and costs. Improvement goals for any selected measure may range from one to twenty percent (1-20%) improvement depending on the provider or group's baseline. HSD/MAD will review the proposed outcomes to ensure that they are consistent with the mission of HSD/MAD and overall State healthcare goals, but will not withhold approval of proposed measures.

iv. On an annual basis, the CONTRACTOR shall report the number of providers or groups that have attained Level Three NCQA recognition for PCMH and have been audited as being in compliance with such. The annual outcomes will be measured for each group, with analysis of observed trends and further opportunities for improvement in care processes with the continued objective of improving outcomes and overall health status of members assigned to the CONTRACTOR.

d. The CONTRACTOR shall develop specific modules that will enhance a practice setting's achievement of NCQA recognition for PCMH. Financial incentives may be used upon initiation and upon completion of each independent module. A practice setting must be evaluated for demonstrated implementation using the NCQA standards for PCMH recognition. Modules for implementation shall include: Electronic Medical Record (EMR); Patient Tracking and Registry Functions; Test Tracking; Referral Tracking; e-Prescribing; Access and Communication; and Performance Reporting and Improvement.

e. The CONTRACTOR may develop a PCMH/MH model that is not based on NCQA recognition of a Patient Centered Medical Home; provided, however that any such

models must incorporate the principles and quality/safety hallmarks described in Section 2.7.G.(8)(a) hereof.

f. The CONTRACTOR shall align programs with the following focus areas:

i. Screening/identification and targeting of PCMH/MH participants;

ii. Coordination of care with the Statewide Entity for members that are eligible and/or receive behavioral health services;

iii. Care is continuous, accessible, comprehensive and coordinated using community-based resources as appropriate;

iv. Care is focused on prevention, chronic care management, reducing emergency department visits and unnecessary hospitalizations and includes improving care transitions;

v. Use access and quality measures (HEDIS and surveys);

vi. Demonstrative improved health status and outcomes for members; and

vii. Promote adoption of Health Information Technology (HIT) and support Health Information Exchanges (HIE).

g. Any amounts expended by the CONTRACTOR in implementing or operating the PCMH program shall be counted as direct service expenses as defined in Section 2.12.R of this Agreement. HSD/MAD agrees that the CONTRACTOR is not obligated to spend any amounts on the PCMH program other than the twenty-five percent (25%) of the Challenge Fund, if available for P4P program.

h. All PCMH/MH models must be approved annually by HSD/MAD.

i. The CONTRACTOR reporting of PCMH/MH model activities and expenditures to HSD/MAD shall be in a format and methodology specified by HSD/MAD.

(9) The CONTRACTOR shall participate in the State's multi-payer regional quality improvement coalition, Albuquerque Coalition for Healthcare Quality (AC4HQ).

a. The CONTRACTOR shall participate in the AC4HQ performance measurement and public reporting activities. Activities include submitting data required to measure the quality of care delivered to the CONTRACTOR's participating Medicaid members and complying with a format, programming specifications and timelines requested by AC4HQ.

b. The CONTRACTOR shall submit data to AC4HQ to support AC4HQ disparities measurement activities. The CONTRACTOR shall use race and ethnicity data currently provided to the CONTRACTOR by HSD/MAD to submit performance results stratified by race and ethnicity. Ethnicity categories will be those currently provided by HSD/MAD.

H. Performance Measures and Tracking Measures

The CONTRACTOR shall:

(1) implement as agreed upon, all Performance and Tracking Measures as defined by HSD/MAD;

(2) monitor these measures on an on-going basis, for over and under-utilization of services, and report results to HSD/MAD;

(3) ensure that these initiatives, in clinical and non-clinical areas, are designed to achieve significant improvement through ongoing measurements and interventions, are sustainable over time and are expected to have a favorable effect on health outcomes and member satisfaction. The performance and tracking measures must involve:

a. measurement of performance using objective quality indicators;

b. implementation of system interventions to achieve improvement in quality;

c. evaluation of the effectiveness of the intervention; and

d. completion in reasonable time period to generally allow information on the success of the initiative is available for planning and initiation of activities for increasing or sustaining improvement each year; and

(4) collaborate with HSD/MAD on reconciliation of any performance measure or tracking measure reporting monitored by HSD/MAD using encounter data with performance or tracking measure reporting performed by the CONTRACTOR.

I. Salud! and SCI Performance Measures

(1) HEDIS will be the methodology used for all performance measures unless HSD/MAD determines to use a non-HEDIS methodology or a HEDIS measure does not exist.

(2) For those performance measures utilizing HEDIS methodology, HSD/MAD agrees that the measures will be evaluated using the HEDIS technical specifications applicable to the measurement year.

(3) For those measures that HSD/MAD determines to use a non-HEDIS measure, or for which a HEDIS measure does not exist, HSD/MAD will provide to the CONTRACTOR the methodology to be used to measure the CONTRACTOR's performance before July 1 of the applicable year.

(4) To the extent that the following performance measures are not based on HEDIS measures, the parties agree that the measures shall be evaluated based on the standard reports for such measures already submitted to HSD/MAD by the CONTRACTOR provided that HSD/MAD shall have the right to audit and validate the information or results as reported by the CONTRACTOR.

(5) The performance measures (PMs) shall be evaluated using the following criteria. For Salud! members only:

a. PM #1 – Annual Dental Visit (Combined Rate)

The percentage of enrolled members two (2) to twenty-one (21) years of age, who had at least one (1) dental visit during the measurement year. The final audited HEDIS score for the Dental Care Combined Rate will be seventy percent (70%) or greater.

b. PM #2 - Well Child Visits

The percentage of enrolled members who turned fifteen (15) months during the measurement year who had six (6) or more Well Child visits with a primary care practitioner during the first fifteen (15) months of life. And the percentage of enrolled members who were three (3) through six (6) years of age who received one (1) or more Well Child visits with a primary care practitioner during the measurement year. The final audited HEDIS score for Well Child visits in the first fifteen (15) months of life will be sixty-two percent (62%) or greater. Well Child visits for ages three (3), four (4), five (5) and six (6) years of age will be seventy percent (70%) or greater.

c. PM #3 – Children and Adolescent Access to Primary Care Providers (PCPs)

The percentage of enrollees twelve (12) to twenty-four (24) months of age and twenty-five (25) months through six(6) years of age who had a visit with a PCP during the measurement year. The percentage of enrollees ages seven (7) through eleven (11) years and twelve (12) through nineteen (19) years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year. The final audited HEDIS score for Children Access to Primary Care Practitioners for ages twelve (12) months through twenty-four (24) months will be ninety-seven percent (97%) or greater; ages twenty-five (25) months through six (6) years will be ninety percent (90%) or greater; ages seven (7) through eleven (11) years will be ninety percent (90%) or greater; and ages twelve (12) through nineteen (19) years will be ninety percent (90%) or greater.

d. PM #4 – Childhood Immunizations (Combo 2)

The percentage of children two (2) years of age who received Combo 2 immunizations on or before their second birthday. The final audited HEDIS score for Childhood Immunizations (Combo 2) will be seventy-eight percent (78%) or greater.

e. PM #5 – Use of Appropriate Medications for People with Asthma

The percentage of members five (5) through eleven (11) years of age and ages twelve (12) to eighteen (18) years, who are identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. The final audited HEDIS score for Use of Appropriate Medications for People with Asthma ages five (5) through eleven (11) years will be ninety-one percent (91%) or greater and ages twelve (12) to eighteen (18) years will be eighty-seven percent (87%) or greater.

For both Salud! and SCI members:

a. PM #6 – Breast Cancer Screening

The percentage of enrolled women forty (40) through sixty-nine (69) years of age who had a mammogram to screen for breast cancer during the measurement year. The final audited HEDIS score for the Breast Cancer Screening will be fifty-five (55%) or greater.

b. PM #7 – Comprehensive Diabetes Care (HbA1c Testing)

The percentage of members eighteen (18) through seventy-five (75) years of age with diabetes (Type 1 or Type 2) who had each of the following during the measurement year: an HbA1c Test; HbA1c Poor Control (less than 9.0%); a retinal eye exam; LDL-C screening; a nephropathy screening test for kidney disease. The final audited HEDIS score for HbA1c Testing will be eighty-five percent (85%) or great; for HbA1c Poor Control (less than 9.0%) will be forty-eight percent (48%) or less (lower percentage is better care); for a retinal eye-exam performed will be fifty-six percent (56%) or greater; for LDL-C screening will be seventy-four percent (74%) or greater; for a nephropathy screening test for kidney disease will be seventy-five percent (75%) or greater.

c. PM #8 – Timeliness of Prenatal and Postpartum Care

The percentage of member deliveries that received a prenatal care visit as a member of the organization in the first trimester or within forty-two (42) days of enrollment in the organization; the percentage of member deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) days after delivery. The final audited

HEDIS score for Prenatal Care will be eighty-five percent (85%) or greater; for Postpartum care will be sixty percent (60%) or greater.

d. PM #9 – Frequency of On-going Prenatal Care

The percentage of member deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received greater than eighty-one percent (81%) of expected prenatal visits. The final audited HEDIS score for Frequency of On-going Prenatal Care will be sixty percent (60%) or greater.

e. PM #10 – Timely Submission, Accuracy and Analysis of HSD/MAD Required Reports.

The CONTRACTOR shall achieve and maintain a ninety-five percent (95%) compliance with all format and content requirements for HSD/MAD reports. The CONTRACTOR shall submit a systems analysis of the data interpretation (e.g., tracking and trending). "Timely submission" shall mean that the report was submitted on or before the date it was due. "Accuracy" shall mean the report was substantially prepared according to the specific written guidance, including report template, provided by HSD/MAD to the CONTRACTOR. All elements must be met for each required report submission. Therefore, the report must be timely, accurate and contain an analysis. If any portion of the report element is not met, the report is deemed in "error".

The CONTRACTOR shall not be penalized if an error in a previously submitted report is identified by the CONTRACTOR and reported to HSD/MAD prior to HSD/MAD's identification of the error. Corrected reports in this type of situation will be submitted to HSD/MAD in a timeframe determined by HSD/MAD after consultating with the CONTRACTOR. Within forty-five (45) working days of CONTRACTOR's report submission, HSD/MAD will provide a status update that indicates the CONTRACTOR's compliance with report.

J. Challenge Fund

(1) For Salud! and SCI capitation payments made pursuant to the terms of this Agreement, the CONTRACTOR shall withhold one

percent (1%), net of premium taxes, NMMIP assessments and adjustments, of HSD/MAD's capitation payments. Capitation payments are based on the full capitation cycle which, in general, runs the first Monday after the first Friday of each month. The withheld funds shall be named the Challenge Fund. The CONTRACTOR shall place this Challenge Fund in a separate account and shall provide to HSD/MAD a monthly statement of the account in order to verify that the funds are being maintained during the period of time specified in this Agreement.

(2) The Challenge Fund shall be released to the CONTRACTOR based on the following scoring system for each of the performance measures listed below:

a. PM #1 – Annual Dental Visit (Combined Rate) shall be worth ten (10) points;

b. PM #2 – Well Child Visits in the first fifteen (15) months of life shall be worth four (4) points; Well Child Visits for ages three (3), four (4), five (5) and six (6) years of age shall be worth a total of six (6) points;

c. PM #3 – Children and Adolescent Access to Primary Care Providers (PCPs) ages twelve (12) to twenty-four (24) months shall be worth two and one-half (2.5) points; ages twenty-five (25) months through six (6) years shall be worth two and one-half (2.5) points; ages seven (7) through eleven (11) shall be worth two and one-half (2.5) points; and ages twelve (12) through nineteen (19) years shall be worth two and on-half (2.5) points;

d. PM #4 – Childhood Immunization Status (Combo 2) shall be worth ten (10) points;

e. PM #5 – Use of Appropriate Medications for People with Asthma ages five (5) to eleven (11 years shall be worth five (5) points; ages twelve (12) through eighteen (18) years shall be worth five (5) points;

f. PM #6 – Breast Cancer Screening shall be worth ten (10) points;

g. PM #7 – Comprehensive Diabetes Care (HbA1c Testing) shall be worth two (2) points; HbA1c Poor Control (less than 9.0%) shall be worth two (2) points; a retinal eye exam shall be worth two (2) points; LDL-C screening shall be

worth two (2) points; nephropathy screening test for kidney disease shall be worth two (2) points;

h. PM #8 – Timeliness for Prenatal Care shall be worth five (5) points; timeliness for Postpartum Care shall be worth five (5) points;

i. PM #9 – Frequency of On-going Prenatal Care shall be worth ten (10) points; and

j. PM #10 – Timely Submission, Accuracy, Analysis, and Data Certification of HSD/MAD Required Reports shall be worth ten (10) points.

K. Release of Challenge Fund

(1) The percentage of the CONTRACTOR's Challenge Fund to be released shall be calculated by summing all earned points, dividing the sum by one hundred (100) points for Salud!, and fifty (50) points for SCI and converting to a percentage (Withheld Percentage). Points are specified for each component of each performance measure where applicable. No partial number of points shall be assigned if the CONTRACTOR fails to completely meet performance measures; however, when a performance measure has more than one component, earned points for each component of a performance measure are awarded as specified. PM #10 compliance will be considered based on all submission per quarter and such criteria shall be applied consistently across all contractors. The CONTRACTOR shall comply with all PM #10 requirements or be subject to a loss of between two and one-half (2.5) points per quarter and ten (10) points annually. The maximum penalty will be assessed for repeated noncompliance within the applicable contract year. Other penalties or sanctions may be imposed for incomplete, inaccurate or untimely submission of reports/analyses. HSD/MAD staff shall notify the CONTRACTOR, in writing, of changes to required reports at least forty-five (45) calendar days prior to implementing the reporting change. The CONTRACTOR shall be held harmless if HSD/MAD fails to meet the requirement for any changes to existing reports. If the CONTRACTOR does not comply with the new required changes upon the first submission, a one-time resubmission within five (5) business days will be allowed without penalty. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports.

(2) The funds in the Challenge Fund account shall first be appropriated to the P4P Program in the amount of twenty-five percent (25%), in accordance with Section 2.7.G.(5) and the remaining seventy-five percent (75%) of the withheld funds shall be released for use by the CONTRACTOR only after HSD/MAD has submitted in writing that, in HSD/MAD's judgment, the performance goals in this Agreement have been achieved for the period of time specified in this Agreement. HSD/MAD shall provide written confirmation no sooner than July 1st and no later than October 31st of the appropriate contract year or within thirty (30) days of verification, whichever comes first.

(3) Funds remaining in the Challenge Fund account as a result of the CONTRACTOR's inability to meet performance goals may either be:

(i) released by HSD/MAD to the CONTRACTOR and be entirely appropriated to HSD/MAD directed initiatives; or

(ii. HSD/MAD has the right to recoup the funds from the CONTRACTOR. These remaining funds are considered penalty assessments. If the CONTRACTOR is allowed to expend the funds on HSD/MAD's approved initiatives, the CONTRACTOR shall submit a report detailing all expenditures to HSD/MAD on a monthly basis until all funds are disbursed. Funds dispersed to providers will be considered medical costs. All funds must be disbursed within the twelve (12) months of the written confirmation of release of the Challenge Fund account by HSD/MAD. If HSD/MAD recoups the penalty dollars, those dollars shall be considered administrative costs. The final distribution of the dollars shall be determined by HSD/MAD.

(4) HSD/MAD shall direct the CONTRACTOR to release any Challenge Funds remaining in the P4P portion of the Challenge Fund account twenty-five percent (25%) at the termination of this Agreement and without an Amendment to this Agreement or a new agreement between HSD and the CONTRACTOR. The terms and conditions of this Agreement regarding the disposition of the performance goals portion of the Challenge Fund account (seventy-five percent (75%)) shall survive termination. The asynchrony between the timing of the contract termination and the

HEDIS data cycle shall be later and further addressed in the Transition Management Agreement and/or in an Amendment to this Agreement.

L. Tracking Measures

(1) The following measures are not subject to the Challenge Fund and shall be reported to HSD/MAD for Salud! members only:

a. TM #1 – Teen Maternity Care

b. TM #4 – EPSDT Waiver Services

c. TM #10 – Ambulatory Care – Emergency Department (ED) Visits

Use the HEDIS specifications to track number of ED visits for age stratifications described (<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, 85+)

d. TM #11 – Hospital Readmissions within thirty (30) days

Use the HEDIS specifications to track the number of hospital readmissions within thirty (30) days for ages eighteen (18) and over, except add age stratification two (2) to seventeen (17) years.

(2) The following measures are not subject to the Challenge Fund and shall be reported to HSD/MAD for Salud! and SCI members:

a. TM #2 - Obesity

b. TM #3 – Customer Support Services

c. TM #6 – Provider Payment Timeliness

The CONTRACTOR shall pay ninety percent (90%) of all clean claims within thirty (30) days and ninety-nine percent (99%) of all clean claims within ninety (90) days. The CONTRACTOR may reference the Balance Budget Act of 1997 for specifications. A "clean claim" means a manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan'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 necessity. The following specifications apply:

a. the date receipt is the date the CONTRACTOR or its subcontractor receives the claim, as indicated by its date stamp on the claim; and

b. the date of payment is the date of the check or other form of payment.

d. TM #5 – Encounter Data Reporting

The CONTRACTOR shall submit ninety-nine percent (99%) of all required production encounter data on a timely basis for submissions and necessary re-submissions as set forth in this Agreement. The submissions and required re-submissions shall have an annual error rate of three percent (3%) or less per invoice type (8371, 837P, 837D, NCPDP) for at least ninety percent (90%) of the files.

(3) The following measures are not subject to the Challenge Fund and shall be reported to HSD/MAD for SCI members only, in order to provide data for the State Coverage Insurance Section 1115 Medicaid Demonstration Waiver for childless adults and the Section 1115 CHIPRA Demonstration Waiver for parents. Data for each measure shall be reported separately for the childless adult population and parent population enrolled in the SCI program.

a. TM #7 – Access to Primary Care Providers (PCPs)

The percentage of enrollees who had a visit with a PCP during the measurement year. "HEDIS-like" specifications should be used whenever possible with certain exceptions in order to provide the requested data for the SCI population. Percentage shall be reported separately for childless adults and parents enrolled in SCI.

b. TM #8 – Ambulatory Care Utilization

The percentage of enrollees who had an ambulatory care visit during the measurement year. "HEDIS-like" specifications should be used whenever possible with certain exceptions in order to provide the requested data for the SCI population. Percentage shall be reported separately for childless adults and parents enrolled in SCI.

c. TM #9 – Emergency Department Utilization

The percentage of enrollees who had one visit to the Emergency Department during the measurement year. The percentage of enrollees who had two or three visits during the measurement year. The percentage of enrollees who had four or more visits during the measurement year. Percentages shall be reported separately for childless adults and parents enrolled in SCI.

M. Publication

At its discretion, HSD/MAD shall release all aggregate results of the QI/audit functions to the public and to the federal government. For purposes of this section the term "aggregate results" shall mean the combination of information or data such that no individual member's personal health information can be identified.

N. Disease Management (DM) Programs

Disease Management is a comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification, collaborative practice models, patient self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement processes.

Disease Management applies a strategy of delivering health services using interdisciplinary clinical teams, continuous analysis of relevant data, and cost-effective technology to improve the health outcomes of individuals with specific diseases or health conditions. HSD/MAD seeks to improve the health status of all individuals in the population with specific diseases. Disease Management programs and Performance Measures are two of the tools that HSD/MAD has chosen to use to measure the CONTRACTOR's ability to impact health outcomes. The CONTRACTOR shall improve its ability to manage chronic illnesses/diseases through DM protocols in order to meet goals based on established targets. The CONTRACTOR shall:

(1) participate in a DM program and DM projects annually;

(2) provide comprehensive DM for a minimum of two (2) chronic disease entities, one applicable/relevant to the adult population and one to the pediatric population, if applicable, using strategies consistent with nationally recognized DM guidelines, such as those available through Agency of Healthcare Research and Quality's

(AHRQ), NQMC web site, or the Disease Management Association of America;

(3) submit cumulative data-driven measurements from each of its DM programs with written analysis describing the effectiveness of its DM interventions as well as any modifications implemented by the CONTRACTOR to improve its DM performance. All DM data submitted to HSD/MAD shall be New Mexico Medicaid-specific;

(4) submit to HSD/MAD the CONTRACTOR's DM plan, which includes a program description, the overall program goals, measurable objectives, and targeted interventions. The CONTRACTOR shall also submit to HSD/MAD its methodology used to identify other diseases for potential DM programs; and

(5) submit to HSD/MAD a quantitative and qualitative evaluation of the efficacy of the prior year's DM program; document how well goals were addressed, such as, enrollment, targeted interventions, identification and outcomes.

O. Referral and Coordination

The CONTRACTOR shall have and comply with written policies and procedures for coordination of services. The CONTRACTOR's policies and procedures shall ensure that referrals to specialists, non-network providers, and all publicly supported providers for medically necessary covered services are available to members if such services are not reasonably available in the CONTRACTOR's network. The CONTRACTOR's referral policy for non-network providers shall require the CONTRACTOR to coordinate with the non-network provider with respect to payment. The CONTRACTOR shall ensure that the cost to the member is no greater than it would be if covered services were furnished within the network.

P. Standards for Utilization Management (UM)

The CONTRACTOR shall:

(1) comply with NMAC 8.305.8.13 and 8.306.8.9 regarding Standards for Utilization Management;

(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;

(3) submit existing utilization review (UR) edits in the CONTRACTOR's claims processing system that will control utilization and prevent payment for claims that are duplicates, unbundled when they should be bundled, already covered under another charge, etc., on an annual basis;

(4) define and submit annually to HSD/MAD a written copy of the UM program description, UM plan, and UM evaluation, which shall include but is not limited to:

a. a description of the UM program structure and accountability mechanisms;

b. a description of how the UM plan shall support the goals described in the UM program and define specific indicators that will be used for periodic performance tracking and trending as well as processes or mechanisms used for assessment and intervention. The UM plan must be data driven with key indicators that are used to ensure that under and over-utilization is detected by the CONTRACTOR and addressed appropriately; and

c. a comprehensive UM program evaluation which shall include an evaluation of the overall effectiveness of the UM plan, an overview of UM activities and an assessment of the impact of the UM plan on management and administrative activities. The review and analysis of any impact from the previous year shall be incorporated in the development of the following year's UM plan;

(5) ensure the involvement of appropriate, knowledgeable, currently practicing practitioners in the development of UM procedures;

(6) submit proposed UR/UM clinical criteria to be used for services requiring prior authorization. HSD/MAD reserves the right to review and approve all UR clinical criteria, not otherwise meeting the requirements of 8.305.8.13;

(7) define how UR/UM decisions will be communicated to the member and the member's PCP or to the provider requesting the authorization;

(8) comply with the most rigorous standards or applicable provisions of either NCQA, HSD/MAD regulation, or the Balanced Budget

Act of 1997, related to timeliness of decisions including routine/non-routine urgent and emergent situations;

(9) ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise to understand the treatment of the member's condition or disease, such as the CONTRACTOR's medical director;

(10) approve or deny covered services for routine/non-urgent and urgent care requests, requested by either members or providers, within the timeframes stated in regulation. These required timeframes are not to be affected by a "pend" decision. The decision-making timeframes must accommodate the clinical urgency of the situation and must not result in the delay of the provision of covered services to members beyond HSD/MAD specified timeframes;

(11) develop and implement policies and procedures by which UM decisions may be appealed by members or their representatives in a timely manner, which must include all necessary requirements and timeframes for submission based on all applicable CMS and state law and regulations;

(12) comply with NMAC 8.305.14.13 and 8.306.8.9 related to Utilization and Quality Management Reporting, including, monthly utilization review activity reports that provide service-specific data related to requests, approval, clinical denials, terminations of care, reductions of care, administrative denials and "pends," reports related to all consumer and provider appeals, expedited appeals, and Fair Hearings. HSD/MAD and the CONTRACTOR shall agree on reporting elements, formats, and submission templates;

(13) provide education, assistance, and monitoring of network providers regarding appropriate health consultation and treatment;

(14) provide education, assistance, and monitoring of network providers, members, and family regarding how to access CONTRACTOR provided care coordination; and

(15) ensure that the Pharmacy and Therapeutics Committee membership includes behavioral health expertise to aid in the proper development of pharmacy and practice guidelines for PCPs regarding psychotropic and antidepressant medications.

Q. Compensation for UM Activities

The CONTRACTOR shall ensure that, consistent with 42 C.F.R. §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 member.

R. Authorization and Notice of Services

Coverage of Services

The CONTRACTOR shall:

(1) identify, define and specify the amount, duration, and scope of each covered service;

(2) require that the services be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under Medicaid Fee-For-Service, as set forth in 42 C.F.R. § 440.230;

(3) ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished;

(4) not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of diagnosis, type of illness, or member's condition;

(5) place appropriate limits on service:

a. on the basis of criteria approved by HSD/MAD; or

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

(6) specify what constitutes "medically necessary" services" in a manner that:

a. is no more restrictive than that used by HSD/MAD as indicated in state law and regulations, the State Plan, and other state policy and procedures; and

b. addresses the extent to which the CONTRACTOR is responsible for covering services related to the prevention, diagnosis, and treatment of health impairments and the ability to attain, maintain, or regain functional capacity; and

(7) define "medically necessary" services as:

a. clinical and rehabilitative physical or behavioral health services that:

i. are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

ii. are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;

iii. are provided within professionally accepted standards of practice and national guidelines; and

iv. are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

b. Application of the definition:

i. a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

ii. the CONTRACTOR making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the Salud! and SCI benefit packages applicable to an eligible individual shall do so by:

1. evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical

history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

2. considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

3. considering the services being provided concurrently by other service delivery systems;

iii. physical and behavioral health services shall not be denied solely because the individual has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition; and

iv. decisions regarding benefit coverage for children shall be governed by the Early Periodic Screening Diagnostic and Treatment (EPSDT) coverage rules.

S. Authorization of Services

For the processing of requests for initial and continuing authorization of services, the CONTRACTOR shall:

(1) require that its subcontractors have in place and follow written policies and procedures for processing requests for initial and continuing authorizations for services;

(2) have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(3) consult with the network provider and non-network provider when appropriate;

(4) require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by health care professional who has

appropriate clinical expertise in treating the member's condition or disease, such as the CONTRACTOR's Medical Director;

(5) for standard authorization decisions, the CONTRACTOR shall provide notice as expeditiously as the member's health condition requires, within fourteen (14) calendar days following receipt of a request for new services and within ten (10) calendar days following receipt of request for ongoing services and within the parameters stated in NMAC 8.305.8.13.E. A possible extension of up to fourteen (14) calendar days may be granted if:

a. the member or the provider requests the extension; or

b. the CONTRACTOR justifies (to HSD/MAD upon request) a need for additional information and how the extension is in the member's best interest; and

c. if the CONTRACTOR extends the timeframe, the CONTRACTOR must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file an appeal if he or she disagrees with the decision; and

(6) in cases in which the provider indicates, or the CONTRACTOR determines, that following the standard timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain or regain maximal function, the CONTRACTOR must make an expedited authorization decision and provide notice as expeditiously as required and no later than three (3) business days after the receipt of request for services. Extensions may be granted as per the above, section e., requirements.

T. Notice of Adverse Action.

The CONTRACTOR must notify the requesting network provider or non-network provider, and give the member written notice of any decision by the CONTRACTOR to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements set forth in 42 C.F.R. §438.

U. Denials

The CONTRACTOR shall:

(1) clearly document in English or other prevalent language, as appropriate, on a form agreed to by HSD/MAD, and communicate in writing the reasons for each denial to a requesting network

provider and non-network provider and the member. For purposes of this section, a "denial" is defined as a refusal by the CONTRACTOR to authorize a service requested or recommended by the member's PCP or specialist;

(2) provide in writing the specific reason/criteria for the denial of service coverage to the requesting network provider or non-network provider and the affected member or his/her representative. There shall be an established and well-publicized internal and accessible Grievance and Appeals mechanism for both providers and members; the notification of a denial shall include a description of how to file a Grievance and an Appeal in the CONTRACTOR's system and how to obtain an HSD/MAD Fair Hearing;

(3) recognize that a UR decision resulting from an HSD/MAD Fair Hearing conducted by the designated HSD/MAD official is final and shall be honored by the CONTRACTOR. However, the CONTRACTOR shall have the right to dispute the financial responsibility for the decision through the dispute resolution process found in Article 14 of this Agreement and/or seek judicial review of HSD/MAD's decision;

(4) evaluate member and network provider satisfaction with the UM process as a part of its Member Satisfaction Survey and the Provider Satisfaction Survey while maintaining the federal and state confidentiality requirements set forth in federal and state laws and regulations of surveyed members and providers;

(5) forward survey results to HSD/MAD; and

(6) provide HSD/MAD with access to the CONTRACTOR's UM review documentation for purposes of compliance audits and/or other contract oversight activities.

V. Standards for Credentialing and Recredentialing

The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.8.14. The CONTRACTOR shall document the mechanism for credentialing and recredentialing of providers with whom it contracts or employs to treat members outside of the inpatient setting and who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions that may not be discriminatory

and the extent of delegated credentialing and recredentialing arrangements. The CONTRACTOR shall:

(1) have written policies and procedures for the credentialing and recredentialing process;

(2) meet NCQA standards and state and federal regulations for credentialing and recredentialing: including 42 CFR §455.104, 42 CFR §455.105, 42 CFR §455.106 and 42 CFR §1002.3(b);

(3) use one standard credentialing form;

(4) collaborate with the other MCOs to define and use the same NCQA approved primary source verification sources for all factors related to credentialing and recredentialing process and other forms used for credentialing and recredentialing;

(5) use one entity for primary source verification or collection and storage of provider credentialing application information, unless there are more cost effective alternatives approved by HSD/MAD;

(6) designate a credentialing committee or other peer review body to make recommendations regarding credentialing issues;

(7) participate and collaborate with any statewide initiatives to standardize the credentialing process;

(8) complete the credentialing process within forty-five (45) days from receipt of completed application with all required primary source documentation;

(9) ensure credentialing forms require ownership and control disclosures, disclosure of business transactions, and criminal conviction information; and

(10) ensure providers and subcontractors are not employing or contracting with excluded individuals; and require all entities enrolled by Medicaid and providing direct services to Medicaid recipients (e.g., home health, personal care) are screened against the "List of Excluded Individuals/Entities (LEIE)" or Medicare Exclusion Databases.

W. Member Bill of Rights and Responsibilities

The CONTRACTOR shall comply with NMAC 8.305.8 and NMAC 8.306.8 regarding Member Education and Member Bill of Rights. The

CONTRACTOR shall provide each member with written information, in English or the prevalent language, as appropriate, which encompasses all the provisions regarding the Member Bill of Rights. The CONTRACTOR must ensure that each member is free to exercise his or her rights and that the exercise of these rights does not adversely affect the way the CONTRACTOR and its providers or the state agency treat the member. The CONTRACTOR must have written policies regarding the member's rights including, but not limited to:

(1) each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;

(2) each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

(3) each member is guaranteed the right to participate in decisions regarding his of her health care, including the right to refuse treatment;

(4) each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; and

(5) each member is guaranteed the right to request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 CFR part §164.

X. Standards for Access

The CONTRACTOR shall comply with: (i) Access to Service requirements in NMAC 8.305.6.14 and NMAC 8.306.6.14 and (ii) Standards for Access in NMAC 8.305.8.18.

Y. Delegation

The CONTRACTOR 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 HSD/MAD, which may choose to waive further review of any existing delegated arrangements that CONTRACTOR may have;

(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 CONTRACTOR 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. The CONTRACTOR is responsible for the evaluation, thorough review and analysis of reports submitted by its delegates at least semiannually. Additionally, the CONTRACTOR must conduct an annual evaluation of its delegates that includes policies and procedures, an audit of applicable files or records and implementation of a corrective action plan if warranted. The CONTRACTOR must conduct two audits per year: one on-site audit and the other a desk review. All delegated entities under a Corrective Action Plan must be reported to HSD/MAD; and

(6) ensure that if deficiencies or areas for improvement are identified, corrective action must be taken by the CONTRACTOR and the subcontractor.

2.8 CULTURALLY COMPETENT SERVICES

A. The CONTRACTOR shall develop and implement a Cultural Competency/Sensitivity Plan, through which the CONTRACTOR shall ensure that it provides both directly and through its network providers and subcontractors, culturally competent services to its members. The CONTRACTOR shall participate with HSD/MAD's efforts to promote the delivery of covered services in a culturally competent manner to all Salud! and SCI members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The CONTRACTOR shall:

(1) develop a Cultural Competency Plan that describes how the CONTRACTOR shall ensure that covered services provided to members are culturally competent and shall submit the plan to the HSD/MAD on August 1st of the contract year for approval;

(2) develop written policies and procedures that ensure that covered services provided to members are culturally competent both directly and through its network providers and subcontractors;

(3) target cultural competency training to PCP, care coordinators, case managers, home health care staff and ensure that staff at all levels receive on-going education and training in culturally and linguistically appropriate service delivery;

(4) develop and implement a plan for interpretive services and written materials to meet the needs of members and their decision-makers whose primary language is not English, using qualified medical interpreters, if available, and make available easily understood member-oriented materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area;

(5) identify community advocates and agencies that could assist non-English and limited-English speaking individuals and/or that provide other culturally appropriate and competent services, which include methods of outreach and referral;

(6) incorporate cultural competence into utilization management, quality improvement and planning for the course of treatment;

(7) identify resources and interventions for high-risk health conditions found in certain cultural groups;

(8) develop and incorporate contract language to cultural competency requirements for inclusion in contracts between the CONTRACTOR and its network providers and subcontractors;

(9) recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the CONTRACTOR's service area; and

(10) ensure that new member assessment forms contain questions related to primary language preference and cultural expectations and that information received is maintained in the member's file.

B. The CONTRACTOR shall conduct initial and annual organizational self-assessments of culturally and linguistically competent-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, member satisfaction assessments and outcomes-based evaluations. The MCO shall submit the organizational self-assessment to HSD/MAD

annually, and include the results of performance improvement programs and outcome based evaluations, as they relate to health disparities in the MCO's membership.

2.9 NATIVE AMERICANS

The CONTRACTOR shall:

A. identify a "Tribal liaison" to assist the CONTRACTOR with issues specifically related to Native Americans and IHS and Tribal facilities and report such "Tribal liaison" to the HSD/MAD for approval; and

B. hold at least one annual meeting with Native American representatives from around the State of New Mexico that represent geographic and member diversity. Minutes of such meetings shall be transmitted to the HSD/MAD within thirty (30) days of such meetings, identifying:

(1) how the CONTRACTOR determined the representation of Native American representatives;

(2) how notice of such meeting was delivered to Native American representatives that were asked to attend the meeting;

(3) matters discussed at the meeting;

(4) action items and/or recommendations to the CONTRACTOR and/or HSD/MAD; and

(5) the date, time and location of the next meeting;

C. make documented efforts to contract with the appropriate urban Indian clinics, Tribally owned health centers, and IHS facilities for the provision of medically necessary services;

D. ensure that translation services are reasonably available when needed, both in providers' offices and in contacts with the CONTRACTOR;

E. ensure appropriate medical transportation for Native American members residing in rural and remote areas for Salud! members;

F. ensure that Native American members accessing the pharmacy benefit at IHS and Tribal 638 facilities will be exempt from the CONTRACTOR's PDL;

G. ensure that culturally appropriate materials are available to Native Americans; and

H. services provided within the IHS and Tribal 638 facilities are not subject to prior authorization requirements.

2.10 COORDINATION OF SERVICES

A. General Requirements

CONTRACTOR must comply with all coordination of services requirements of NMAC 8.305.9 and NMAC 8.306.9. "Care coordination" is defined as an office-based administrative service to assist members with multiple and complex, special health care needs, gain access to services covered in their Medicaid managed care plans or services available in their communities, on an as-needed basis. It is member-centered and consumer-directed, family focused when appropriate, culturally competent and strength based. Care coordination ensures that when medical and behavioral health needs are identified, services are provided and coordinated with the member and family if appropriate. Care coordination operates independently within the CONTRACTOR's organization and has a separately defined function with a dedicated care coordination staff but is structurally linked to the CONTRACTOR's other systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on medically necessary covered services and not fiscal considerations. If both physical and behavioral aspects of care exist, the care coordination responsibility lies with the condition that is most acute.

Care coordination provides services statewide, both internally for services, which are covered under Salud! and SCI and externally to the CONTRACTOR for non-covered services. Examples of services external to the benefit packages for Salud! and SCI with which the CONTRACTOR shall coordinate include: behavioral health services with the SE, the Home and Community–based Waiver programs; special rehabilitation; Children's Medical Services (CMS); the Family, Infant and Toddler Program (FIT); CYFD Protective Services; Juvenile Justice Divisions; and the Medicaid School-Based Services program. The CONTRACTOR will also provide care coordination activities with the New Mexico's safety net providers, and the primary care clinics, as these are applicable to the benefit package.

B. Primary Elements of Care Coordination

The CONTRACTOR shall:

(1) develop and implement policies and procedures, approved by HSD/MAD, which govern how members with multiple and complex health care needs will be identified and how each relevant

problem will be identified;

(2) develop and implement policies and procedures, approved by HSD/MAD, to identify members most likely to need and benefit from ongoing care coordination;

(3) develop policies and procedures, approved by HSD/MAD, to ensure access to care coordination for all Salud! and SCI members with special health care needs;

(4) develop policies and procedures, approved by HSD/MAD, to designate who has primary care coordination responsibility and serves as the single point of contact for the member; inform the member regarding the care coordinator's name and how to contact him/her;

(5) develop policies and procedures, approved by HSD/MAD, to designate who has primary care coordination responsibility, the MCO or the SE, when both chronic and complex physical and behavioral care needs exist;

(6) develop policies and procedures, approved by HSD/MAD, that establish pathways for communication between care coordinators, PCPs, medical specialists, multidisciplinary providers and facilities to ensure medical care and services are not duplicated, neglected or unnoticed;

(7) ensure development of a member's individual plan of care by a qualified provider, based on a comprehensive assessment of goals, capabilities and medical condition of the member and with consideration of the needs and goals of the family, if appropriate;

(8) monitor members to ensure covered services are received; utilize evaluation criteria to measure member care and health outcomes;

(9) provide statewide care coordination by qualified professionals either directly or through subcontractors, for Salud! and SCI members with multiple and complex health care needs;

(10) take the responsibility for linking individuals to case management as needed if the local case manager/designated provider is not available;

(11) develop and maintain a directory of and working relationships with public and voluntary programs, services, agencies and systems available to provide care coordination needs for members;

(12) for Salud! members only, provide the five (5) applicable targeted case management programs included in the Medicaid benefit package, and be held accountable for delivering these services according to HSD/MAD policy;

(13) actively coordinate care of members with the SE, coordinate care of members transitioning into CoLTS, and with all MCOs contracted to provide services under Centennial Care;

(14) educate and assist PCPs to make appropriate referrals for behavioral health consultation and treatment;

(15) work with the Medicaid School-Based Services (SBS) program providers to identify and coordinate care with the child's Salud! PCP; and

(16) specify how care coordination will be supported by an internal electronic information system.

C. Specific Coordination Requirements

(1) Initial Written Referral Report. A copy of the referral consultant's office note or a written summary of any referral shall be forwarded to the PCP by the specialty care health provider at the time of the referral office visit unless the member does not agree to release this information.

(2) Ongoing Reporting. The PCP, with the member's consent, shall keep the specialty care health provider and the care coordinator informed of drug therapy, laboratory and radiology results, medical consultations, and sentinel events such as hospitalization and emergencies.

(3) Coordination of Salud! Physical and Behavioral Health Services

Physical and behavioral health services shall be provided through a clinically coordinated system between the CONTRACTOR and SE. The CONTRACTOR and the SE shall work together to coordinate a member's care, if the member has both physical and behavioral health needs. Both physical and behavioral health care providers would benefit by having access to relevant medical records of mutually-served members to ensure the maximum benefit of services to the member. Coordination between the CONTRACTOR and the SE requires coordinated and collaborative policies and procedures to ensure effective care coordination

across systems including access to appropriate behavioral health medications. Both CONTRACTOR and the SE shall be responsible for monitoring the effectiveness of referrals, coordinating with multiple providers and for the process of information sharing between the physical and behavioral health care providers. Confidentiality and the Health Insurance Portability and Accountability Act (HIPAA) regulations apply during this coordination process.

(4) Physical Health Consultation and Treatment. The CONTRACTOR shall have and comply with written policies and procedures governing referrals from behavior health providers for physical health consultation and treatment.

(5) Coordination with Waiver Programs. (Salud! only) The CONTRACTOR shall provide all covered benefits to members who are waiver participants in the following home and community-based waivers: the Developmentally Disabled Waiver, the CoLTS C Waiver, the Medically Fragile Waiver, the AIDS Waiver and the Mi Via Waivers. An integral part of each waiver is the provision of case management or for the Mi Via Waiver, the consultant. The CONTRACTOR shall coordinate closely with the waiver case manager or consultant to ensure that case information is shared, that necessary services are provided and that they are not duplicative. HSD/MAD shall monitor utilization to ensure that the CONTRACTOR provides all benefits included in the CONTRACTOR benefit package to members that are waiver recipients.

(6) Coordination of Services with Children, Youth and Families Department (CYFD). (Salud! only) The CONTRACTOR shall have written policies and procedures requiring coordination with the CYFD Protective Services and Juvenile Justice Divisions to ensure that members receive medically necessary services regardless of the member's custody status. The policies and procedures shall specifically address compliance with the current New Mexico Children's Code. If Child Protective Services (CPS), Juvenile Justice or Adult Protective Services (APS) has an open case on a member, the CYFD social worker or the Juvenile Probation Officer assigned to the case shall be involved in the assessment and planning for the course of treatment, including decisions regarding the provision of services for the member. The CONTRACTOR shall designate a single contact point for these cases. The CONTRACTOR has the right to demand a release of information from CYFD that is consistent with information sharing through the JPA between HSD/MAD and CYFD.

(7) Coordination of Services with Schools. (Salud! only) The CONTRACTOR shall have and implement written policies and procedures regarding coordination with the schools for those members receiving services excluded from managed care as specified in the Individualized Education Program (IEP) or Individualized Family Service Program (IFSP). The CONTRACTOR shall provide the names of the members' PCPs to schools participating in the School Based Services (SBS) program.

(8) Coordination with the SE for Transportation (Salud! only). The CONTRACTOR shall coordinate and manage the delivery of the transportation benefit to members receiving behavioral health services. The CONTRACTOR shall coordinate with the SE as necessary to perform this function. Such coordination will include receiving information from and providing information to the SE regarding members, providers, and services; meeting with the SE to resolve provider and member issues to improve services, communication, and coordination; contacting the SE as necessary to provide quality transportation services; and maintaining and distributing statistical information and data as may be required.

(9) Coordination with the SE for Pharmacy. (Salud! only). The CONTRACTOR shall coordinate as necessary with the SE, the agency that will administer behavioral health services. This will ensure that member and provider questions are appropriately directed. The CONTRACTOR shall edit claims to assure any authorizations given and any claims paid are within the scope of the responsibility of the pharmacy contractor. The pharmacy contractor will appropriately inform members and providers when the claim falls within the scope of the responsibility of the SE for behavioral health services. Such determination will be made primarily on the basis of the prescriber and other criteria as may be provided by HSD/MAD.

(10) Coordination with CoLTS. The CONTRACTOR shall have written policies and procedures for transitioning members to and from the Salud! and CoLTS programs.

(11) Coordination with Centennial Care. Within ninety (90) days after HSD publically announces the Centennial Care MCOs, the CONTRACTOR shall have written policies and procedures approved by HSD/MAD for transitioning members from Salud! and SCI to Centennial Care.

2.11 REQUIRED SYSTEM CAPABILITIES

A. System Requirements

(1) The CONTRACTOR is required to use the file layouts and data requirements included in the MCO/CSP Systems Manual, along with any HIPAA requirements and implementation and companion guides.

(2) System Hardware, Software and Information Systems Requirements: The CONTRACTOR is required to maintain system hardware, software, and information systems (IS) resources sufficient to provide the capability to:

a. accept, transmit, maintain and store electronic data and enrollment roster files;

b. accept, transmit, process, maintain and report specific information necessary to the administration of Salud! and SCI, including, but not limited to, data pertaining to providers, members, claims, encounters, grievance and appeals, disenrollment for other than loss of Medicaid eligibility and HEDIS and other quality measures;

c. comply with the most current federal standards for encryption of any data that is transmitted via the internet by the CONTRACTOR or its subcontractors;

d. conduct automated claims processing with current National Provider Identification Number (NPI) for health care providers and FEIN/SSN numbers for atypical providers in HIPAA compliant formats;

e. accept and maintain at least a ten (10) digit member identification number to be used for all communication to HSD/MAD and is cross-walked to the CONTRACTOR's assigned universal member number and which is used by the member and providers for identification, eligibility verification, and claims adjudication by the CONTRACTOR and all subcontractors;

f. estimate the number of records to be received from providers and subcontractors; monitor and transmit electronic encounter data to HSD/MAD according to encounter data submission standards, in order to monitor the completeness of the data being received and to detect

providers or subcontractors who are transmitting partial or no records;

g. transmit data electronically over a web-based FTP server;

h. disseminate enrollment information to providers and subcontractors/vendors within twenty-four (24) hours of receipt of the information or, at a minimum, ensure that current eligibility information is available to providers for eligibility verification within twenty-four (24) hours of receiving the information, via a website, automated voice response system, or other means. Providers must be able to verify eligibility on weekends, holidays and after normal business hours;

i. maintain a website for dispersing information to providers and members, and be able to receive comments electronically and respond when appropriate, including responding to practitioner transactions for eligibility and formulary information;

j. receive data elements associated with identifying members who are receiving ongoing services under Fee-For-Service Medicaid or from another contractor and using, where possible, the formats that HSD/MAD uses to transmit similar information to an MCO;

k. transmit to HSD/MAD or another contractor, data elements associated with its members who have been receiving ongoing services within its organization or under another contractual arrangement;

l. have systems capabilities to receive data elements associated with identifying members who are receiving ongoing services under FFS Medicaid, another contractor or the SE, and using, where possible, the formats that HSD/MAD uses to transmit similar information to a CONTRACTOR;

m. have systems capability to transmit to HSD/MAD or another CONTRACTOR or the SE, data elements associated with their members who have been receiving ongoing services within the MCO or under a contractual arrangement;

n. have an automatic access system for providers to obtain member enrollment information that includes the cross-reference capability of the system to the member's ten-digit identification number designated by HSD/MAD to the member's social security number as a means of identifying the member's most current benefits such as providing a category of eligibility; and

o. maintain a system backup and recovery plan.

B. Provider Network Information Requirements:

The CONTRACTOR's provider network capabilities shall include, but not be limited to:

(1) maintaining complete provider information for all providers contracted with the CONTRACTOR and its subcontractors and any other non-contracted providers who have provided services to date;

(2) transmitting an initial Provider Network File, if the CONTRACTOR has not previously submitted a Provider Network File to HSD/MAD and on an ongoing basis, which must be sent along with encounter files, to include new network providers, new non-network servicing providers, changes to existing providers and termination of provider status including provider type and specialties assigned according to HSD/MAD criteria and definitions;

(3) providing a complete and accurate designation of each network provider according to the data elements and definitions included in the MCO/SC Systems Manual, including assignment of a unique provider numbers (i.e., NPI) to each type of certification the provider organization has according to national standards;

(4) using the National Provider Identifier (NPI) to identify health care providers and send a separate provider network file record for each unique combination of NPI, provider type and ZIP code;

(5) sending the tax ID (FEIN or SSN) for all providers and, for atypical providers, send a separate network file record for each unique combination of FEIN/SSN, provider type and ZIP code;

(6) ensuring that the provider type file contains no duplicate combinations of NPI or FEIN/SSN, provider type and ZIP code;

(7) determining and reporting both billing and servicing provider types and specialties according to Medicaid provider type and specialty codes which are based on the provider's licensure/certification and not the service that the provider is rendering; and

(8) providing automated access to members and providers of a member's PCP assignment.

C. Member Information Requirements:

The CONTRACTOR's member information requirements shall include, but not be limited to accepting, maintaining and transmitting all required member information;

Mandatory Requirements for Salud!:

The CONTRACTOR shall:

(1) monitor newborns whose mothers are enrolled in managed care at the time of the newborn's birth to ensure minimal lapse in time between the infant's birth and their determination of eligibility. After eligibility is approved, newborns of Medicaid eligible MCO enrolled mothers are eligible for a period of twelve (12) months starting with the month of birth. The newborn is enrolled retroactively to the month of birth with the same MCO the mother had during the birth month. However, the parent or legal guardian may choose a different MCO for the newborn as early as the second month of life. In such a case, the MCO of the mother is only entitled to capitation for the birth month. If the newborn's mother is not a member of an MCO at the time of birth, the newborn is enrolled during the first enrollment cycle following the determination of eligibility and the choice of a contractor. HSD/MAD agrees that CONTRACTOR shall not be obligated to provide any services for a newborn, born to an enrolled mother, until the newborn appears on the CONTRACTOR's membership roster;

(2) generate member information to providers within twenty-four (24) hours of receipt of the enrollment roster from HSD/MAD. The CONTRACTOR must ensure that current eligibility information is available to subcontractors for eligibility verification on weekends and holidays;

(3) assign as the key Medicaid client ID number, the RECIP-MCD-CARD-ID-NO that is sent on the Enrollment Roster file, but accepting and using all four (4) occurrences of the Medicaid client ID number sent to the CONTRACTOR on the Enrollment Roster

file for identification, eligibility verification and claims adjudication by the CONTRACTOR or any subcapitated contractors that pay claims. These numbers will be cross-referenced to the member's social security number and any internal number used in the CONTRACTOR's system to identify members;

(4) maintain a special medical status identifier on its system's database consistent with HSD/MAD for this field. This requirement also applies to any subcontractor who maintains a copy of the member rosters for the purpose of distributing eligibility or roster information to providers for verifying member eligibility;

(5) meet federal CMS and HIPAA standards for release of member information (applies to subcontractors as well). Standards are specified in the MCO/CSP Systems Manual and at 42 CFR Section 431.306(b);

(6) track changes in the member's category of eligibility for Salud! and for SCI, the Federal Poverty Level when appropriate to ensure accurate application of copayments for covered services;

(7) maintain accurate member eligibility and demographic data;

(8) upon learning of third party coverage that was previously unknown, notify HSD/MAD within fifteen (15) calendar days when a member is verified as having dual coverage with the CONTRACTOR and within thirty (30) calendar days when a member is verified as having coverage with any other managed care organization or health insurance carrier;

(9) provide automated access to providers regarding member eligibility;

(10) provide a means for providers to verify eligibility twenty-four (24) hours a day, seven (7) days a week, and to verify eligibility of new enrollees within twenty-four (24) hours of receiving updated eligibility data from HSD/MAD; and

(11) exclude the member's social security number from the member's ID card.

Mandatory Requirements for SCI:

The CONTRACTOR shall:

(1) maintain an automated SCI system for tracking client demographics and identification codes, eligibility and enrollment by dates and income category, premium payment, and billing and payment history;

(2) have the ability to upload and download client descriptive and enrollment information through standardized text file formats for information sharing and billing processes;

(3) submit a Reverse Roster file to HSD/MAD each month, using a standardized text format, to request capitation for all enrolled members. The file will contain separate segments for each month(s) for which the member has paid a premium and/or met reenrollment requirements. HSD/MAD will use this file in conjunction with the eligibility file received from ISD to determine the capitation payment;

(4) have a system that is able to manage enrollment for individuals and groups;

(5) have system functionality to manage different co-payment amounts for different services and for members with different co-payment requirements, including effective dates of the co-payments as they could change over time;

(6) have system functionality to manage member co-payments and premium payments to indicate when maximum yearly out-of-pocket amount requirements have been met;

(7) have system functionality to manage pharmacy co-payments;

(8) maintain a member activity system to track and report co-pays, annual maximum out-of-pocket amounts and benefit maximums. the amounts will vary by member category of eligibility or individual member income; and

(9) have system functionality to manage member benefit thresholds, including the twenty-five (25) inpatient separate physical and behavioral health hospitalization bed-day limits and aggregate claim amounts to indicate when the maximum amount has been reached.

D. Claims Processing Requirements: A claim means:

(1) a bill for services; or

(2) a line item of service; or

(3) all services for one member within a bill.

The CONTRACTOR and any of its subcontractors or providers paying their own claims are required to maintain claims processing capabilities to include, but not be limited to:

(1) accepting NPI and HIPAA-compliant formats for electronic claims submission;

(2) assigning unique identifiers for all claims received from providers;

(3) standardizing protocols for the transfer of claims information between the CONTRACTOR and its subcontractors/providers, audit trail activities, and the communication of data transfer totals and dates;

(4) date stamping all claims in a manner that will allow determination of the calendar date of receipt;

(5) paying ninety percent (90%) of all clean claims within thirty (30) calendar days of receipt, and shall pay ninety-nine percent (99%) of all such clean claims within ninety (90) calendar days of receipt.

(6) paying interest at the rate of one and one-half percent (1 ½%) for each month or portion of any month on a prorated basis the amount of a clean claim electronically submitted by a contracted provider and not paid within thirty (30) calendar days of the date of receipt;

(7) paying interest at the rate of one and one-half percent (1 ½%) for each month or portion of any month on a prorated basis the amount of a clean claim manually submitted by a contracted provider and not paid within forty-five (45) calendar days of the date of receipt;

(8) reporting the number and allowed amount of clean claims submitted electronically that were not processed within the thirty (30)-day requirement and the number and allowed amount of clean claims submitted manually that were not processed within the forty-five (45)-day requirement, including the amount of interest paid to providers. Such reports will be submitted in a time frame determined by HSD/MAD;

(9) meeting both state and federal standards for processing claims;

(10) generating remittance advice to providers;

(11) participating on a committee with HSD/MAD to discuss and coordinate systems-related issues;

(12) accepting from providers and subcontractors only national HIPAA-compliant standard codes;

(13) editing claims to ensure that services being billed are provided by providers licensed to render these services, that services are appropriate in scope and amount, that members are eligible to receive the service, and that services are billed in a manner consistent with national coding criteria (e.g., discharge type of bill includes discharge date, rendering provider is always identified for facility and group practices, services provided in any inpatient/residential setting are coded with an inpatient type of bill, etc.);

(14) using the Third Party Liability (TPL) file provided on a monthly basis by HSD/MAD to coordinate benefits with other payers; and

(15) developing and maintaining a NPI HIPAA-compliant electronic billing system for all providers submitting bills directly to the CONTRACTOR and requiring all subcontractor benefit managers to meet the same standards.

E. Encounter and Provider Network Reporting Requirements:

The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.10 and NMAC 8.306.10. CMS requires that encounter data be used for rate-setting purposes. Encounter data is also used to determine compliance with performance measures and other contractual requirements as appropriate.

F. Encounter Data Requirements

HSD/MAD maintains oversight responsibility for evaluating and monitoring the volume, timeliness, and quality of encounter data submitted by the CONTRACTOR. If the CONTRACTOR elects to contract with a subcontractor to process and submit encounter data, the CONTRACTOR remains responsible for the quality, accuracy, and timeliness of the encounter data submitted to HSD/MAD. HSD/MAD shall communicate directly with the CONTRACTOR any requirements

and/or deficiencies regarding quality, accuracy and timeliness of encounter data, and not with the third party contractor. Failure to submit accurate and complete encounter data may result in financial penalties determined by HSD/MAD based upon the error, and/or the repetitive nature of the error and/or the frequency of the errors. The CONTRACTOR shall submit encounter data to HSD/MAD in accordance with the following:

(1) Encounter Submission Media

The CONTRACTOR shall provide encounter data to HSD/MAD by electronic media, such as magnetic tape or direct file transmission. Paper submission is not permitted.

(2) Encounter Submission Requirements

The CONTRACTOR shall:

a. submit to HSD/MAD at least sixty percent (60%) of its encounter files within sixty (60) days of the date of payment, at least eighty percent (80%) of its encounters within ninety (90) days and a total of ninety-nine percent (99%) of its encounters within one hundred and twenty (120) days of the date of payment in accord with the specifications included in the MCO/CSP Systems Manual, regardless of whether the encounter is from a subcontractor or subcapitated arrangement;

b. submit encounter files with no more than a three percent (3%) error rate per invoice type (837I, 837P, 837D, NCPDP). HSD/MAD will monitor the MCO corrections to denied encounters by random sampling. Seventy-five percent (75%) of the denied encounters included in the random sample must have been corrected and resubmitted by the MCO within thirty (30) days of denial.

c. include the CONTRACTOR paid amount on each encounter submitted;

d. submit adjustments/voids to encounters, in a HIPAA compliant format, that have previously been accepted by HSD/MAD within thirty (30) calendar days of the adjustment or void of the claim by the CONTRACTOR;

e. have written contractual requirements of subcontractors or providers that pay their own claims to submit encounters to

the CONTRACTOR on a timely basis which ensures that the CONTRACTOR can meet its timeliness requirements for encounter submission;

f. edit encounters prior to submission to prevent or decrease submission of duplicate encounters, encounters from providers not on the CONTRACTOR's provider network file and other types of encounter errors;

g. have a formal monitoring and reporting system to reconcile submissions and resubmission of encounter data between the CONTRACTOR and HSD/MAD to assure timeliness of submissions, resubmissions and corrections and completeness and accuracy of data. The CONTRACTOR shall be required to report the status of their encounter data submissions overall on a form developed by HSD/MAD;

h. have a formal monitoring and reporting system to reconcile submissions and resubmissions of encounter data between the CONTRACTOR and the subcontractors or providers who pay their own claims to assure timeliness, completeness and accuracy of their submission of encounter data to the CONTRACTOR;

i. comply with the most current federal standards for encryption of any data that are transmitted via the internet (also applies to subcontractors). A summary of the current CMS and HIPAA guidelines is included in the MCO/CSP Systems Manual;

j. comply with CMS and HIPAA standards for electronic transmission, security and privacy (also applies to subcontractors);

k. report all data noted as "required" in the HIPAA Implementation Guide and HSD/MAD's Encounter Companion Guide;

l. make necessary adjustments to their system capabilities in order to submit both paid and denied encounters when HSD/MAD is capable of accepting denied encounters;

m. for SCI, maintain a running balance of year-to-date expenditures for each member, which must include expenditures reported from the SE on behavioral health services; and

n. for SCI, maintain a claims tracking method to identify members who reach the $50,000 benefit claims threshold and/or the twenty (20)-day hospital bed threshold on a benefit year basis in order to coordinate with HSD/MAD in instituting appropriate measures to ensure that members who reach this limit are being monitored and that another program of care can be identified for their care once the annual claims limit or the twenty-five (25) day limit for inpatient hospitalization or the twenty-five (25) day limit for behavioral health hospitalization is reached.

(3) Encounter Data Elements

Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and managed care organizations, and those required by CMS or HSD/MAD for use in managed care. Subject to the provisions of Section 4.2 of this Agreement, HSD/MAD may increase or reduce or make mandatory or optional, data elements, as it deems necessary. The CONTRACTOR will be held harmless in conversion to HIPAA coded encounter data when delays are the result of HIPAA implementation issues at HSD/MAD. The transition to HIPAA codes and requirements does not relieve the CONTRACTOR of timely submission of encounter data.

(4) Encounter Data Formats

The CONTRACTOR shall submit encounter data to HSD/MAD using the 837 and NCPDP formats. HSD/MAD will work with the CONTRACTOR and HSD/MAD's claims processing contractor to provide the CONTRACTOR with an electronic disposition of each submitted encounter.

2.12 REIMBURSEMENT AND COMPENSATION

A. General Requirements

The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.11 and NMAC 8.306.11. HSD/MAD shall make payments under capitated risk contracts, which are actuarially sound. Rates shall be developed in accordance with generally accepted actuarial principles and practices. Rates must be appropriate for the populations to be covered, the services to be furnished under the contract 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.

To the extent, if any, it is determined by the appropriate taxing authority that the performance of this Agreement by the CONTRACTOR is subject to taxation, the amounts paid by HSD/MAD to the CONTRACTOR under this Agreement shall include such tax(es) and no additional amount shall be due from HSD/MAD. Therefore, the amount paid by HSD/MAD shall include all taxes that may be due and owing by the CONTRACTOR. The CONTRACTOR is responsible for reporting and remitting all applicable taxes to the appropriate taxing agency.

B. Compensation and Programmatic Changes

The Parties to this contract understand and agree that the compensation and payment reimbursement for managed care is dependent upon federal and state funding and regulatory approvals. The Parties further understand that program changes affecting the rate of compensation for managed care are likely to occur during the term of this Agreement and further agree to the following if such program changes are implemented by HSD/MAD during the term of this contract:

(1) In the event that HSD/MAD initiates a programmatic change affecting compensation and payment reimbursement for managed care during the term of this Agreement, HSD/MAD shall, prior to initiating any such change, provide the CONTRACTOR with as much notice as is possible, given the circumstance, of the contemplated change and the effect it will have on compensation and payment reimbursement for managed care.

(2) Upon notice of (i) a proposed program change, (ii) a change in government costs, taxes or fees, or (iii) a benefit modification, i.e., a change or a final judicial decision affecting reimbursement rates, the CONTRACTOR may initiate negotiations for a modification of the Agreement concerning changes in compensation and payment reimbursement for managed care and program changes. Such programmatic changes and any resulting negotiations and modifications shall be limited to the change in compensation and payment reimbursement for managed care and program changes, and shall not subject the entire contract to being reopened.

(3) If the CONTRACTOR does not request negotiations for a modification of the Agreement concerning the change in compensation and payment reimbursement for managed care and program changes, within fifteen (15) calendar days of the notice

from HSD/MAD, then the change shall be implemented and become effective under Article 34 of this contract, subject to the continued actuarial soundness of the rates.

C. Payment for Services

(1) HSD/MAD shall pay a capitated amount to the CONTRACTOR for the provision of the managed care benefit package. The monthly rate for each member is based on actuarially sound capitation rate cells. Salud! and SCI members shall be held harmless against any liability for debts of a CONTRACTOR that were incurred within the Agreement in providing covered services to the Medicaid member.

(2) In the Salud! program, if a member loses eligibility for any reason and is reinstated as eligible by HSD/MAD before the end of the month, the CONTRACTOR must accept a retro-capitation payment for that month of eligibility and assume financial responsibility for all services supplied to the member. HSD/MAD must notify the CONTRACTOR of this retro capitation by the last day of the month. If this notification is not made by the last day of the month, the CONTRACTOR may choose to refuse the retro capitation.

(3) Reimbursement to CONTRACTOR Indian Health Services (IHS)/Tribal 638 facilities for Services rendered to Salud! and SCI members:

a. The State will pay the CONTRACTOR, on a quarterly basis, for the costs of services provided to Salud! and SCI Members at IHS and Tribal 638 facilities. This payment shall be separate from the Capitation Rate process and be based upon the State's validation of data provided by the CONTRACTOR to the State.

b. HSD/MAD will reimburse the CONTRACTORS based on encounters that have been accepted as paid by the MMIS. Reimbursement shall not exceed amounts reported as paid by the CONTRACTOR on IHS Report 41 for the same period.

c. The CONTRACTOR shall submit a quarterly report to HSD/MAD, including claims data, in a format specified by the State within forty-five (45) calendar days of the end of the quarter of their payment for services provided under this Section.

d. The CONTRACTOR shall have up to two (2) years from a claim's first date of service to submit a claim or within six (6) months after the termination of this Agreement. Claims not submitted within this time-period are not eligible for reimbursement and will not be paid.

(4) Salud! members, including SCHIP members, and SCI members shall be held harmless against any liability for debts of the CONTRACTOR which were incurred within the Agreement in providing health care to the Salud! or SCI members, excluding any member's liability for applicable premiums, co-payment or member's liability for an overpayment resulting from benefits paid pending the results of a fair hearing. If the member fails to meet co-payment requirements, the CONTRACTOR's providers have no obligation to continue to see the member except in an emergency situation.

(5) 42 CFR Section §438.6(c), which regulates participation in the Medicaid program, requires that all payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound and approved as such by the CMS prior to implementation. To meet the requirement for actuarial soundness, all capitation rates must be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles, as set forth in the standards of practice established by the Actuarial Standards Board. Accordingly, HSD/MAD's offer of all capitation rates is contingent on both certifications by HSD/MAD's actuary and final approval by CMS, prior to becoming effective for payment purposes. In the event such certification or approval is not obtained for any or all capitation rates subject to this regulation, HSD/MAD reserves the right to renegotiate these rates. HSD/MAD's decision to renegotiate the rates under the circumstances described above is binding on the CONTRACTOR.

(6) Retro capitation payments may not be issued for clients for the same coverage month in which Fee-For-Service claims have already been paid by Medicaid except in special situations determined by HSD/MAD. When retro capitation is not issued for a particular month, the member will remain enrolled with Fee-For-Service for that month.

D. Payment on Risk Basis

The CONTRACTOR is at risk of incurring losses if its expenses for providing the Salud! or SCI benefit package exceed its capitation payment. HSD/MAD shall not provide a retroactive payment adjustment to the CONTRACTOR to reflect the cost of services actually furnished by the CONTRACTOR. The CONTRACTOR may retain its profits subject to the limitations set forth in Section 2.12.R below.

E. Changes in the Capitation Rates

(1) The capitation rates awarded with this Agreement shall be effective for the time period shown on the attached rate sheet. HSD/MAD reserves the right to prospectively reset the rates, if necessary. The capitation rates may be adjusted based on factors such as: changes in the scope of work, CMS requiring a modification of HSD/MAD's waiver if new or amended federal or state laws or regulations are implemented, inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of the CONTRACTOR by members in certain rate cohorts. Any changes to the rates shall be actuarially sound under applicable law and reset and implemented pursuant to Articles 11 (Contract Modification) and 34 (Amendments) of this Agreement.

(2) HSD/MAD shall compensate the CONTRACTOR for work performed under this Agreement at the rates shown on the attached rate sheet.

(3) The CONTRACTOR remains ultimately liable to HSD/MAD for the services rendered under the terms of this Agreement. If the CONTRACTOR is required to obtain reinsurance, the CONTRACTOR shall provide a copy of its proposed reinsurance agreement to HSD/MAD annually, beginning with the effective date of this Agreement.

F. Reimbursement to Providers – General Expectations

The CONTRACTOR shall:

(1) pay at least HSD/MAD Fee-For-Service rates for services provided to members unless otherwise negotiated with a provider;

(2) make payments to IHS and Tribal and urban Indian facilities which furnish services to Salud! and SCI members;

(3) make extensive efforts to contract with Family Planning Clinics and make payments to out-of-network family planning providers which serve CONTRACTOR Salud! and SCI members; and

(4) reimburse providers for EPSDT services, specific services to be determined by HSD/MAD, delivered to members less than twenty-one years of age, covered by one of the Medicaid home-and-community based waivers.

G. Premium Sharing – SCI only

In addition to capitation payments from HSD/MAD, the CONTRACTOR shall receive premium payments as specified by HSD/MAD.

(1) Premium Timeframes

Initial premiums (if required) are due to the CONTRACTOR on or before the date that the CONTRACTOR uses for its commercial products. Coverage can begin only after the initial premium (if required) has been paid. All other premiums (if required) are due in accordance with the monthly due date established by the CONTRACTOR.

a. In the case of employer group coverage, if a premium other than the initial premium is not received within an agreed upon specified time period the CONTRACTOR shall send a notice of premium lapse to the employer. If the CONTRACTOR still does not receive the required premiums by a specified time, it shall send a notice to the employer that the employees will be notified. Within an agreed upon time period, the CONTRACTOR shall send a notice of premium payment lapse to the employees, and if payment is not received by the time period described in the notice the CONTRACTOR shall not include that employer group on the enrollment roster submitted to HSD/MAD. The employer group will not be covered effective the first day of the following month. When the CONTRACTOR excludes the employer group from the roster submitted to HSD/MAD, the CONTRACTOR shall send a notice of coverage termination to the employees, the employer, and HSD/MAD. At that time, the CONTRACTOR shall also notify HSD/MAD of the year-to-date benefits paid for each member in the employer group and then update this information one hundred and twenty (120) days later. The employer will not be able to re-enroll in an SCI MCO for a period of twelve (12) months. The premiums owed by the

employer and employees are a debt to the CONTRACTOR.

b. In the case of a member not part of an employer group, if a premium payment, other than the initial premium, is not received within an agreed upon specified time period the CONTRACTOR shall send a notice of premium lapse and that coverage will be terminated. If the premium payment is not received by an agreed upon time period the CONTRACTOR shall remove that member from the enrollment roster submitted to HSD/MAD, so the member will not be covered effective the first day of the following month. When the CONTRACTOR excludes the member from the roster submitted to HSD/MAD, the CONTRACTOR shall send a notice of coverage termination to the member and HSD/MAD. At that time the CONTRACTOR shall also notify HSD/MAD of the year to date benefits paid for the member and then update this information one hundred and twenty (120) days later. The member will not be able to re-enroll in an SCI MCO for a period of six (6) months. The premiums owed by the member are a debt to the CONTRACTOR.

(2) Responsibility for Premium Payment

For members in an employer group, the employer shall be responsible for ensuring payment of the employer and the member share (if any) of premiums. For members who are not affiliated with an employer group, the member shall be responsible for payment of both the employer (if any) and the member share (if any). If a member has met the cost-sharing maximum, as verified by the CONTRACTOR, HSD/MAD shall be responsible for payment of the member's (but not the employer's) share of premiums. If a member has met the cost-sharing maximum, as verified by the CONTRACTOR, the CONTRACTOR shall issue a new identification card and, for members in an employer group, send an adjusted bill to the employer.

H. Fiduciary Responsibilities

(1) Solvency Requirements and Risk Protections

A CONTRACTOR that contracts with HSD/MAD for the provision of services shall comply with and is subject to all applicable state and federal laws and regulations including those regarding solvency and risk standards. In addition to requirements imposed by state or federal law, the CONTRACTOR shall be

required to meet specific Medicaid financial requirements and to present to HSD/MAD or its agent any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD/MAD, at no cost to HSD/MAD, in a reasonable time from the date of request or as specified herein.

(2) Reinsurance

The CONTRACTOR 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. The CONTRACTOR shall submit to HSD/MAD such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance. Information provided to HSD/MAD on the CONTRACTOR's reinsurance must be computed on an actuarially sound basis. In lieu of this requirement, the CONTRACTOR may provide sufficient documentation to HSD/MAD that the CONTRACTOR has adequate protection against financial loss due to outlier (catastrophic) cases. HSD/MAD shall review such documentation and at its discretion, deem this requirement to be met.

(3) Third-Party Liability

The CONTRACTOR is responsible for identification of third-party coverage of members and coordination of benefits with applicable third parties. The CONTRACTOR shall inform HSD/MAD of any member who has other health care coverage. The CONTRACTOR shall provide documentation to HSD/MAD enabling HSD/MAD to pursue its rights under state and federal law. Documentation includes payment information, collections and/or recoveries for services provided to enrolled members as requested by HSD/MAD, Third Party Liability Unit of the HSD/MAD, to be delivered within twenty (20) business days from receipt of the request. Other documentation to be provided by the CONTRACTOR, upon request by HSD/MAD, includes a quarterly listing of potential accident and personal injury cases that are known to the CONTRACTOR. The CONTRACTOR has the sole right of subrogation, for twelve (12) months, to initiate recovery or to attempt to recover any third-party resources available to Medicaid members, for all services provided by CONTRACTOR pursuant to this Agreement.

The CONTRACTOR shall work with the other Salud!/SCI Contractors to jointly develop and submit to HSD/MAD a single

reporting format to carry out the requirement of this subsection. However, if an agreed upon format cannot be developed, HSD/MAD retains the right to make a final determination of the reporting format.

(4) Fidelity Bond Requirement

The CONTRACTOR shall maintain in force a fidelity bond in the amount of at least $250,000 as specified under the Insurance Code, NMSA 1978, §§ 59A-1-1 et. seq.

(5) Net Worth Requirement

The CONTRACTOR shall at all times be in compliance with the net worth requirements set forth in the Insurance Code.

(6) Solvency Cash Reserve Requirement

a. The CONTRACTOR shall maintain a reserve account to ensure that the provisions of Covered Services to Members are not at risk in the event of the CONTRACTOR's insolvency. The CONTRACTOR shall comply with all state and federal laws and regulations regarding solvency, risk, and audit and accounting standards. CONTRACTOR must be licensed or certified by the state as a risk-bearing entity.

b. Per Member Cash Reserve

The CONTRACTOR shall, in an amount equal to three percent (3%) of the estimated annualized monthly capitation payments, either: (1) procure a performance, surety or other bond reasonably acceptable to HSD/MAD, or (ii) deposit such an amount into a reserve account. If the CONTRACTOR elects to establish a reserve account, the CONTRACTOR shall maintain this case reserve for the duration of this Agreement. HSD/MAD shall adjust this cash reserve requirement annually, as needed, based on the number of the CONTRACTOR's members. The cash reserve account may be accessed solely for payment for Covered Services to the CONTRACTOR's members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned. The CONTRACTOR shall be permitted to invest its cash

reserves consistent with the Division of Insurance regulations and guidelines.

If the cash reserve account falls below the required amount, the CONTRACTOR shall increase the reserve account to the one hundred percent (100%) level within thirty (30) days. Failure to maintain the reserve as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month. If the cash reserve account exceeds one hundred and five percent (105%) of an amount equal to three percent (3%) of the annualized capitation as determined above, for more than two (2) months, the CONTRACTOR shall reduce the reserve to the one hundred percent (100%) level and the CONTRACTOR shall comply with such direction within thirty (30) days.

(7) Inspection and Audit for Solvency Requirements

The CONTRACTOR shall meet all requirements for licensure within the State with respect to inspection and auditing of financial records. The CONTRACTOR shall also cooperate with HSD/MAD or its designee, and provide all financial records required by HSD/MAD or its designee so that they may inspect and audit the CONTRACTOR's financial records at least annually or at HSD/MAD's discretion.

(8) Insurance

a. The CONTRACTOR, its successors and assignees shall procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance shall include, but not be limited to, the following:

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

ii. Workers compensation as required by state and/or federal regulations;

iii. Unemployment insurance as required by state and/or federal regulations;

iv. Reinsurance;

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

vi. Health insurance for employees as further set forth in Article 37.

b. The CONTRACTOR shall provide HSD/MAD with documentation at least annually that the above specified insurance has been obtained; and the CONTRACTOR's subcontractors shall provide the same documentation to the CONTRACTOR.

(9) The CONTRACTOR shall have and maintain adequate protections against financial loss due to outlier (catastrophic) cases and member utilization that is greater than expected. The CONTRACTOR shall submit to HSD/MAD such written documentation as is necessary to show the existence of this protection, which may include policies and procedures of reinsurance.

(10) Special contract provisions as required by 42 CFR Section §438.6 (c)(5): Pursuant to 42 CFR Section §438.6(c)(5), contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis. Certification of actuarial soundness must be submitted by HSD/MAD annually or with thirty (30) days of any change.

I. Capitation Procedures

(1) HSD/MAD shall distribute an aggregate amount of capitation revenue to the CONTRACTOR for all members enrolled with the CONTRACTOR on or before the second Friday of each month.

(2) HSD/MAD shall make a full monthly payment to the CONTRACTOR for the month in which the member's enrollment is terminated. The CONTRACTOR shall be responsible for covered medical services provided to the member in any month for which HSD/MAD paid the CONTRACTOR for the member's care under the terms of this Agreement.

(3) HSD/MAD shall have the discretion to recoup payments from the CONTRACTOR made by HSD/MAD pursuant to the time periods governed by this Agreement for the following:

a. members incorrectly enrolled with more than one CONTRACTOR;

b. members who die prior to the enrollment month for which payment was made; and/or

c. members whom HSD/MAD later determines were not eligible for Salud! or SCI during the enrollment month for which payment was made. HSD/MAD acknowledges and agrees that in the event of any recoupment pursuant to this section, CONTRACTOR shall have the right to recoup from providers or other persons to whom CONTRACTOR has made payment during this period of time.

(4) In the event of an error which causes payment(s) to the CONTRACTOR to be issued by HSD/MAD, the CONTRACTOR shall reimburse HSD/MAD within thirty (30) days of written notice of such error for the full amount of the payment, subject to the provision of Section 2.12.I(3) of the Agreement. Interest shall accrue at the statutory rate on any amounts determined to be due but not paid and determined to be due after the thirtieth (30th) day following the notice. Any process that automates the recoupment procedures will be discussed in advance by HSD/MAD and the CONTRACTOR and documented in writing prior to implementation of a new automated recoupment process. The CONTRACTOR has the right to dispute any recoupment requests in accordance with Article 14 (DISPUTES).

(5) For individuals who were enrolled with more than one CONTRACTOR, the CONTRACTOR from whom the capitation payment is recouped shall have the right to recoup incurred expenses from the CONTRACTOR who retains the capitation payment.

J. Coordination of Benefits

On a periodic basis, HSD/MAD shall provide the Salud! CONTRACTOR with coordination of benefits information for enrolled members. The CONTRACTOR shall:

(1) not refuse or reduce services provided under this Agreement solely due to the existence of similar benefits provided under other health care contracts;

(2) notify HSD/MAD as set forth below when the CONTRACTOR learns (not identified in enrollment roster) that a member has TPL for medical care:

a. within fifteen (15) calendar days when a member is verified as having dual coverage under its managed care organization; and

b. within fifteen (15) calendar days when a member is verified as having coverage with any other managed care organization or health carrier;

(3) communicate and ensure compliance with the requirements of this section by subcontractors that provide services under the terms of this Agreement;

(4) not charge members for services covered under the terms of this Agreement, except as provided in the HSD/MAD Provider Policy Manual NMAC 8.302.3, ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS; and

(5) deny payments provided for under this Agreement for new members when, and for so long as, payment for those members is denied under 42 CFR Section §438 Subpart I.

K. Data Certification Requirements

For HSD/MAD payments to a CONTRACTOR that are based on financial data submitted by the CONTRACTOR, the CONTRACTOR shall certify the financial data as per 42 CFR §438.606. HSD/MAD considers all required financial reports and related requests as elements of payment determination and process. Therefore, the data that shall be certified include, but are not limited to, all financial reports designated by requested by and submitted to HSD/MAD, all associated documents specified by HSD/MAD, enrollment information, encounter data and other information contained in contracts or proposals. The certification shall attest, based on best knowledge, information and belief as to the accuracy, completeness and truthfulness of the documents and data. The CONTRACTOR shall submit the certification concurrently with the certified data and documents.

The data and documents the CONTRACTOR submits to HSD/MAD shall be certified by one of the following:

(1) the CONTRACTOR's Chief Executive Officer;

(2) the CONTRACTOR's Chief Financial Officer; or

(3) an individual who has been delegated the authority to sign for, and who reports directly to, the CONTRACTOR's Chief Executive Officer or Chief Financial Officer.

For all other non-financial reports, CONTRACTOR will indentify on the reports the name and title of the person who can attest, based on best knowledge, information and belief as to the accuracy, completeness and truthfulness of the documents and data.

L. Timely Payments

The CONTRACTOR shall make timely payments to both its contracted and non-contracted providers. The CONTRACTOR and any of its subcontractors or providers paying their own claims are required to maintain claims processing capabilities to comply with all state and federal regulations.

M. Finance – General Expectations

The CONTRACTOR shall:

(1) track all financial information related to Salud! separately from all other lines of business and maintain accounting systems that are in accordance with generally accepted accounting principles and standards; and/or statutory accounting principles and standards;

(2) track all financial information related to SCI separately from all other lines of business and maintain accounting systems that are in accordance with generally accepted accounting principles and standards; and/or statutory accounting principles and standards;

(3) have net profit/margins of not more than three percent (3%) of revenue generated in the aggregate for the programs, not including the Premium Assistance programs, covered under this Agreement. Excess profit margins shall be expended on service-related programs as designated by HSD/MAD or recommended by the CONTRACTOR and approved by HSD/MAD; and

(4) provide a record of all Salud! program expenditures for all services including all Salud! subcontracted services; and

(5) provide a record of all SCI program expenditures for all services including all SCI subcontracted services.

N. Special Reimbursement Requirements

This section lists special payment requirements by provider type:

(1) Reimbursement of Federally Qualified Health Centers (FQHCs)

FQHCs are entitled to reimbursement at one hundred percent (100%) of reasonable cost as determined by the State or federal government. The FQHC can waive its right to reasonable cost and elect to receive the rate negotiated with the CONTRACTOR. During the course of the contract negotiations with the CONTRACTOR, the FQHC shall state explicitly that it elects to receive one hundred percent (100%) of reasonable costs or waive this requirement.

If the FQHC does not waive its rights to receive 100% of reasonable costs, the CONTRACTOR is required to reimburse the FQHC at the current Medicaid fee schedule or Alternative Payment Methodology (APM). This rate meets the CONTRACTOR's responsibility toward HSD/MAD's obligation to reimburse FQHCs at one hundred percent (100%) of reasonable costs as determined by HSD/MAD's external audit agency.

The FQHC reports annually to HSD/MAD's audit agent the reimbursement received from the CONTRACTOR. HSD/MAD's audit agent will perform a reconciliation annually based upon FQHC revenue and encounters. HSD/MAD's audit agent will submit an Accounting Transaction Request (ATR) to HSD/MAD to initiate additional HSD/MAD funding to meet HSD/MAD's obligation to pay the one hundred percent (100%) threshold or request recoupment of payments in excess of the one hundred percent (100%) threshold.

(2) Reimbursement for IHS and Tribal 638 facilities

If an IHS or Tribal 638 provider delivers services to the CONTRACTOR's member, the CONTRACTOR shall reimburse the provider at the rate currently established for the IHS facilities or federally leased facilities by the Office of Management and Budget (OMB). If a rate is not established for a particular service, then reimbursement shall be at the fee schedule established by HSD/MAD. Pharmacy, inpatient physician services, case management, vision appliances, nutritional services and ambulatory surgical center services shall be paid at the fee schedule established by HSD/MAD. Services provided within the

IHS and Tribal 638 facilities are not subject to prior authorization requirements.

(3) Reimbursement for Family Planning Services

The CONTRACTOR shall reimburse out-of-network family planning providers for provision of services to CONTRACTOR Salud! and SCI members at a rate, which at a minimum equals the applicable Medicaid Fee-For-Service rate appropriate to the provider type.

(4) Reimbursement for Women in the Third Trimester of Pregnancy

If a pregnant woman in the third trimester of pregnancy has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not participating with the CONTRACTOR, the CONTRACTOR shall reimburse the nonparticipating provider at the applicable Medicaid Fee-For-Service rate appropriate to the provider type.

(5) Reimbursement for Pregnancy Termination

The CONTRACTOR shall pay claims submitted by qualified and credentialed provider for State and Federally approved pregnancy termination procedures rendered to eligible MCO Salud! and SCI enrollees.

The CONTACTOR shall be reimbursed for the Healthcare Common Procedure Coding System ("HCPCS") Procedure Codes: S0190, S0191, S2260, S2262, S2265, S2266, and S2267 with appropriate modifiers, as changed and as modified and Current Procedural Terminology ("CPT") Procedure Codes: 59840, 59841, 59850, 59851, 59852, 59855, 59856, and 59857 with appropriate modifiers, as changed and modified. The CONTRACTOR shall be reimbursed for claims at either the established Medicaid fee schedule rate or the contracted rate, whichever is less, as of the date of service, plus gross receipts tax as applicable. HSD/MAD shall reimburse the CONTRACTOR with State funds for State funded services and State funds and federal match for federally funded services via invoicing methodology.

(6) Reimbursement for members who disenroll while hospitalized

a. Salud! Members and Medicaid Fee-For-Service (FFS) Members:

If an MCO or FFS member is hospitalized at the time of enrollment or disenrollment from managed care or upon an approved switch from one MCO to another, the originating MCO or FFS shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico Department of Health. The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud!

b. Salud! MCO and CoLTS MCO Members:

For members transitioning to or from CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud!

For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE.

c. SCI Members

If the member is hospitalized at the time of disenrollment from SCI, or upon an approved switch from one SCI Contractor to another, the CONTRACTOR at the time of admission remains responsible for all covered and/or approved services until the earliest of the date of discharge, date of switch to another Contractor, date of the member's termination/disenrollment of until the maximum benefit limits are reached.

For the purposes of this Agreement:

a. When a member is moved from or to a Prospective Payment System (PPS) exempt unit (such as a rehabilitation or psychiatric unit) within an acute care hospital, the move is considered a "discharge."

b. When a member is moved from or to a specialty hospital as designated by DOH or HSD/MAD, the move is considered a "discharge."

c. When a member is moved from or to a PPS exempt hospital (such as a psychiatric or rehabilitation hospital), the move is considered a "discharge."

d. When a member leaves the acute care hospital setting to a home/community setting, the move is considered a discharge."

e. When a member leaves the acute care hospital setting to an institutional setting, the "discharge" date is based upon approval of the abstract and/or by HSD/MAD.

NOTE: It is not a "discharge" when a member is moved from one acute care facility to another acute care facility, including out-of-state acute case facilities.

If a member is hospitalized and is disenrolled from manage care/FFS due to a loss in Medicaid coverage, the MCO or FFS, respectively, is only financially liable for the inpatient hospitalization and associated professional services until such time that the member/client is determined to be ineligible for Medicaid.

(7) If a member is in a nursing home at the time of disenrollment (not including loss of Medicaid eligibility), the CONTRACTOR shall be responsible for the payment of all covered services until the date of discharge or the date of disenrollment from Salud!, whichever occurs first.

O. Special Payment Requirements

In the event HSD/MAD obtains additional funding identified for increased reimbursement to specific service providers, the CONTRACTOR agrees that it will pass on all such additional funding less applicable taxes following the receipt of the additional funding by CONTRACTOR from HSD/MAD. The CONTRACTOR shall make such payments only to those types of service providers identified by HSD/MAD in writing and who are contracted directly, or through a delegated arrangement, with CONTRACTOR. The CONTRACTOR and HSD/MAD agree that CONTRACTOR's obligation under this section to pass through any additional funding will require at least thirty (30) days prior written notice. HSD/MAD and CONTRACTOR agree that no payments will be required to be made pursuant to this section until HSD/MAD has provided written

approval of the payment process to be utilized by CONTRACTOR to ensure that the process will meet HSD/MAD audit requirements. HSD/MAD reserves the right to direct payments to providers if the CONTRACTOR fails to comply with the pass-through requirements. HSD/MAD and the CONTRACTOR shall develop a mechanism to report outcomes associated with the pass-through.

P. Reimbursement for Emergency Services

Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept, as payment in full, no more than the amount it would receive if the services were provided under the State's Fee-For-Service Medicaid plan. This rule applies whether the non-contracting provider is within the state or outside of the state in which the managed care entity has a contract.

(1) The CONTRACTOR shall ensure that acute general hospitals are reimbursed for emergency services, which they are required to provide because of federal mandates such as the "anti-dumping" law in the Omnibus Budget Reconciliation Act of 1989. P.L. 101-239 and 42 U.S.C. Section 1395 dd (Section 1867 of the Social Security Act).

(2) The CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member, if the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists. The CONTRACTOR may not refuse to cover emergency services based on an emergency room provider, hospital or fiscal agent not notifying the member's primary care provider or the CONTRACTOR of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member. The member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, as provided in 42 CFR §438.114(d).

(3) The CONTRACTOR is required to pay for all emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

(4) If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the present symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. The CONTRACTOR may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. If the member believes that a claim for emergency services has been inappropriately denied by the CONTRACTOR, the member may seek recourse through the CONTRACTOR or an HSD/MAD appeal.

(5) When the member's primary care physician or other CONTRACTOR representative instructs the member to seek emergency care in-network or out-of-network, the CONTRACTOR is responsible for payment of at least the negotiated network rate or, for out of network providers, the Medicaid Fee-for Service Fee Schedule, for the medical screening examination and for other medically necessary emergency services intended to stabilize the member without regard to whether the member meets the prudent layperson standard.

(6) The attending emergency physician or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the entities identified in 42 CFR §438.114(b) as responsible for coverage and payment. In addition, the CONTRACTOR is financially responsible for post-stabilization services administered to maintain, improve or resolve the member's stabilized condition if:

a. the CONTRACTOR does not respond to a request for pre-approval within one hour;

b. the CONTRACTOR cannot be contacted; or

c. the CONTRACTOR representative and the treating physician cannot reach an agreement concerning the

member's care and a CONTRACTOR physician is not available for consultation. In this situation, the CONTRACTOR must give the treating physician the opportunity to consult with a CONTRACTOR and the treating physician may continue with care of the member until a CONTRACTOR physician is reached or one of the criteria of 42 CFR 422.113(c)(3) is met.

(7) The CONTRACTOR is financially responsible for post-stabilization services obtained within or outside the CONTRACTOR's network that are pre-approved by CONTRACTOR's network provider. The CONTRACTOR's financial responsibility for post-stabilization services that have not been pre-approved shall end when:

a. a CONTRACTOR physician with privileges at the treating hospital assumes responsibility for the member's care;

b. a CONTRACTOR physician assumes responsibility for the member's care through transfer;

c. a CONTRACTOR representative and the treating physician reach an agreement concerning the member's care; or

d. the member is discharged.

Q. Special Circumstances for Pharmacy Reimbursement

The CONTRACTOR may determine their formula for estimating acquisition cost and establishing pharmacy reimbursement. The CONTRACTOR must comply with the provisions of NMSA 1978, §27-2-16(B). Specifically, the CONTRACTOR must base its formula for estimation of acquisition cost and reimbursement on regulations promulgated and published by HSD/MAD regarding the wholesale cost for the ingredient component of pharmacy reimbursement.

The CONTRACTOR is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted in instances for which a practitioner has written a prescription and for which the item is an economical or preferred therapeutic alternative to prescription drug items. The CONTRACTOR shall:

(1) cover brand name drugs and drug items not generally on the CONTRACTOR formulary or PDL when determined to be medically necessary by the CONTRACTOR or through a Fair Hearing process;

(2) include on the CONTRACTOR's formulary or PDL all 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 necessary, and cough, cold and allergy medications. This requirement does not preclude a CONTRACTOR from requiring authorization prior to dispensing a multi-source generic item;

(3) reimburse family planning clinics, school-based health clinics and Department of Health public health clinics for oral contraceptive agents and Plan B when dispensed to members and billed using HCPC codes and CMS 1500 forms; and

(4) shall meet all federal and state requirements related to pharmacy rebates, and submit all necessary information as directed by HSD/MAD.

R. Acceptance of Capitation Rates

The CONTRACTOR shall accept the capitation rate paid each month by the HSD/MAD as payment in full for all services to be provided pursuant to this Agreement, including all administrative costs associated therewith. The CONTRACTOR's income generated under this Agreement includes, but is not limited to, all capitated payments paid to the CONTRACTOR, Third Party Recoupments and Interest.

HSD/MAD will calculate the CONTRACTOR's income and expenditures at the end of the Agreement to determine the percent expended on direct services. Determinations shall be made utilizing information reported by the CONTRACTOR to HSD/MAD, the Insurance Division of the Public Regulation Commission, and other governmental departments and/or other public sources. The minimum percent expended on direct services shall be eighty-five percent (85%) over the life of the Agreement.

Determinations shall be made using the following list as administrative expenses and/or costs; all other expenses shall be considered paid for by CONTRACTOR for direct services to Medicaid members with the exception of premium tax and the NMMIP assessments which are neither administrative or direct medical expense.

(1) network development and contracting;

(2) direct provider contracting;

(3) credentialing/re-credentialing;

(4) information systems;

(5) encounter data collection and submission;

(6) claims processing for select contractors;

(7) Consumer Advisory Board and tribal meetings;

(8) Member Services;

(9) training and education for providers and consumers;

(10) financial reporting;

(11) licenses;

(12) taxes, excluding premium tax and NMMIP assessments;

(13) plant expenses;

(14) staff travel;

(15) legal and risk management;

(16) recruiting and staff training;

(17) salaries and benefits;

(18) supplies, non-medical;

(19) purchased service, non-medical, excluding member and attendant travel, meals and lodging costs, reinsurance expense and risks delegated to third parties with HSD/MAD's approval;

(20) depreciation and amortization;

(21) audits;

(22) grievance and appeals;

(23) capital outlay;

(24) reporting and data requirements;

(25) compliance;

(26) profit;

(27) care coordination, as defined in Article 2.10;

(28) surveys;

(29) quality assurance;

(30) quality improvement/quality management;

(31) marketing; and

(32) penalties.

The CONTRACTOR may, during the current fiscal year, request a determination by HSD/MAD as to whether any particular payment or future payment made by CONTRACTOR to any individual or entity would be considered an administrative expense or calculated as a direct service expense. HSD/MAD shall have thirty (30) calendar days from receipt of the request to make such determination. All determinations made by HSD/MAD pursuant to this Section shall be considered final and valid only for the State Fiscal Year for which the determination is made.

The parties agree that for the life of this Agreement, the minimum expended on direct services shall be no less than eighty-five percent (85%) of the CONTRACTOR's gross revenue.

HSD/MAD shall issue its final calculation in writing within one hundred and eighty (180) days after the close of the fiscal year or termination of this Agreement. To the extent that CONTRACTOR fails to meet the minimum percent set forth herein, HSD/MAD shall, at the time it issues its final calculation, advise CONTRACTOR of this deficiency and require CONTRACTOR to remit the overpayment to HSD/MAD, or its designee, or otherwise advise CONTRACTOR as to how the overpayment shall be treated for purposes of compliance with this Section. If CONTRACTOR disputes HSD/MAD's final calculation, it must advise HSD/MAD within fourteen (14) calendar days of receipt of the final calculation. Thereafter, the parties shall informally meet to resolve the matter; such meeting must take place within fourteen (14) calendar days of HSD/MAD's receipt of CONTRACTOR's dispute. If the parties cannot informally resolve the matter, CONTRACTOR may exercise its rights under Article 14 of this Agreement.

Members shall be entitled to receive all covered services for the entire period for which payment has been made by HSD/MAD. Any and all

costs incurred by the CONTRACTOR in excess of the capitation payment will be borne in full by the CONTRACTOR. Interest generated through investment of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and, to the extent maintained in a segregated account, considered as income.

S. Maximum Percentage of Administrative Costs

In order to ensure that the average expended on direct medical services is at least eighty-five percent (85%) of the CONTRACTOR's gross revenue over the life of the Agreement, the maximum percentage of CONTRACTOR's income expended on administrative costs shall be no more than fifteen percent (15%) measured over the life of the Agreement.

For the purpose of MLR calculation, the CONTRACTOR's income generated under this Agreement includes all combined Salud! and SCI revenue, net of premium taxes, adjustments and NMMIP assessments, as described in Article 2, Section 2.2.E.(2). of this Agreement.

If the CONTRACTOR fails to meet the maximum percentage of Administrative Costs (15%) or the minimum percentage of Direct Medical Services (85%) over the life of the Agreement, then HSD/MAD will impose a monetary penalty of three percent (3%) of the CONTRACTOR's last monthly Medicaid capitation payment.

2.13 GRIEVANCE SYSTEM

The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.12 and NMAC 8.306.12. The CONTRACTOR shall have a grievance system in place for members which includes a grievance process related to dissatisfaction, and an appeals process related to a CONTRACTOR action, including the opportunity to request an HSD/MAD fair hearing.

The member, legal guardian of the member for minors or incapacitated adults, or a representative of the member as designated in writing to the CONTRACTOR, has the right to file a grievance or an appeal of a CONTRACTOR action on behalf of the member. A provider acting on behalf of the member and with the member's written consent may file a grievance and/or an appeal of a CONTRACTOR action.

In addition to the CONTRACTOR grievance process described above, a member, legal guardian of the member or an incapacitated adult, or the representative of the member, as designated to the CONTRACTOR in writing, has the right to request a fair hearing on behalf of the member with HSD/MAD directly as described in HSD/MAD Program Manual NMAC 8.352.2, Fair Hearings, if the member believes the CONTRACTOR has taken an action erroneously. For

Salud! members, a fair hearing may be requested prior to, concurrent with, subsequent to or in lieu of a grievance and/or appeal to the CONTRACTOR. For SCI members, the CONTRACTOR's appeal process must be exhausted before the member may request a Fair Hearing. SCI members may request continuation of benefits if enrolled in SCI. Continuation of benefits may be provided to enrolled recipients who request a hearing within thirteen (13) days of the notice and the CONTRACTOR must comply by providing continuation of benefits per NMAC 8.352.2.16.

A. General Requirements for Grievance & Appeals

The CONTRACTOR shall:

(1) implement written policies and procedures describing how the member may register a grievance or an appeal with the CONTRACTOR and how the CONTRACTOR resolves the grievance or appeal;

(2) provide a copy of its policies and procedures for resolution of a grievance and/or an appeal to all service providers in the CONTRACTOR's network;

(3) 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 Teletypewriting Device for the Deaf/Teletypewriter ("TTY/TTD") and interpreter capability;

(4) name a specific individual(s) designated as the CONTRACTOR's Salud! and SCI member grievance/appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action;

(5) ensure that the individuals who make decisions on grievances and/or appeals are not involved in any previous level of review or decision-making. The CONTRACTOR shall also ensure that health care professionals with appropriate clinical expertise will make decisions for the following:

a. an appeal of a CONTRACTOR denial that is based on lack of medical necessity;

b. a CONTRACTOR denial that is upheld in an expedited resolution; and

c. a grievance or appeal that involves clinical issues;

(6) provide members, within thirty (30) calendar days of enrollment and at no cost, with a member information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD/MAD Hearings Bureau. The information shall meet the standards for communication specified in HSD/MAD Program Manual Section 8.305.2.9; and

(7) ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or against a provider that supports a member's grievance and/or appeal.

B. Grievance

A grievance is a member's expression of dissatisfaction about any matter or aspect of the CONTRACTOR or its operation other than a CONTRACTOR action.

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

(2) Within five (5) working days of receipt of the grievance, the CONTRACTOR 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 CONTRACTOR resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the CONTRACTOR or as expeditiously as the member's health condition requires and shall include a resolution letter to the grievant.

(4) The CONTRACTOR may request an extension from HSD/MAD of up to fourteen (14) calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD/MAD that there is need for additional information, and the extension is in the

member's interest. For any extension not requested by the member the CONTRACTOR shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

(5) Upon resolution of the grievance, the CONTRACTOR shall mail a resolution letter to the member no later than thirty (30) days after the initial date of the grievance. The resolution letter must include, but not be limited to, the following:

a. all information considered in investigating the grievance;

b. findings and conclusions based on the investigation; and

c. the disposition of the grievance.

C. Appeal

An appeal is a request for review by the CONTRACTOR of a CONTRACTOR action.

(1) An "action" is defined as:

a. the denial or limited authorization of a requested service, including the type or level of service;

b. the reduction, suspension, or termination of a previously authorized service;

c. the denial, in whole or in part, of payment for a service;

d. the failure of the CONTRACTOR to provide services in a timely manner, as defined by HSD/MAD in Section 2.7; or

e. the failure of the CONTRACTOR to complete the authorization request in a timely manner as defined in 42 CFR Section §438.408.

(2) Notice of CONTRACTOR Action

a. Service authorizations

The CONTRACTOR shall mail a notice of action to the member or provider and all those parties affected by the decision in accordance with NMAC 8.305.8.13 and NMAC

8.305.6.13, except as follows (42 CFR §438.404 and 42 CFR §431.200):

i. the period of advance notice is shortened to five (5) days if probable member fraud has been verified; and

ii. no later than the date of the action for the following:

1. the death of a member;

2. a signed written member statement requesting service termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information);

3. the member's admission to an institution where he is ineligible for further services;

4. the member's address is unknown and mail directed to him has no forwarding address;

5. the member has been accepted for Medicaid services by another local jurisdiction;

6. the member's physician prescribes the change in the level of medical care;

7. the adverse determination made with regard to the preadmission screening requirements for Nursing Facility admissions on or after January 1, 1989;

8. the safety or health of the individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) days (applies only to adverse actions for Nursing Facility transfers);

9. claim denial that may result in member financial eligibility; or

10. when the required timeframe expires for a service authorization, either standard or expedited.

(3) A member may file an appeal of a CONTRACTOR action within ninety (90) calendar days of receiving the CONTRACTOR's notice of action. The legal guardian of the member for minors or incapacitated adults, a representative of the member as designated in writing to the CONTRACTOR, or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member. The member or the member's representative may file an appeal either orally or in writing and must follow an oral filing with a written, signed appeal. The CONTRACTOR shall make best efforts to assist the member or the member's with this requirement. The CONTRACTOR shall consider the member, representative, or estate representative of a deceased member as parties to the appeal.

(4) The CONTRACTOR has thirty (30) calendar days from the date the oral or written appeal is received by the CONTRACTOR to resolve the appeal.

(5) The CONTRACTOR shall have a process in place that assures that an oral inquiry from the member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within ten (10) calendar days that is signed by the member. The CONTRACTOR shall make best efforts to assist the members with this written appeal.

(6) Within five (5) working days of receipt of the appeal, the CONTRACTOR shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. This written notice must be sent in addition to a resolution letter, unless the CONTRACTOR has resolved the issue within the timeframe required for delivery of the written notice, in which case the two letters may be combined.

The CONTRACTOR shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

(7) The CONTRACTOR may extend the thirty (30)-day timeframe by

fourteen (14) calendar days if the member requests the extension, or, if the CONTRACTOR demonstrates to HSD/MAD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the CONTRACTOR must give the member written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the timeframe.

(8) The CONTRACTOR shall provide the member and/or the representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

(9) The CONTRACTOR shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. The CONTRACTOR shall include as parties to the appeal the member and his or her representative or the legal representative of a deceased member's estate.

(10) For all appeals, the CONTRACTOR shall provide written notice within the thirty (30)-calendar-day timeframe of the appeal resolution to the member and the provider, if the provider filed the appeal.

a. The written notice of the appeal resolution must include, but not limited to, the following information:

i. the result(s) of the appeal resolution; and

ii. the date it was completed.

b. The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:

i. the right to request an HSD/MAD fair hearing and how to file for a fair hearing;

ii. the right to continue to receive benefits while the hearing is pending, and how to make the request; and

iii. that the member may be held liable for the cost of those benefits if the hearing decision upholds the CONTRACTOR's action.

c. The CONTRACTOR may continue benefits while the appeal and/or the HSD/MAD fair hearing process is pending. The CONTRACTOR shall continue the member's benefits only if all of the following are met:

i. the member or the provider files a timely appeal of the CONTRACTOR action (within thirteen (13) days of the date the CONTRACTOR mails the notice of action);

ii. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

iii. the services were ordered by an authorized provider;

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

v. the member requests extension of the benefits;

vi. the SCI member has not met his/her maximum benefit allowances (dollars and/or bed-days) and has paid the premiums in a timely manner.

d. The CONTRACTOR shall provide benefits until one of the following occurs:

i. the member withdraws the appeal;

ii. thirteen (13) days have passed since the date the CONTRACTOR mailed the resolution letter, providing the resolution of the appeal was against the member and the member has not requested an HSD/MAD fair hearing;

iii. HSD/MAD issues a hearing decision adverse to the member;

iv. the time period or service limits of a previously authorized service has expired; or

v. the SCI member meets his/her maximum benefit allowances (dollars or bed-days) or fails to pay the required premium in a timely manner.

e. If the final resolution of the appeal is adverse to the member, that is, the CONTRACTOR's action is upheld, the CONTRACTOR may recover the cost of the services furnished to the member 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 Section 431.230 (b).

f. If the CONTRACTOR or HSD/MAD, reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the CONTRACTOR must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

g. If the CONTRACTOR or HSD/MAD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the CONTRACTOR must pay for these services.

D. Expedited Resolution of Appeals

An expedited resolution of an appeal is an expedited review by the CONTRACTOR of a CONTRACTOR action.

(1) The CONTRACTOR shall establish and maintain an expedited review process for appeals when the CONTRACTOR 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. Such a determination is based on:

a. a request from the member;

b. a provider's support of the member's request;

c. a provider's request on behalf of the member; or

d. the CONTRACTOR's independent determination.

(2) The CONTRACTOR shall ensure that the expedited review process is convenient and efficient for the member. The member or

provider may request an expedited appeal either orally or in writing. No additional member follow-up is required.

(3) The CONTRACTOR shall resolve the appeal within three (3) working 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 CONTRACTOR shall also make reasonable efforts to provide and document oral notice.

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

(5) The CONTRACTOR shall ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.

(6) The CONTRACTOR shall provide expedited resolution of an appeal in response to an oral or written request from the member or provider on behalf of the member.

(7) The CONTRACTOR shall inform the member of the limited time available to present evidence and allegations in fact or law.

(8) If the CONTRACTOR 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 CONTRACTOR received the request;

b. make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

c. inform the member in the written notice of the right to file an appeal if the member is dissatisfied with the CONTRACTOR's decision to deny an expedited resolution.

(9) The CONTRACTOR shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

E. Special Rule for Certain Expedited Service Authorization Decisions

In the case of certain expedited service authorization decisions that deny or limit services, the CONTRACTOR shall, within seventy-two (72) hours of receipt of the request for service, automatically file an appeal on behalf of the member, make a best effort to give the member oral notice of the decision of the automatic appeal, and make a best effort to resolve the appeal.

F. Other Related CONTRACTOR Processes

(1) Information about Grievance System to Providers and Subcontractors

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

(2) Grievance and/or Appeal Files

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

b. The CONTRACTOR will have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the member of receipt of the grievance and/or appeal, all correspondence between the CONTRACTOR and the member, the date the grievance and/or appeal is resolved, the resolution, and notices of final decision to the member and all other pertinent information.

c. Documentation regarding the grievance shall be made available to the member, if requested.

G. Provider Grievance and Appeal Process

The CONTRACTOR 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 CONTRACTOR. Provider grievances or appeals shall be resolved within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the CONTRACTOR shall request a fourteen (14) day extension from the provider. If the provider requests the extension, the extension will be approved by the CONTRACTOR. A provider may not file a grievance or appeal on behalf of a member without written designation by the member as the member's representative. A provider shall have the right to file an appeal with the CONTRACTOR regarding provider payment issues and/or utilization management decisions. See HSD/MAD Program Manual NMAC 8.305.12.13 and NMAC 8.306.12.13 for special rules for certain expedited service authorizations.

2.14 PROGRAM INTEGRITY

A. The CONTRACTOR shall:

(1) have written policies and procedures developed in conjunction with HSD/MAD to address prevention, a way to verify that services are actually provided, utilizing "Explanation of Medicaid Benefits" notices, detection, preliminary investigation, reporting of potential and/or actual Medicaid fraud and abuse; policies and procedures shall articulate the CONTRACTOR's commitment to comply with all federal and state standards;

(2) have a comprehensive internal program that includes the designation of a compliance officer and a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(3) have an effective training and education program for the compliance officer and the CONTRACTOR's employees, which must be submitted to HSD/MAD for review upon request, and have specific controls for prevention such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR's contracts with its network providers and subcontractors;

(4) cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in

writing and in accordance with all provisions of NMSA 1978, 27-11-1 et seq. – New Mexico Provider Act;

(5) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005 and the ACA;

(6) establish effective lines of communication between the compliance officer and the CONTRACTOR's employees to facilitate the oversight of systems that monitor service utilization and encounters for fraud and abuse, have a provision for a prompt response to detected offenses and for the development of corrective action initiatives relating to the CONTRACTOR's contract;

(7) immediately, but no later than (5) business days, report to HSD/MAD any activity giving rise to a reasonable suspicion of fraud and abuse including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to HSD/MAD. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR with HSD/MAD and the Medicaid Fraud Control Unit (MFCU) as mutually agreed to in writing between the parties will be required;

(8) send to HSD/MAD as required, the names of all providers identified with aberrant utilization according to provider profiling, regardless of the cause of the aberrancy, and do not utilize the CONTRACTOR's determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD. As required in 42 CFR 455.17, the CONTRACTOR shall report to HSD/MAD:

a. the number of complaints of fraud and abuse made that warranted preliminary investigation; and

b. for each complaint that warrants investigation, provide the:

c. provider's name and ID number;

d. source of complaint;

e. type of provider;

f. nature of complaint;

g. approximate dollars involved; and

h. legal and administrative disposition of the case;

(9) have the sole right of subrogation, for twelve (12) months from the date of service, to initiate recovery or to attempt to recover any third-party resources available to Salud! and SCI members, overpayments, underpayments, fraud, waste and abuse. If the CONTRACTOR fails to identify and/or initiate action for TPL recovery, overpayment, underpayment or fraud, waste and abuse within the twelve (12)-month period, HSD/MAD shall have the sole right to recover for those activities. The exception to this twelve (12)-month period is for cases in which a capitation has been recouped from the CONTRACTOR pursuant to Article 2.12.I.(3), whereupon the CONTRACTOR shall retain the sole right of recovery for all paid claims related to the members and months that were recouped; and

(10) make records pertaining to Third Party Collection (TPL) overpayments, underpayments, fraud, waste and abuse for Salud! and SCI payments available to HSD/MAD for audit and review and provide reports to HSD/MAD as requested.

B. The CONTRACTOR and all subcontractors shall:

(1) establish written policies for all 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 entity's policies and procedures for detecting and preventing fraud, waste and abuse;

(3) not knowingly have a relationship with the following:

a. an individual who is debarred, 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; and

b. For purposes of this section, an "individual" includes an affiliate, as defined in the Federal Acquisition Regulation.

c. 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:

i. a director, officer or partner of a CONTRACTOR;

ii. a person with beneficial ownership of five percent (5%) or more of the CONTRACTOR's equity; or

iii. a person with an employment, consulting or other arrangement with the CONTRACTOR obligations under its Agreement with HSD/MAD;

(4) The CONTRACTOR notify HSD/MAD within thirty (30) days when an adverse action is taken against a contracted provider's participation in the program. For purposes of this Agreement an "adverse action" shall mean termination of provider's contract with the CONTRACTOR "for cause" as such term is defined in the provider's contract with the CONTRACTOR.

C. include in any employee handbook, a specific discussion of the laws described in subparagraph (A.[1]), the rights of employees to be protected as whistleblowers, and the CONTRACTOR's or subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

D. HSD/MAD may, at its sole discretion, exempt the subcontractor from the requirements set forth in this section; however, HSD/MAD shall not exclude the CONTRACTOR or subcontractor, if the CONTRACTOR or subcontractor receives at least $ 5,000,000 in annual payments from the HSD/MAD.

E. The CONTRACTOR shall comply with all program integrity provisions of the ACA including, but not limited to:

(1) Enhanced provider screening and enrollment, Section 6401;

(2) Termination of provider participation, Section 6501;

(3) Provider disclosure of current or previous affiliation with excluded provider(s), Section 6401; and

(4) Suspension of payments pending an investigation for credible allegations of fraud, Section 6402.

F. The following definitions apply to this section:

(1) An "employee" includes any officer or employee of the CONTRACTOR.

(2) A "subcontractor" includes any agent or person which or who, on behalf of the CONTRACTOR, furnishes, or otherwise authorizes the furnishing of Medicaid or other health care program items or services, performs billing or coding functions or is involved in monitoring of health care provided by the provider.

G. The CONTRACTOR shall cooperate fully in any activity performed by the HSD-Medicaid Recovery Audit Contractor ("RAC"). With forty-eight (48) hours advance notice, the CONTRACTOR shall make available during normal business hours all requested administrative, financial and medical records of the CONTRACTOR, its subcontractors, and Network Providers.

2.15 REPORTING REQUIREMENTS

The CONTRACTOR shall comply with all reporting requirements stated in NMAC 8.305.14 and NMAC 8.306.14. The CONTRACTOR shall provide to HSD/MAD routine managerial, financial, utilization and quality reports. The CONTRACTOR shall report for the Salud! population and the SCI population separately. The content, format, and schedule for submission shall be determined by HSD/MAD in advance for the financial reporting period and shall conform to reasonable industry and/or CMS standards. HSD/MAD may also require the CONTRACTOR to submit non-routine ad hoc reports, provided that HSD/MAD shall pay the CONTRACTOR to produce any non-routine ad hoc reports that require a significant amount of time, resources or effort on the part of the CONTRACTOR. HSD/MAD shall notify CONTRACTOR, in writing, of changes to required report content, format or schedule at least forty-five (45) calendar days prior to implementing the reporting change. The CONTRACTOR shall be held harmless if HSD/MAD fails to meet this requirement for any changes for existing reports. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report revised by HSD/MAD to include a change in data requirements or definition will not be subject to penalty for accuracy. HSD/MAD, in order to reduce administrative duplication, may provide exceptions to the requirement for the submission of specific hard copy reports. Extensions to report submission dates will be considered by HSD/MAD after the CONTRACTOR has contacted the department in advance of the report due date. If HSD/MAD grants an extension, the report(s) are considered timely

and are not subject to penalty. HSD/MAD shall notify the CONTRACTOR regarding the change in routine report requirements.

A. Reporting Standards

Reports submitted by the CONTRACTOR to HSD/MAD shall meet the following standards:

(1) reports or other required data shall be received on or before scheduled due dates;

(2) reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or HSD/MAD defined standards and templates;

(3) defined reports shall be analyzed prior to submitting to HSD/MAD;

(4) all required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omission;

(5) the submission of late, inaccurate, or otherwise incomplete reports constitutes failure to report. In such cases, financial penalties and/or sanctions may be assessed by HSD/MAD;

(6) HSD/MAD requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the managed care contract. The CONTRACTOR shall comply with all changes specified in writing by HSD/MAD, after HSD/MAD has discussed such changes with the CONTRACTOR; and

(7) If a report due date falls on a weekend or a holiday, receipt of the report the next business day is acceptable.

B. Utilization Reporting

HSD/MAD expects the CONTRACTOR to maintain a health information system that collects, integrates, analyzes and reports data necessary to implement its utilization management (UM) and quality management (QM) activities. The CONTRACTOR shall:

(1) submit monthly and quarterly UM reports required by HSD/MAD;

(2) provide ad hoc utilization reports upon request by HSD/MAD; and

(3) submit reports that contain written analysis of differences from the previous reporting period, trends, system changes or identified problems/issues. Issues/deficiencies in reported data must be addressed through education or other corrective action. Positive results derived from targeted actions must be reported when the outcome impacts the data reported from previous time frames.

C. Critical Indicators Reporting

HSD/MAD utilizes critical indicators as one method to monitor, assess and improve the overall health status of Salud! and SCI members. The CONTRACTOR shall report critical indicators as directed by HSD/MAD.

D. Grievance and Appeals Resolution Report

The CONTRACTOR shall submit to HSD/MAD reports of all provider and member Grievance, Appeals, Fair Hearings and informal Grievances received from or about Salud! and SCI members by the CONTRACTOR or its subcontractors utilizing the State-provided reporting templates and grievance codes. The analysis shall include the identification of any provider and member specific trends and/or changes of more than five percent (5%) from the previous reporting period as well as any interventions taken to address these trends.

E. Financial Reports

(1) The CONTRACTOR shall submit annual audited financial statements including, but not limited to, it's Income Statement, Statement of Changes in Financial Condition or cash flow, and Balance Sheet. The CONTRACTOR shall include separate audited schedules of Salud! and SCI revenues and expenses according to generally accepted accounting principles. Accounting principles applied must be consistent across all Medicaid-related lines of business. The result of the CONTRACTOR's independent annual audit and related management letters shall be submitted no later than one hundred and fifty (150) days following the close of the CONTRACTOR's fiscal year. The audit shall be performed by an independent Certified Public Accountant. The CONTRACTOR shall submit for examination any other financial reports requested by HSD/MAD and related to the CONTRACTOR's solvency or performance of this Agreement.

(2) The CONTRACTOR and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other

generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between the CONTRACTOR and its subcontractors, and the CONTRACTOR and HSD/MAD. These transactions shall include, but are not limited to, claim payments, refunds, and adjustments of payments.

(3) The CONTRACTOR and its subcontractors shall make available to HSD/MAD and any other authorized state or federal agency, any and all financial records required to examine the compliance by the CONTRACTOR insofar as those records are related to CONTRACTOR's performance under this Agreement. For the purpose of examination, review, and inspection of its records, the CONTRACTOR and its subcontractors shall provide HSD/MAD access to its facilities.

(4) The CONTRACTOR and its subcontractors shall retain all records and reports relating to agreements with HSD/MAD for a minimum of ten (10) years from the date of final payment. In cases involving incomplete audits and/or unresolved audit findings, administrative sanctions, or litigation, the minimum ten (10) year retention period shall begin when such actions are resolved.

(5) The CONTRACTOR is mandated to notify HSD/MAD immediately when any change in ownership can legally be disclosed. The CONTRACTOR shall submit a detailed work plan during the transition period or no later than the date of the approval of sale by the DOI that identifies areas of the contract that will be impacted by the change in ownership, including management and staff.

(6) The CONTRACTOR shall submit records involving any business restructuring when changes in ownership interest of five percent (5%) or more have occurred. These records shall include, but are not limited to, an updated list of names and addresses of all persons or entities having ownership interest of five percent (5%) or more. These records shall be provided no later than sixty (60) days following the change of ownership.

(7) The following table gives an overview of the reporting requirements the HSD/MAD has established to monitor and examine the CONTRACTOR for solvency and compliance with state and federal requirements for financial stability. These requirements shall enable HSD/MAD or its designee to determine if changes have occurred which affect a CONTRACTOR and/or its subcontractors' financial condition. The CONTRACTOR's required level of reinsurance, fidelity bond, or insurance and

solvency cash reserves may change with changes to the CONTRACTOR's net worth or other financial condition. Such changes must be reported to HSD/MAD prior to the effective date of change.

(8) Financial Reporting Requirement

Reports post-marked with the due date will be considered as timely submission. If report due date falls on a weekend or holiday, receipt of the report the next business day is acceptable. Data and/or information for Salud! and SCI reports shall be submitted separately unless HSD/MAD directs otherwise. Unless otherwise specified, timeframes indicated are "calendar" days.

Reporting requirements include, but are not limited to, the following:

Definition	Frequency	Objective	Due Date
Calendar-Year Independently Audited Financial Statements	Annual	Examine for Solvency and CMS Compliance	June 1, 2013
Calendar-Year SCI and Salud!- Specific Audited Schedule of Revenue and Expenses	Annual	Examine for Solvency and CMS Compliance	June 1, 2013
Quarterly Salud! and SCI - specific unaudited Schedule of Revenue and Expenses	Quarterly	Examine and compare Administrative expenditures by line of business.	45 days from the end of Quarter or the 15th day of the second month following the Quarter.
Department of Insurance Reports	Quarterly Quarters 1, 2 and 3 (45 days from end of quarter) and annually on 3/1	Examine and confirm solvency and CMS compliance	45 days from the end of the Quarter or the 15th day of the second month the Quarter and March 1 for the annual statement

Definition	Frequency	Objective	Due Date
Expenditures by Category of Services for hospital, pharmacy, physician, dental, transportation and other (as applicable to Salud! and SCI)	Quarterly	Determine Cost Efficiency	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Utilization by Category of Services for hospital, pharmacy, physician, dental, transportation and other (as applicable to Salud! and SCI)	Quarterly	Determine Cost Efficiency	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Expenditures of services to FQHCs and RHCs	Quarterly	Enable HSD/MAD to make wraparound payments to FQHCs	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Expenditures specifically made to IHS and Tribal 638 facilities	Quarterly	Enable HSD/MAD to reconcile the payments made by the CONTRACTOR to IHS and Tribal 638 facilities, against the supplemental capitation payments made by HSD/MAD to the CONTRACTOR	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Identify the Fidelity Bond or Insurance Protection by Amount of Coverage in relation to Annual Payments. Identify MCO Directors, Officers, Employees or Partners.	Annual	Examine and confirm solvency and CMS compliance	Initially and upon renewal

Definition	Frequency	Objective	Due Date
Analysis of Stop-loss protection with Detail of Panel Composition	Quarterly	Examine for Solvency, Rate Payment.	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Reinsurance Policy	Annual	Assess Solvency and CMS Compliance	Initially and upon renewal
Cash Reserve Statement	Quarterly	Examine and confirm solvency and CMS compliance	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Subcapitation Expenditures and Utilization	Quarterly	Determine Cost Efficiency	45 days from the end of the Quarter or the 15th day of the second month following the end of the Quarter.
Withholding Bank Statement for Performance Measures	Monthly	Compliance with performance measures	45 days after month end
Risk Withholding Report	Annual	Analyze risk sharing	July 1, 2012 and July 1, 2013

F. Automated Reporting

(1) The CONTRACTOR is required to submit data to HSD/MAD, subject to the provisions of Section 4.2 of this Agreement. HSD/MAD shall define the format and data elements after having consulted with the CONTRACTOR on the definition of these elements.

(2) The CONTRACTOR is responsible for identifying and reporting to HSD/MAD immediately upon discovery any inconsistencies in its

automated reporting. The CONTRACTOR shall make necessary adjustments to its reports at its own expense. Financial penalties and/or other sanctions may be applied if certified but erroneous data are reported through an automated system as set forth in this Agreement.

(3) HSD/MAD, in conjunction with its fiscal agent, intends to implement electronic data interchange standards for transactions related to managed health care. Subject to the provisions of Section 4.2 of this Agreement, the CONTRACTOR shall work with HSD/MAD to develop the technical components of such an interface.

G. Disease Reporting

The CONTRACTOR shall ensure that its providers comply with the disease reporting required by the New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980.

H. HEDIS Reporting

The CONTRACTOR shall participate in the most current HEDIS reporting system, submit a copy of the HEDIS data in accordance with the NCQA requirement, and submit a final audit report to HSD/MAD along with the HEDIS data submission tool. The HEDIS compliance audit will be at the expense of the CONTRACTOR.

I. Provider Network Reports

The CONTRACTOR shall submit Provider Network reports as directed by HSD/MAD. The CONTRACTOR shall notify HSD/MAD within five (5) working days of any unexpected changes to the composition of its provider network that negatively affect member access or the CONTRACTOR's ability to deliver all services included in the benefit package in a timely manner. Any anticipated material changes in the CONTRACTOR's provider network shall be reported to HSD/MAD in writing when the CONTRACTOR knows of the anticipated change or within thirty (30) calendar days, whichever comes first. The notice submitted to HSD/MAD shall include the following information: nature of the change; information about how the change affects the delivery of covered services or access to the services; and the CONTRACTOR's plan for maintaining the access and quality of member care.

In the event that substantial or material provider network changes occur, including when it is determined that a provider is otherwise unable to meet its contractual obligation, the CONTRACTOR shall be required to submit

transition plans to HSD/MAD. The CONTRACTOR shall provide member demographic information, date or anticipated date of transition, any special conditions or barriers to transition, and other related information requested by HSD/MAD.

2.16 INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN)

A. General Requirements

The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.15 and NMAC 8.306.15. ISHCN require a board range of primary, specialized, medical, behavioral and social services.

The CONTRACTOR shall:

(1) produce a special handbook or create an insert to include in its Member Handbook a description of network providers and programs available to ISHCN;

(2) identify ISHCN among its membership, using the criteria for identification and information provided by the HSD/MAD to the CONTRACTOR as well as internal criteria such as service utilization, clinical assessment or diagnosis;

(3) work with HSD/MAD to develop and implement written policies and procedures, which govern how members with multiple and complex physical health care needs shall be identified; and

(4) have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify ISHCN and potential ISHCN.

B. Assessment Requirements

The CONTRACTOR shall:

(1) implement mechanisms to assess each Salud! and SCI member identified as having special health care needs in order to identify any current and/or ongoing special conditions of the member that require a course of treatment or regular care monitoring;

(2) ensure that the assessment process includes appropriate health care professionals; and

(3) ensure that, if the assessment process identifies the need for services, a plan of care is:

a. developed by the member's PCP with member and/or parent/guardian participation, and in consultation with any specialists caring for the member; and

b. is in accord with any applicable State quality assurance and utilization review standards.

C. Specialty Providers

The CONTRACTOR shall:

(1) develop and implement written policies and procedures governing the process for member selection of a PCP, including the right to choose a specialist as a PCP, if warranted and agreed upon by the specialist provider; and

(2) have policies and procedures in place to allow direct access to necessary specialty care, consistent with Salud! and SCI access appointment standards for clinical urgency.

D. Information and Education for ISHCN

The CONTRACTOR shall:

(1) make best efforts during the enrollment process and afterwards to educate the member, legal guardian, parent or caregiver as indicated, regarding all applicable aspects of the Salud! and SCI programs;

(2) develop and distribute, as appropriate, information and materials specific to the needs of ISHCN, and, in the case of children with special health care needs (CSHCN), their caregiver(s). This includes, but is not limited to:

a. a list of goods and services that are in the Salud! and SCI benefit package and those that are carved out;

b. for Salud! members, how to plan for and arrange transportation that provides the necessary accommodations for receipt of covered services, including behavioral health services;

c. how to present for care in an emergency room unfamiliar with ISCHN;

d. how to access rehabilitative therapy services and obtain durable medical equipment;

e. the availability of a care coordinator; and

f. services and/or assistance that a care coordinator can provide.

(3) make available health education programs to assist ISHCN, and, in the case of CSHCN, the caregiver(s), in understanding how to cope with the day-to-day stress of living with the limitation or providing care;

(4) provide a list of key CONTRACTOR resource staff and their telephone numbers, email addresses; and

(5) designate a single point of contact that can be called for information during the enrollment process and after becoming a member.

E. Clinical Practice Guidelines for ISHCN

The CONTRACTOR shall develop clinical practice guidelines, practice parameters, and/or other specific criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic medical health care services to this population. The guidelines should be professionally accepted standards of practice and national guidelines, be adopted in consultation with contracting health care professionals, reviewed and updated periodically, as appropriate, and provided to the State upon initiation of this Agreement, and thereafter, upon request.

F. Utilization Management for ISHCN

The CONTRACTOR shall develop written policies and procedures to exclude prior authorization any item or service in the course of treatment, and/or extend the authorization periodically, for goods and services provided for a chronic condition. There should be a process for review and periodic update of the course of treatment, as indicated.

G. Consumer Surveys Specific to ISHCN

The CONTRACTOR shall add questions about ISHCN to all Consumer Surveys, including CAHPS, as appropriate.

H. ISHCN Performance Improvement Project

The CONTRACTOR shall develop and implement a performance improvement project specific to ISHCN.

2.17 TRANSITION

The CONTRACTOR shall comply with all transition requirements of NMAC 8.305.16 and NMAC 8.306.16. The CONTRACTOR shall have the resources and policies and procedures related to transition of care, including continuity of care in place, and shall ensure transition of care without disruption in service to members. This transition includes, switching enrollment from or to Salud!, SCI, CoLTS, Centennial Care, Fee-For-Service programs including Premium Assistance programs.

A. General Requirements

The CONTRACTOR shall:

(1) within ninety (90) days of the effective date of this Agreement, develop and provide to HSD/MAD a detailed plan that addresses the clinical transition issues and transfer of potentially large numbers of members into or out of its organization. This plan shall include how the CONTRACTOR proposes to identify members currently receiving services;

(2) within ninety (90) days of the effective date of this Agreement, develop and provide to HSD/MAD a detailed plan for the transition of an individual member, which includes member and provider education about the CONTRACTOR, and the CONTRACTOR process to assure any existing courses of treatment are revised as necessary;

(3) identify members and provide necessary data and clinical information to the future CONTRACTOR for members switching plans, either individually or in large numbers to avoid unnecessary delays in treatment that could be detrimental to the member; and

(4) as soon as practicable but no later than ninety (90) days after HSD publically identifies the Centennial Care MCOs, enter into a Memorandum of Understanding with each Centennial Care MCO that outlines the transition of care, including continuity of care, to ensure transition of care without disruption in services to Medicaid recipients;

(5) provide pharmacy, dental, facility, practitioner, vision, durable medical equipment and transportation encounter data for the 365 days immediately preceding the transition to another MCO for each member identified as an individuals with special health care needs, each home and community-based waiver recipient, each member receiving long-term services, each member eligible for disease management, and each member receiving care coordination to another MCO as directed by HSD/MAD. HSD/MAD reserves the right to include other encounter data and other populations as it deems necessary.

(6) HSD/MAD will withhold twenty-five percent (25%) of the full last monthly capitation cycle for this contract period from the CONTRACTOR until all transition requirements are completed and approved by HSD/MAD.

B. Salud! Member Requirements

The CONTRACTOR shall:

(1) honor all prior approvals granted by HSD/MAD directly or through another Medicaid Contractor for the first sixty (60) calendar days of enrollment or until the CONTRACTOR has made other arrangements for the transition of services. Providers associated with these services shall be reimbursed by the CONTRACTOR;

(2) reimburse the providers and facilities approved by HSD/MAD, if a donor organ becomes available during the first sixty (60) calendar days of enrollment and transplant services have been prior approved by HSD/MAD;

(3) fill prescriptions for drug refills for the first ninety (90) calendar days or until the CONTRACTOR has made other arrangements, for newly enrolled managed care members;

(4) pay for Durable Medical Equipment (DME) costing two thousand dollars ($2,000) or more, approved by the CONTRACTOR but delivered after disenrollment;

(5) be responsible for covered medical services provided to the member for any month they receive a capitation payment;

(6) be responsible for payment of all inpatient services provided by a general acute-care or rehabilitation hospital until discharge from the hospital if the member is hospitalized in such a facility at the

time the member becomes exempt. This does not apply to a disenrollment from Salud! caused by a member becoming eligible and being enrolled in the CoLTS program. The CONTRACTOR shall only be responsible for the payment for the inpatient hospital stay including professional services through the last day of the month of the last capitation payment;

(7) ensure the transition of care requirements outlined above can be met with both individual and mass enrollment into and out of its organization; and

(8) cooperate with the SE in the transition of services and the provision of records as necessary for behavioral health services.

C. SCI Member Requirements

The CONTRACTOR shall:

(1) track members who are nearing the annual claims benefit maximum or annual bed-day maximum by:

a. tracking dollars paid for claims and hospital inpatient days (including home care days) for each SCI member and identify members who are at 50% of claims benefits paid out in a benefit year and those who have utilized 80% of their available hospital inpatient resources;

b. providing care coordination for these members to identify ways to best utilize the remaining dollars and days to maximize care and prevent member from reaching benefit claims and/or hospital day maximums; and

c. report these members to HSD/MAD who will work in conjunction with the CONTRACTOR to find alternative health care options for these individuals through state or other insurance programs.

2.18 VALUE ADDED SERVICES

The CONTRACTOR shall offer its members services that are not included in the Salud! or SCI benefit package and the cost of these services will not be included when HSD/MAD determines the payment rate.

Since Value Added Services are not Medicaid funded services there is no appeal or fair hearing rights. A denial of a Value Added Service will not be considered an action. The CONTRACTOR shall submit criteria to HSD/MAD for all Value

Added Services. The CONTRACTOR shall send the member a notification letter if the Value Added service is not approved.

The CONTRACTOR shall provide a schedule for implementing these added services pursuant to the CONTRACTOR's proposal and approved by HSD/MAD. All added services shall be identifiable and measurable through the use of unique payment and/or processing codes, approved by HSD/MAD. These added services shall be:

A. three or more direct services and not be administrative in nature;

B. reasonably expected to be provided to three percent (3%) of the CONTRACTOR's population in the aggregate; and

C. reports to HSD/MAD in a format and frequency determined by HSD/MAD.

ARTICLE 3 – LIMITATION OF COST

In no event shall capitation fees or other payments provided for in this Agreement exceed payment limits set forth in 42 C.F.R. §§447.361 and 447.362. In no event shall the State pay twice for the provision of services.

ARTICLE 4 - HSD/MAD RESPONSIBILITY

4.1 HSD/MAD shall:

A. establish and maintain Medicaid eligibility information and transfer eligibility and enrollment information to ensure appropriate enrollment in and assignment to the CONTRACTOR. This information shall be transferred electronically. The CONTRACTOR shall have the right to rely on eligibility and enrollment information transmitted to the CONTRACTOR by HSD/MAD. Either party shall notify the other of possible errors or problems as soon as reasonably possible;

B. support implementation deadlines by providing technical information at the required level of specificity in a timely fashion;

C. provide the CONTRACTOR with enrollment information concerning each Salud! and SCI member enrolled with the CONTRACTOR, including the member's name and social security number, the member's address and telephone number, the member's date of birth and gender, the availability of third-party coverage (for Salud! only), the member's rate category and the member's State assigned identification number;

D. compensate the CONTRACTOR as specified in Article 2.12 Reimbursement and Compensation;

E. provide a mechanism for fair/administrative hearings to review denials and UM decisions made by the CONTRACTOR. SCI members must go through the CONTRACTOR's appeal process before requesting a fair hearing;

F. monitor the effectiveness of the CONTRACTOR's QM/QI program;

G. review the CONTRACTOR's grievance files as necessary;

H. establish requirements for review and make decisions concerning the CONTRACTOR's requests for disenrollment;

I. determine the period of time within which a member cannot be reenrolled with a CONTRACTOR that successfully has requested his/her disenrollment;

J. provide mandatory Medicaid enrollees with specific information about services, benefits, contractors from which to choose, and member enrollment;

K. have the right to receive solvency and reinsurance information from the CONTRACTOR, and to inspect all of the CONTRACTOR's financial records related to the CONTRACTOR's performance of this Agreement as frequently as necessary, but at least annually;

L. have the right to receive all information regarding third party liability and fraud and abuse from the CONTRACTOR so that it may pursue its rights under state and federal laws and regulations;

M. review the CONTRACTOR's policies and procedures concerning Salud! and SCI fraud and abuse and require modifications until they are deemed acceptable;

N. provide the content, format and schedule for the CONTRACTOR's report submission;

O. inspect, examine, and review the CONTRACTOR's financial records as necessary to ensure compliance with all applicable state and federal laws and regulations;

P. monitor encounter data submitted by the CONTRACTOR and provide data elements for reporting;

Q. provide the CONTRACTOR with specifications related to data reporting requirements;

R. amend its Fee-For-Service and other provider agreements, or take such other action as may be necessary to encourage health care providers paid by HSD/MAD to enter into contracts with the CONTRACTOR at the applicable Medicaid reimbursement rate for the provider, absent other negotiated arrangements, and encourage any Medicaid participating provider who is not contracted with the CONTRACTOR to accept the applicable Medicaid reimbursement as payment in full for covered services provided to a member who is enrolled with the CONTRACTOR. The applicable Medicaid reimbursement rate is defined to exclude disproportionate share and medical education payments;

S. establish maximum enrollment levels as necessary to ensure that all CONTRACTORS maintain statewide enrollment capacity;

T. ensure that no requirement or specification established or provided by HSD/MAD under this section conflicts with requirements or specifications established pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated there under. All requirements and specifications established or provided by HSD/MAD under this section shall comply with the requirements of Section 4.2 of this Agreement; and

U. cooperate with the CONTRACTOR in the CONTRACTOR's efforts to achieve compliance with HIPAA requirements. The CONTRACTOR shall be held harmless for implementation delays when the CONTRACTOR is not responsible for the cause of the delay.

4.2. HSD/MAD and/or its fiscal agent shall implement electronic data standards for transactions related to managed health care. In the event that HSD/MAD and/or its fiscal agent requests that the CONTRACTOR or its subcontractors deviate from or provide information in addition to the information called for in required and optional fields included in the standard transaction code sets established under HIPAA, such request shall be made by amendment to this Agreement in accordance with the provisions of Article 34.

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

to perform any obligation or meet any deadline under this Agreement because of the failure of HSD/MAD to perform its specific responsibilities under the Agreement, the CONTRACTOR's performance shall be excused or delayed, as appropriate. The CONTRACTOR shall provide HSD/MAD 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 HSD/MAD has failed to meet, as well as the reason HSD/MAD's failure impacts the CONTRACTOR's ability to meet its performance obligations under the Agreement.

4.4 Promptly upon becoming aware of any claim or information that may have an impact on the CONTRACTOR or the services to be performed by the CONTRACTOR under this Agreement, HSD/MAD will provide the CONTRACTOR with written notice of such claim or information.

ARTICLE 5 – STATE CONTRACT ADMINISTRATOR

The Contract Administrator(s) for Salud! and SCI and his /her successor shall be designated by the Secretary of HSD. The State shall notify the CONTRACTOR of any changes in the identity of the Contract Administrator. The Contract Administrator is empowered and authorized as the agent of the State to represent HSD in all matters related to this Agreement except those reserved to other State personnel by this Agreement. Notwithstanding the above, the Contract Administrator does not have the authority to amend the terms and conditions of this Agreement. All events, problems, concerns or requests affecting this Agreement shall be reported by the CONTRACTOR to the Contract Administrator.

ARTICLE 6 - CONTRACTOR PERSONNEL

6.1 The CONTRACTOR warrants and represents that it shall assign sufficient employees to the performance of this Agreement to meet all aspects of its performance as represented by the CONTRACTOR to HSD/MAD in its proposal.

6.2 Replacement of any key CONTRACTOR personnel shall be with personnel of equal ability, experience, and qualifications.

6.3 HSD/MAD reserves the right, for matters related to this contract and for reasonable cause, to request in writing that the CONTRACTOR make changes in its staff assignments. If after the receipt of written notice, and the expiration of a 60 day cure period during which time CONTRACTOR shall address the reasonable cause for HSD/MAD's request, HSD/MAD still desires that CONTRACTOR change its staff assignments, CONTRACTOR will, subject to all applicable laws, rules, and regulations, make such change within thirty (30) days.

6.4 The CONTRACTOR 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 entity's obligations under the Agreement.

ARTICLE 7 – ENFORCEMENT

7.1 The parties acknowledge and agree that efficient implementation and operation of the Salud! and SCI programs are enhanced through a cooperative relationship between the parties. HSD/MAD and the CONTRACTOR agree to first attempt to resolve any dispute involving the parties' respective performance through good faith informal negotiations. To that end, HSD/MAD shall stress communication, notice and corrective action as the preferred method for initiating action related to the CONTRACTOR's performance hereunder; provided that nothing in this Section shall preclude HSD/MAD from initiating the sanctions set forth in Article 7 if damages to the State and the CONTRACTOR's members cannot be avoided or cured through the informal negotiations.

7.2 **STATE SANCTIONS**

A. Unless otherwise required by law, the level or extent of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to (or incurred by) members or to the integrity of the Salud! or SCI programs.

B. If the State determines, after notice and opportunity by the CONTRACTOR to be heard in accordance with Article 14, that the CONTRACTOR or any agent or employee of the CONTRACTOR, or any persons with an ownership interest in the CONTRACTOR, or related party of the CONTRACTOR, has or have failed to comply with any applicable law, regulation, term of this Agreement, policy, standard, rule, or for other good cause, the State may impose any or all of the following in accordance with applicable law.

(1) Plans of Correction: The CONTRACTOR shall be required to provide to the State, within fourteen (14) days, a plan of correction to remedy any defect in its performance.

(2) Directed Plans of Correction: The CONTRACTOR shall be required to provide to the State, within fourteen (14) days, a response to the directed plan of correction as directed by the State.

(3) Civil or Administrative Monetary Penalties: The State may impose upon the CONTRACTOR civil or administrative monetary penalties to the extent authorized by federal or state law.

a. The State retains the right to apply progressively strict sanctions against the CONTRACTOR, including an assessment of a monetary penalty against the CONTRACTOR, for failure to perform in any contract areas.

b. Unless otherwise required by law, the level of extent of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to or incurred by members or to the integrity of the Salud! or SCI programs. The State shall impose liquidated damages consistent with this Agreement where appropriate. The State will seek corrective action of any defect in the CONTRACTOR's performance prior to resorting to financial penalties.

c. Monetary penalty assessments, depending on the severity of the infraction, shall range up to five percent (5%) of the CONTRACTOR's Medicaid capitation payment for each month in which the penalty is assessed.

d. Any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the CONTRACTOR to interrupt services provided to members.

e. The limit on, or specific amount of, civil monetary penalties that the State may impose upon the CONTRACTOR varies, depending upon the nature and severity of the CONTRACTOR's action or failure to act, as specified below:

    i. a maximum of twenty-five thousand dollars ($25,000) for each of the following determinations: failure to provide medically necessary services; misrepresentation or false statements to members, potential members, or health care provider(s); or failure to comply with physician incentive plan requirements and marketing violations;

    ii. a maximum of one hundred thousand dollars ($100,000) for each of the following determinations: for acts of discrimination against members or for material misrepresentation or false statements to the State, or CMS;

iii. a maximum of fifteen thousand dollars ($15,000) for each member the State determines was not enrolled, or was not reenrolled, or whose enrollment was terminated because of a discriminatory practice. This is subject to an overall limit of one hundred thousand dollars ($100,000) under (ii) above; and

iv. a maximum of twenty-five thousand dollars ($25,000) or double the amount of excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the Medicaid program. The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s).

f. Any withholding of capitation payments in the form of a penalty assessment shall be reasonable. Although penalty assessments may be paid by the CONTRACTOR pursuant to a spending plan approved by HSD/MAD, penalty dollars are considered administrative costs and must be reported as such.

g. Any other administrative, contractual or legal remedies available to the State shall be employed in the event that the CONTRATOR violates or breaches the terms of this Agreement.

(4) Adjustment of Automated Assignment Formula. The State may selectively assign members who have not selected a CONTRACTOR to an alternative CONTRACTOR in response to the CONTRACTOR's failure to fulfill its duties.

(5) Suspension of New Enrollment. The State may suspend new enrollment to the CONTRACTOR.

(6) Appointment of a State Monitor. Should the State be required to appoint a State monitor to assure the CONTRACTOR's performance, the CONTRACTOR shall bear the reasonable cost of the State intervention.

(7) Payment Denials. The State may deny payment for all members or deny payment for new members.

(8) Rescission. The State may rescind marketing consent and require that the CONTRACTOR cease any or all marketing efforts.

(9) Actual Damages. The State may assess to the CONTRACTOR actual damages to the State or its members resulting from the CONTRACTOR's non-performance of its obligations.

(10) Liquidated Damages. The State may pursue liquidated damages in an amount equal to the costs of obtaining alternative health benefits to the member in the event of the CONTRACTOR's non-performance. The damages shall include the difference in the capitated rates that would have been paid to the CONTRACTOR and the rates paid to the replacement health plan. The State may withhold payment to the CONTRACTOR for liquidated damages until such damages are paid in full.

(11) Removal. The State may remove members with third-party coverage from enrollment with the CONTRACTOR.

(12) Temporary Management.

a. Optional imposition of sanction. The State may impose temporary management to oversee the operations of the CONTRACTOR upon a finding by the State that there is continued egregious behavior by the CONTRACTOR, including but not limited to, behavior that is described in 42 CFR Section §438.700, or that is contrary to any requirements of 42 USC, Sections 42 USC 1396b (m) or 1396u-2; there is substantial risk to member's health; or the sanction is necessary to ensure the health of the CONTRACTOR's members while improvement is made to remedy violations under 42 CFR Section §438.700; or until there is an orderly termination or reorganization of the CONTRACTOR.

b. The CONTRACTOR does not have the right to a predetermination hearing prior to the appointment of temporary management if the conditions set forth in 7.2(B)(12)(a) are met.

c. Required imposition of sanction. The State shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in 42 USC §§ 1396b (m) or 1396u-2 or 42 C.F.R §438, Subpart I (Sanctions).

d. Hearing. The State shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

e. Duration of Sanction. The State shall not terminate temporary management until it determines that the CONTRACTOR can ensure that the sanctioned behavior will not recur.

(13) Terminate Enrollment. The State shall grant members the right to terminate enrollment without cause as described in 42 C.F.R. §438.702 (a) (3), and shall notify the affected members of their right to terminate enrollment.

(14) Intermediate Sanctions. The State may issue an intermediate sanction in the form of administrative order requiring the CONTRACTOR to cease or modify any specified conduct or practice engaged in by it or its employees, subcontractors or agents to fulfill its contractual obligations in the manner specified in the order; to provide covered services that have been denied or take steps to provide or arrange for the provision of any services that it has agreed to or is otherwise obligated to make available.

a. Basis for imposition of Sanctions. The State will impose the foregoing sanctions if the State determines that the CONTRACTOR acts or fails to act as follows:

i. fails substantially to provide medically necessary services and items that the CONTRACTOR is required to provide, under law or under this Agreement with the State, to a member;

ii. imposes on members' premiums or charges that are in excess of the premiums or charges permitted under the Salud! or SCI program;

iii. acts to discriminate among members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a member, except as permitted under this Agreement, or any practice that would reasonably be expected to discourage enrollment by members whose medical condition or history indicate probable need for substantial future medical services;

iv. intentionally misrepresents or falsifies information that it furnishes to the State, or CMS;

v. intentionally misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider;

vi. fails to comply with federal requirements for physician incentive plans, including disclosures;

vii. has distributed directly, or becomes aware of and fails to make efforts to correct material distributed indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;

viii. has violated any of the other applicable requirements of sections 1903 (m), 1932 or 1905(t) (3) of the Act and any implementing regulations; or

ix. fails to perform a material part of this Agreement.

b. The State's determination of any of the above may be based on findings from onsite reviews; surveys or audits; member or other complaints; financial status; or any other source.

c. The State retains authority to impose additional sanctions under state statutes or state regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance.

(15) Suspension: Unless the State determines that this Agreement shall remain in full force and effect to meet requirements imposed or needs of the State to fulfill obligations under any other law, rule, regulation, agreement or compact of the State of New Mexico or the State, then, in addition to the foregoing provisions, this Agreement may be suspended by the parties in the following manner:

a. by written Agreement of the parties; and/or

b. for Force Majeure. 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 Agreement shall be suspended during the period that any circumstances of Force Majeure persists, or for a consecutive period of ninety (90) 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 which would prevent such party from meeting its obligations under this Agreement.

(16) Termination. The State has the authority to terminate the contract and enroll the CONTRACTOR's members in another MCO or other MCOs, or provide covered services through other options included in the State plan, if the State determines that the CONTRACTOR has failed to do either of the following:

a. carry out the substantive terms of this Agreement; or

b. meet applicable requirements in Sections 1932, 1903 (m), and 1905 of the Social Security Act.

(17) Notice of Sanction. Except as provided in subsection (12) this Article regarding Temporary Management, before imposing any of the intermediate sanctions specified, the State must give the CONTRACTOR timely written notice that explains the basis and nature of the sanction and any other due process protections that the State elects to provide.

a. Pre-termination hearing: Before terminating this Agreement, the State must provide the CONTRACTOR a pre-termination hearing within thirty (30) calendar days of written notice, which consist of the following procedures:

i. the State shall give the CONTRACTOR written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;

ii. after the hearing, the State shall give the CONTRACTOR written notice of the decision affirming or reversing the proposed termination of

the contract and, for an affirming decision, the effective date of termination;

iii. for an affirming decision, give CONTRACTOR's members notice of the termination and information, consistent with their options for receiving covered services following the effective date of termination;

iv. the pre-termination hearing procedures shall proceed according to the Dispute Procedures of this Agreement; and

v. after notifying the CONTRACTOR that it intends to terminate the contract, the State may give the CONTRACTOR's members notice of the State's intent to terminate the contract and allow the members to disenroll immediately without cause.

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

7.3 FEDERAL SANCTIONS

A. Section 1903 (m)(5)(A) and (B) of the Social Security Act vests the Secretary of HHS with the authority to deny Medicaid payments to a health plan for members who enroll after the date on which the health plan has been found to have committed one of the violations set forth in the Agreement. State payments for the CONTRACTOR's members are automatically denied whenever, and for so long as, federal payment for such members has been denied as a result of the commission of such violations and in accordance with the requirements in 42 CFR §438.730. The following violations can trigger denial of payment pursuant to §1903(m) (5) of the Social Security Act:

(1) substantial failure to provide required medically necessary items or services when the failure has adversely affected or has substantial likelihood of adversely affecting a member;

(2) imposition of premiums on CONTRACTOR's members in excess of any permitted premium;

(3) discrimination among members with respect to enrollment, re-enrollment, or disenrollment on the basis of member's health status or requirements for health care services;

(4) misrepresentation or falsification of certain information; or

(5) failure to cover emergency services under §1932(b) (2) of the Social Security Act when the failure affects or has a substantial likelihood of adversely affecting a member.

B. The State may also deny payment if the State learns that a CONTRACTOR subcontracts with an individual provider, an entity, or an entity with an individual who is an officer, director, agent or 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 the §1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in §1128.

C. The State shall notify the Secretary of Health and Human Services of noncompliance with the provisions of this Section. The State may allow continuance of the Agreement unless the Secretary directs otherwise but may not renew or otherwise extend the duration of the existing Agreement with the CONTRACTOR unless the Secretary provides to the State and Congress a written statement describing the compelling reasons that exist for renewing and extending the Agreement.

D. This Section is subject to the "Non-exclusivity of Remedy" language below.

ARTICLE 8 – TERMINATION

8.1 This Agreement is effective on July 1, 2012, and shall expire on December 31, 2013, unless extended by written agreement of the parties.

8.2 All terminations shall be effective at the end of a month, unless otherwise specified in this Article. This Agreement may be terminated under the following circumstances:

A. by mutual written agreement of the State and the CONTRACTOR, upon such terms and conditions as they may agree;

B. by either party for convenience, upon not less than one hundred and eighty (180) calendar days written notice to all other parties to this Agreement;

C. this Agreement shall terminate on the Agreement termination date. The CONTRACTOR shall be paid solely for services provided prior to the

termination date. The CONTRACTOR is obligated to pay all claims for all dates of service prior to the termination date. In the event of the Agreement termination date or if the CONTRACTOR terminates this Agreement prior to the Agreement termination date, and, if a member is hospitalized at the time of termination, the CONTRACTOR shall be responsible for Salud! members for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge and for SCI members for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge or until the maximum benefit level has been reached. Similarly, in the event of the Agreement termination date or if the CONTRACTOR terminates this Agreement prior to the Agreement termination date and a Salud! member is in a nursing home at the time of termination, the CONTRACTOR shall be responsible for payment of all covered services from the date of admission until the earlier of: (i) date of discharge or (ii) a expiration of a period of six (6) months. In the event that the State terminates this Agreement prior to the agreement termination date and a member is hospitalized at the time of termination, the CONTRACTOR shall be responsible for payment of all covered inpatient facility and professional services for Salud! members from the date of admission to sixty (60) days after the effective date of termination and for SCI members from the date of admission to sixty (60) days after the effective date of termination or until the maximum benefit level is reached Similarly, in the event that the State terminates this Agreement prior to the Agreement termination date, and a Salud! member is in a nursing home at the time of the effective date of termination the CONTRACTOR shall be responsible for payment of all covered services until sixty (60) days after the effective date of termination or the time the nature of the member's care ceases to be sub acute or skilled nursing care, whichever occurs first. Payment to the CONTRACTOR based upon termination of this Agreement is set forth in Article 10.5.

D. by the State for cause upon failure of the CONTRACTOR to materially comply with the terms and conditions of this Agreement. The State shall give the CONTRACTOR written notice specifying the CONTRACTOR's failure to comply. The CONTRACTOR 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 CONTRACTOR has not initiated or completed corrective action, the State may serve written notice stating the date of termination and work stoppage arrangements.

E. by the State, 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 Agreement. The State's decision as to whether sufficient funds are available shall be accepted by the CONTRACTOR and shall be final.

F. by the State, in the event of default by the CONTRACTOR, which is defined as the inability of the CONTRACTOR to provide services described in this Agreement or the CONTRACTOR's insolvency. With the exception of termination due to insolvency, the CONTRACTOR shall be given thirty (30) calendar days to cure any such default, unless such opportunity would result in immediate harm to members or the improper diversion of Salud! or SCI program funds;

G. by the State, in the event of notification by the Public Regulation Commission or other applicable regulatory body that the certificate of authority under which the CONTRACTOR operates has been revoked, or that it has expired and shall not be renewed;

H. by the State, in the event of notification that the owners or managers of the CONTRACTOR, or other entities with substantial contractual relationship with the CONTRACTOR, have been convicted of Medicare or Medicaid fraud or abuse or received certain sanctions as specified in §1128 of the Social Security Act;

I. by the State, in the event it determines that the health or welfare of CONTRACTOR's members is in jeopardy should the Agreement continue. For purposes of this paragraph, termination of the Agreement requires a finding by the State that a substantial number of members face the threat of immediate and serious harm;

J. by the State, in the event of the CONTRACTOR's failure to comply with the composition of enrollment requirement contained in 42 C.F.R. §434.26 and the Scope of Work. The CONTRACTOR shall be given fourteen (14) calendar days to cure any such enrollment composition requirement, unless such opportunity would violate any federal law or regulation;

K. by the State in the event a petition for bankruptcy is filed by or against the CONTRACTOR;

L. by the State if the CONTRACTOR fails substantially to provide medically necessary items and services that are required under this Agreement;

M. by the State, if the CONTRACTOR discriminates among members on the basis of their health status or requirements for covered services, including expulsion or refusal to reenroll a member, except as permitted by this

Agreement and federal law or regulation, or for engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the CONTRACTOR by the eligible member or by members whose medical condition or history indicates a need for substantial future medical services;

N. by the State, if the CONTRACTOR intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, the State, or members, potential members or health care providers under the Social Security Act or pursuant to this Agreement;

O. by the State, if the CONTRACTOR fails to comply with applicable physician incentive prohibitions of §1903(m) (2) (A) (x) of the Social Security Act;

P. by the CONTRACTOR, on at least sixty (60) calendar days prior written notice, in the event the State fails to pay any amount due the CONTRACTOR hereunder within thirty (30) calendar days of the date such payments are due;

Q. by the CONTRACTOR, on at least sixty (60) calendar days prior written notice, in the event that the State is unable to make future payments of undisputed capitation payments due to a lack of a state budget or legislative appropriation; and

R. by any 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.

S. by the CONTRACTOR, upon one hundred twenty (120) calendar days written notice, in the event HSD/MAD provides notice to the CONTRACTOR of a proposed change to the capitation rates.

8.3 If the State terminates this Agreement pursuant to this Article and unless otherwise specified in this Article, the State shall provide the CONTRACTOR written notice of such termination at least sixty (60) calendar days prior to the effective date of the termination, unless the State itself receives less than sixty (60) calendar days notice, in which case the State shall provide the CONTRACTOR with as much notice as possible, but in no event less than sixty (60) calendar days notice. If the State determines a reduction in the scope of work is necessary, it shall notify the CONTRACTOR and proceed to amend this Agreement pursuant to its provisions.

8.4 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 9 - TERMINATION AGREEMENT

9.1 When the State has reduced to writing and delivered to the CONTRACTOR a notice of termination, the effective date, and reasons therefore, if any, the State, in addition to other rights provided in this Agreement, may require the CONTRACTOR to transfer, deliver, and/or make readily available to the State, property in which the State has a financial interest. Prior to invoking the provisions of this paragraph, the State shall identify that property in which it has a financial interest, provided that, subject to the State's recoupment rights herein, property acquired with capitation or other payments made for members properly enrolled shall not be considered property in which the State has a financial interest.

9.2 In the event this Agreement is terminated by the State, immediately as of the notice date, the CONTRACTOR shall:

A. incur no additional financial obligations for materials, services, or facilities under this Agreement, without prior written approval of the State;

B. terminate all purchase orders or procurements and subcontracts and stop all work to the extent specified in the notice of termination, except as the State may direct for orderly completion and transition or as required to prevent the CONTRACTOR from being in breach of its existing contractual obligations;

C. agree that the State is not liable for any costs of the CONTRACTOR arising out of termination unless the CONTRACTOR establishes that the Agreement was terminated due to the State's negligence, wrongful act, or breach of the Agreement;

D. take such action as the State may reasonably direct, for protection and preservation of all property and all records related to and required by this Agreement;

E. cooperate fully in the closeout or transition of any activities so as to permit continuity in the administration of the State programs; and

F. allow the State, its agents and representatives full access upon reasonable notice and during normal business hours to the CONTRACTOR'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 Salud! or SCI claims.

9.3. Dispute Procedure Involving Contract Termination Proceedings. In the event the State seeks to terminate this Agreement with the CONTRACTOR, the CONTRACTOR may appeal the termination directly to the State Secretary within ten (10) business days of receiving the State's termination notice and proceed as follows:

A. the Secretary of the Human Services Department shall acknowledge receipt of the CONTRACTOR's appeal request within three (3) calendar days of the date the appeal request is received;

B. the Secretary of the Human Services Department will conduct a formal hearing on the termination issues raised by the CONTRACTOR within thirty (30) days after receipt of the written appeal;

C. the CONTRACTOR, the State, or its successor, shall be allowed to present evidence in the form of documents and testimony;

D. the parties to the hearing are the CONTRACTOR, the State, or its successor;

E. the hearing shall be recorded by a court reporter paid for equally by the State and the CONTRACTOR. 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 Secretary of the Human Services Department 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 Secretary;

H. the Secretary of the Human Services Department may, but is not required, to allow opening statements from the parties before taking evidence;

I. the Secretary of the Human Services Department may, but is not required to, request written findings of fact, conclusions of law and closing arguments or any combination thereof. The Secretary may, but is not required to, allow oral closing argument only;

J. the Secretary of the Human Services Department shall render a written decision and mail the decision to the CONTRACTOR within sixty (60) days of the date the request for a hearing is received;

K. the State, or their successors, and the CONTRACTOR 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 Secretary of the Human Services Department within fifteen (15) 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 Secretary of the Human Services Department may limit evidence that is redundant or not relevant to the contract termination issues presented for review; and

M. the Secretary of the Human Services Department's written decision shall be mailed by certified mail, postage prepaid, to the CONTRACTOR. Another copy of the decision shall be sent to the State Medicaid Director.

ARTICLE 10 - RIGHTS UPON TERMINATION OR EXPIRATION

10.1 Upon termination or expiration of this Agreement, the CONTRACTOR shall, upon request of the State, make available to the State, or to a person authorized by the State, all records and equipment that are the property of the State.

10.2 Upon termination or expiration, the State shall pay the CONTRACTOR all amounts due for service through the effective date of such termination. The State may deduct from amounts otherwise payable to the CONTRACTOR monies determined to be due by the State from the CONTRACTOR. Any amounts in dispute at the time of termination shall be placed by the State in an interest-bearing escrow account with an escrow agent mutually agreed to by HSD/MAD and the CONTRACTOR.

10.3 In the event that the State terminates the Agreement for cause in full or in part, the State may procure services similar to those terminated and the CONTRACTOR shall be liable to the State for any excess costs for such similar services for any calendar month for which the CONTRACTOR has been paid for providing services to members. In addition, the CONTRACTOR shall be liable to the State for administrative costs incurred by the State in procuring such similar services. The rights and remedies of the State provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

10.4 The CONTRACTOR is responsible for any claims from subcontractors or other providers, including emergency service providers, for services provided prior to the termination date. The CONTRACTOR shall promptly notify the State of any outstanding claims which the State may owe, or be liable for Fee-For-Service payment, which are known to the CONTRACTOR at the time of termination or when such new claims incurred prior to termination are received.

10.5 Any payments advanced to the CONTRACTOR for coverage of members for periods after the date of termination shall be promptly returned to the State. For termination of an Agreement, which occurs mid-month, the capitation payments for that month shall be apportioned on a daily basis. The CONTRACTOR shall be entitled to capitation payments for the period of time prior to the date of termination, and the State 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 members during the month in which termination is effective.

10.6 The CONTRACTOR shall ensure the orderly and reasonable transfer of member's care in progress, whether or not those members are hospitalized or in long-term treatment.

10.7 The CONTRACTOR shall be responsible to the State for liquidated damages arising out of CONTRACTOR's breach of this Agreement.

10.8 In the event the State proves that the CONTRACTOR's course of performance has resulted in reductions in the State's receipt of federal program funds, as a federal sanction, the CONTRACTOR shall remit to the State, as liquidated damages, such funds as are necessary to make the State whole, but only to the extent such damages are caused by the actions of the CONTRACTOR. This provision is subject to Article 14, Disputes.

ARTICLE 11 - CONTRACT MODIFICATION

11.1 In the event that changes in federal or state statute, regulation, rules, policy, or changes in federal or state appropriation(s) or any other circumstances requires a change, including a substantive change in the way HSD/MAD manages its Medicaid program, this Agreement shall be subject to modification by amendment. The amendment process shall be affected by either party sending written notice to the other. Following receipt of such notice, the parties shall meet within ten (10) days to negotiate the terms of the amendment in good faith. The terms of the amendment shall be implemented as provided in Section 11.2 below. If agreement on the terms of such an amendment cannot be reached within fifteen (15) business days following the meeting of the parties, the CONTACTOR shall have the option to terminate this Agreement pursuant to Section 8.1(R) or to exercise the dispute resolution process of Article 14, provided that if the CONTACTOR elects to utilize the dispute resolution process, it may nonetheless and at any time during or after the dispute resolution process, exercise its rights to terminate this Agreement pursuant to Section 8.1(R) if it is not satisfied with the progress or decisions resulting from the dispute resolution process. The CONTRACTOR agrees that HSD/MAD's decision as to whether an HSD/MAD initiated change in the program is necessary shall be final and binding and the amendment process required by this section is not intended to provide the

CONTRACTOR a right to restrict HSD/MAD's ability to implement program changes they determine are required for proper administration of the program.

11.2 The amendment(s) shall be implemented by Agreement in negotiation in accordance with Article 34, Amendments. In addition, in the event that approval of HSD/MAD's Salud!'s 1915(b) or SCI's Section 1115 Demonstration Waivers is contingent upon amendments to obtain such waiver approval, provided that the CONTRACTOR shall not be required to agree if the modification is a substantial change to the business arrangement anticipated by the CONTRACTOR in executing this Agreement. 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 CONTRACTOR or providing the Covered Services herein that is caused by CMS in granting the waiver shall be negotiated and mutually agreed to between the State and the CONTRACTOR. The results of the negotiations shall be placed in writing in compliance with Article 34 (Amendments) of this Agreement.

ARTICLE 12 - INTELLECTUAL PROPERTY AND COPYRIGHT

12.1 In the event the CONTRACTOR shall elect to use or incorporate in the materials to be produced any components of a system already existing, the CONTRACTOR shall first notify the State, who after investigation may direct the CONTRACTOR not to incorporate such components. If the State fails to object, and after the CONTRACTOR obtains written consent of the party owning the same, and furnishing a copy to the State, the CONTRACTOR may incorporate such components.

12.2 The CONTRACTOR 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 CONTRACTOR shall indemnify and hold HSD/MAD harmless from and against any loss, cost, liability, or expense arising out of breach or claimed breach of this warranty.

12.3 All materials developed or acquired by the CONTRACTOR specifically for HSD/MAD under this Agreement shall become the property of the State of New Mexico and shall be delivered to the HSD/MAD no later than the termination date of this Agreement. Nothing developed or produced, in whole or in part, specifically for HSD/MAD by the CONTRACTOR under this Agreement shall be the subject of an application for copyright or other claim of ownership by or on behalf of the CONTRACTOR. Nothing in this Section 12.3 shall operate to grant HSD/MAD of the State of New Mexico any rights in or to any property, whether tangible or intangible, in and to the following: (i) any proprietary or other confidential information of the CONTRACTOR, or (ii) any property, plant or equipment of the CONTRACTOR, except to the extent specifically agreed to in writing as being acquired by CONTRACTOR for HSD/MAD.

ARTICLE 13 - APPROPRIATIONS

13.1 The terms of this Agreement are contingent upon sufficient appropriations or authorizations being made by the Legislature of New Mexico, CMS, or the U.S. Congress for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the Legislature, CMS, or the Congress, this Agreement shall be subject to termination or amendment. Subject to the provisions of Article 26 of this Agreement, the State's decision as to whether sufficient appropriations or authorizations exist shall be accepted by the CONTRACTOR and shall be final and binding. Any changes to the Scope of Work and compensation to CONTRACTOR affected pursuant to this Section 13.1 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 34 (Amendments) of this Agreement and any other applicable state or federal statutes, rules or regulations.

13.2 To the extent CMS, legislation or congressional action impacts the amount of appropriation available for performance under this Agreement, the State has the right to amend the Scope of Work, in its discretion, which shall be effected by the State sending written notice to the CONTRACTOR. Any changes to the Scope of Work and compensation to CONTRACTOR affected pursuant to this Section 13.2 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 34 (Amendments) of this Agreement and any other applicable state or federal statutes, rules or regulations.

ARTICLE 14 - DISPUTES

14.1 The entire agreement shall consist of: (1) this Agreement, including all Exhibits and any amendments; (2) the Request for Proposal, the State written clarifications to the Request for Proposal and CONTRACTOR responses to RFP questions where not inconsistent with, the terms of this Agreement or its amendments; (3) The CONTRACTORs Best and Final Offer, and (4) the CONTRACTOR's additional responses to the Request for Proposal where not inconsistent with the terms of this Agreement or its amendments, all of which are incorporated herein or by reference.

14.2 In the event of a dispute under this Agreement, 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 Agreement in reverse chronological order followed by;

B. the Agreement, including all Exhibits followed by;

C. the CONTRACTOR's Best and Final Offer followed by;

D. the Request for Proposal, including attachments thereto and HSD/MAD's written responses to written questions and HSD/MAD's written clarifications, and the CONTRACTOR's response to the Request for Proposal, including both technical and cost portions of the response (but only those portions of the CONTRACTOR's response including both technical and cost portions of the response that do not conflict with the terms of this Agreement and its amendments).

14.3 Dispute Procedures for Other than Contract Termination Proceedings

A. Except for termination of this Agreement, any dispute concerning sanctions imposed under this Agreement shall be reported in writing to the HSD Medical Assistance Division (MAD) Director within fifteen (15) calendar days of the date the reporting party receives notice of the sanction. The decision of the HSD/MAD Director regarding the dispute shall be delivered to the parties in writing within thirty (30) calendar days of the date the HSD/MAD 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 Secretary of the HSD a written appeal of the decision of the HSD/MAD Director.

B. Any other dispute concerning performance of the Agreement shall be reported in writing to the HSD/MAD Director 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 HSD/MAD Director 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 Secretary of the HSD a written appeal of the decision of the HSD/MAD Director.

C. Failure to file a timely appeal shall be deemed acceptance of the HSD MAD Director's decision and waiver of any further claim.

D. In any appeal under this Article, the CONTRACTOR and the State shall be afforded an opportunity to be heard and to offer evidence and argument in support of their position to the Secretary of the HSD or his/her 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 Secretary of the Human Services Department or his/her designee shall review the issues and evidence presented and issue a determination in writing within thirty (30) calendar days of the informal hearing which shall conclude the administrative process available to the parties. The Secretary 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 Secretary for good cause.

F. Pending decision by the Secretary of the HSD, both parties shall proceed diligently with performance of the Agreement, in accordance with the Agreement.

G. Failure to initiate or participate in any part of this process shall be deemed waiver of any claim.

ARTICLE 15 - APPLICABLE LAW

15.1 This Agreement shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Agreement shall be brought before the First Judicial District Court in Santa Fe, New Mexico.

15.2 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.

15.3 If any provision of this Agreement is determined to be invalid, unenforceable, illegal or void, the remaining provisions of this Agreement shall not be affected, and providing the remainder of the Agreement 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 16 - STATUS OF CONTRACTOR

16.1 The CONTRACTOR is an independent CONTRACTOR performing professional services for the State and is not an employee of the State of New Mexico. The CONTRACTOR 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 Agreement.

16.2 The CONTRACTOR shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business. Should the CONTRACTOR default in these or other responsibilities, jeopardizing the CONTRACTOR's ability to perform services, this Agreement may be terminated for cause in accordance with Article 8.

16.3 The CONTRACTOR shall not purport to bind the State, its officers or employees nor the State of New Mexico to any obligation not expressly authorized herein unless the State has expressly given the CONTRACTOR the authority to so do in writing.

ARTICLE 17 - ASSIGNMENT

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

ARTICLE 18 - SUBCONTRACTS

18.1 The CONTRACTOR is solely responsible for fulfillment of this Agreement. The State shall make payments only to the CONTRACTOR.

18.2 The CONTRACTOR shall remain solely responsible for performance by any subcontractor under such subcontract(s).

18.3 The State may undertake or award other agreements for work related to the tasks described in this document or any portion therein if the CONTRACTOR's available time and/or priorities do not allow for such work to be provided by the CONTRACTOR. The CONTRACTOR shall fully cooperate with such other contractors and with the State in all such cases.

18.4 Subcontracting Requirements

A. Except as otherwise provided in this Agreement, the CONTRACTOR may subcontract to a qualified individual or organization for the provision of any service defined in the benefit package or for any other required CONTRACTOR function. The CONTRACTOR remains legally responsible to HSD/MAD for all work performed by any subcontractor. The CONTRACTOR shall submit to HSD/MAD boilerplate contract language and/or sample contracts for various types of subcontracts during the procurement process. Changes to contract templates that may materially affect Salud! or SCI members shall be approved by HSD/MAD prior to execution by any subcontractor. The CONTRACTOR shall include and require the provider to complete a statement regarding whether the Medicaid provider contracts out any services including billing and claims data, what services are subcontracted out, and where all its documents will be located at a physical address, NOT a post office box.

B. HSD/MAD reserve the right to review and disapprove all subcontracts and/or any significant modifications to previously approved subcontracts to ensure compliance with requirements set forth in 42 C.F.R. §434.6 or in this Agreement. The CONTRACTOR is required to give HSD/MAD prior notice with regard to its intent to subcontract certain significant contract requirements as specified herein or in writing by the State, including, but not limited to, credentialing, utilization review, and claims

processing. HSD/MAD reserves the right to disallow a proposed subcontracting arrangement if the proposed subcontractor has been formally restricted from participating in a federal entitlement program (i.e., Medicare, Medicaid) for other good cause.

C. The CONTRACTOR 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 the Section 1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

D. The CONTRACTOR shall include a provision in its subcontracts requiring subcontractors to perform criminal background checks for all required individuals providing services under this Agreement, as specified in 7.1.9 NMAC, Caregivers Criminal History Screening Requirements.

E. Pursuant to 42 CFR 422.208 and 422.210, the CONTRACTOR may operated a Physician Incentive Plan (PIP) as defined in such regulations only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member. If the CONTRACTOR chooses to have a PIP the CONTRACTOR must disclose to the State the following:

(1) whether services not furnished by the physician/group are covered by the incentive plan. No further disclosure required if the PIP does not cover services not furnished by the physician/group;

(2) type of incentive arrangement, e.g. withhold, bonus, capitation;

(3) percent of withhold or bonus (if applicable);

(4) panel size, and if members are pooled, the approved method used; and

(5) if the CONTRACTOR is at substantial financial risk, the CONTRACTOR must report proof the physician/group has adequate stop loss coverage, including amount and type of stop loss. If there is substantial financial risk for services not provided by the physician group, the CONTRACTOR must ensure adequate stop loss protection to individual physicians and conduct annual member surveys. If a survey is conducted, the CONTRACTOR must disclose the results to HSD/MAD and, upon request, to

members. In addition, the CONTRACTOR shall provide information on its PIP to any Medicaid member upon request.

F. In its subcontracts, the CONTRACTOR shall ensure that subcontractors agree to hold harmless the State and the CONTRACTOR's members in the event that the CONTRACTOR 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 CONTRACTOR/subcontractor contract for authorized services rendered prior to the termination of the contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the members.

G. The CONTRACTOR shall have a written agreement between the CONTRACTOR and any subcontractor that specifies activities, reporting responsibilities and any delegated functions. Provision for revocation of delegated functions and/or for the imposition of other sanctions for inadequate performance must be included in the agreement.

H. The CONTRACTOR shall have policies and procedures to ensure that the delegated agency meets all standards of performance mandated by the State for the Salud! or SCI programs, as applicable. These include, but are not limited to, use of appropriately qualified staff, the application of clinical practice guidelines and utilization management, reporting capability, and ensuring members' access to care.

I. The CONTRACTOR shall have policies and procedures for the oversight of the delegated entity's performance of the delegated functions.

J. The CONTRACTOR shall have policies and procedures, that include the frequency of reporting (if applicable) and the process by which the CONTRACTOR evaluates the delegate.

K. The CONTRACTOR shall have policies and procedures to ensure consistent statewide application of all Utilization Management (UM) criteria when UM is delegated.

L. Credentialing Requirements: The CONTRACTOR shall maintain policies and procedures for verifying that the credentials of all its providers and subcontractors meet applicable standards as stated in this Agreement, including all Exhibits.

M. Review Requirements: The CONTRACTOR shall maintain fully executed originals of all subcontracts, which are accessible to HSD/MAD, upon request.

N. Minimum Requirements: Subcontracts shall contain at least the following provisions which shall be written in the subcontract or written in a subcontract amendment. A reference to an outside source like a Provider Manual is not acceptable. Minimum requirements include:

(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, activities and report responsibilities 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 members;

(5) subcontracts shall include the reimbursement rates and risk assumption, if applicable;

(6) subcontractors shall maintain all records relating to services provided to members for a ten (10)-year period and shall make all enrollee medical records or other service records available for the purpose of quality review conducted by the State, or their designated agents both during and after the contract period;

(7) subcontracts shall require that member information be kept confidential, as defined by federal and state law and be HIPAA compliant;

(8) subcontracts shall include a provision that authorized representatives of the State have reasonable access to 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 CONTRACTOR any information necessary to perform any of its obligations and that the CONTRACTOR 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 CONTRACTOR as payment for any services included in

the benefit package, and cannot request payment from the State for services performed under the subcontract;

(11) subcontracts shall state that if the subcontract includes primary care, provisions for compliance with PCP requirements delineated in this Agreement shall apply;

(12) subcontracts shall require the subcontractor shall comply with all applicable state and federal statutes, rules, and regulations, including the prohibition against discrimination;

(13) subcontracts shall include procedures and criteria for terminating the subcontract, a provision for the imposition of sanctions for inadequate subcontractor performance, and terminating, rescinding, or cancelling the contracts for violation of HSD/MAD requirements.

(14) subcontracts shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another contractor;

(15) subcontracts may not include any incentive or disincentive that encourages a provider or other subcontractor not to enter into a contractual relationship with another CONTRACTOR;

(16) subcontracts shall not contain any gag order provisions nor sanctions against providers who assist members in accessing the grievance process or otherwise act to protect members' interests;

(17) subcontracts shall specify the timeframe for submission of encounter data to the CONTRACTOR;

(18) subcontracts for pharmacy providers shall include a payment provision consistent with NMSA 1978, §27-2-16(B) unless there is a change in law or regulations;

(19) subcontracts to entities that receive annual Medicaid payments of at least $5 million shall include detailed information regarding employee education of the New Mexico False Claims Act;

(20) subcontracts shall include a provision requiring subcontractors to perform criminal background checks, as required by law, for all individuals providing services;

(21) subcontracts shall include a provision requiring providers to submit claims electronically; transportation, meals, lodging, low volume or low dollar providers may have this requirement waved;

(22) subcontracts shall include the HSD contractual provisions from the state of New Mexico Executive order 2007-049 concerning subcontractor health coverage requirements; and

(23) excluded providers: the CONTRACTOR shall not contract with an individual provider, or an entity, or an entity with an individual who is an officer, director, agent, or manager who owns or has a controlling interest in the entity, who has been convicted of crimes specified in Section 1128 of the Social Security Act, excluded from participating in any other state's Medicaid, Medicare, or any other public or private health or health insurance program, assessed a civil penalty under the provision of Section 1128, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

O. The CONTRACTOR shall establish and provide for HSD/MAD approval a plan to utilize the New Mexico State Immunization Information System (SIIS).

The goal of SIIS is to improve immunization rates for all New Mexico children through an innovative public-private partnership. SIIS is working to develop an integrated, statewide computerized registry to network each child's full immunization history. This system will ensure that health care providers have rapid access to complete and up-to-date immunization records.

The CONTRACTOR will collaborate with HSD/MAD and the Department of Health (DOH) in the implementation of the SIIS to ensure the secure, electronic exchange of immunization records to support the elimination of vaccine preventable diseases.

The CONTRACTOR will ensure that all subcontractors comply with the SIIS initiative.

ARTICLE 19 - RELEASE

19.1 Upon final payment of the amounts due under this Agreement, unless the CONTRACTOR objects in writing to such payment within one hundred and eighty (180) calendar days, the CONTRACTOR shall release the State, their officers and employees and the State of New Mexico from all such payment obligations whatsoever under this Agreement. The CONTRACTOR agrees not to purport to bind the State of New Mexico. If the CONTRACTOR objects in a

timely manner to such payment, such objection shall be addressed in accordance with the Dispute provisions provided for in this Agreement.

19.2 Payment to the CONTRACTOR by the State shall not constitute final release of the CONTRACTOR. Should audit or inspection of the CONTRACTOR's records or the CONTRACTOR's member complaints subsequently reveal outstanding CONTRACTOR liabilities or obligations, the CONTRACTOR shall remain liable to the State for such obligations. Any payments by HSD/MAD to the CONTRACTOR shall be subject to any appropriate recoupment by the State.

19.3 Notice of any post-termination audit or investigation of complaint by the State shall be provided to the CONTRACTOR, and such audit or investigation shall be initiated in accordance with CMS requirements. The State shall notify the CONTRACTOR of any claim or demand within thirty (30) calendar days after completion of the audit or investigation or as otherwise authorized by CMS. Any payments by the State to the CONTRACTOR shall be subject to any appropriate recoupment by the State in accordance with the provisions of Article 7 of this Agreement.

ARTICLE 20 - RECORDS AND AUDIT

20.1 Financial and Compensation Records

After final payment under this Agreement or ten (10) years after a pending audit is completed and resolved, whichever is later, the State or its designee shall have the right to audit billings both before and after payment. The CONTRACTOR shall maintain all necessary records to substantiate the services it rendered under this Agreement. These records shall be subject to inspection by the State, 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 Agreement shall not foreclose the right of the State to recover excessive or illegal payments as well as interest, attorney fees and costs incurred in such recovery.

20.2 Other Records

In addition, the CONTRACTOR shall retain all member medical records, social service records, collected data, and other information subject to the state and federal reporting or monitoring requirements for ten (10) years after the contract is terminated under any provisions of Article 8 of this Agreement or ten (10) years after any pending audit is completed and resolved, whichever is later. These records shall be subject to inspection by the State, and/or the Department of Finance and Administration and/or any authorized state or federal entity. The Health and Human Services (HHS) awarding agency, the U.S. Comptroller General, or any representatives, shall have access to any books, documents, papers and records of the CONTRACTOR 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 the CONTRACTOR'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 Agreement shall not foreclose the right of the State, to recover excessive or illegal payments and if such excessive and illegal payments are recovered, then the State shall also be entitled to interest, attorney fees and costs incurred in such recovery.

20.3 Standards for Medical Records

A. The CONTRACTOR shall require medical records to be maintained on paper and/or in electronic format in a manner that is timely, legible, current, set forth, and organized, and that permits effective and confidential patient care and quality review.

B. The CONTRACTOR shall have written medical record confidentiality policies and procedures that implement the requirements of state and federal law and policy and of this Agreement. 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 member. Medical record content must be consistent with the utilization control requirement in CFR 42 Part 456.

C. The CONTRACTOR shall establish, and shall require its practitioners to have, an organized medical record keeping system and standards for the availability of medical records appropriate to the practice site.

D. The CONTRACTOR shall include provisions in its contracts with providers requiring appropriate access to the medical records of the CONTRACTOR's members for purposes of quality reviews to be conducted by HSD/MAD, or agents thereof, and requiring that the medical records are available to health care practitioners for each clinical encounter.

20.4 The CONTRACTOR shall comply with HSD/MAD's reasonable requests for records and documents as necessary to verify that the CONTRACTOR is meeting its obligations under this Agreement, or for data reporting legally required of the State. However, nothing in this Agreement shall require the CONTRACTOR to provide HSD/MAD 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 Member(s).

20.5 The CONTRACTOR shall provide the State of New Mexico, and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the CONTRACTOR's premises or other places where work under this Agreement is performed to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract. The CONTRACTOR shall provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g. assistance from the CONTRACTOR staff to retrieve and/or copy materials). The State and its authorized agents shall schedule access with the CONTRACTOR in advance within a reasonable period of time except in 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 Agreement.

20.6 In the event right of access is requested under this section, the CONTRACTOR 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 state or federal representatives conducting the audit or inspection effort.

20.7 All inspections or audits shall be conducted in a manner as shall not unduly interfere with the performance of the CONTRACTOR's or any subcontractor's activities. The CONTRACTOR shall be given ten (10) working days to respond to any findings of an audit before HSD/MAD shall finalize its findings. All information so obtained shall be accorded confidential treatment as provided in applicable law.

ARTICLE 21 - INDEMNIFICATION

21.1 The CONTRACTOR 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 CONTRACTOR 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 Agreement, 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 CONTRACTOR in the performance or failure in performance of this Agreement resulting from such acts of omissions. The provisions of this Section 21.1 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, HSD/MAD or any of its officers, employees or agents.

21.2 The CONTRACTOR shall at all times during the term of this Agreement, indemnify and hold harmless the State against any and all liability, loss, damage, costs or expenses which the State may sustain, incur or be required to pay (1) by reason of any member 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 CONTRACTOR either while participating with or receiving care or services from the CONTRACTOR under this Agreement, or (2) while on premises owned, leased, or operated by the CONTRACTOR 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 CONTRACTOR 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, or any of its officers, employees, or agents. In the event that any action, suit or proceeding, excepting CONTRACTOR's appeal and grievance reviews or other administrative process, related to the services performed by the CONTRACTOR or any officer, agent, employee, servant or subcontractor under this Agreement is brought against the CONTRACTOR, the CONTRACTOR shall, as soon as practicable but no later than five (5) business days after it receives notice thereof, notify the legal counsel of the HSD and the Risk Management Division of the New Mexico General Services Department by certified mail.

21.3 The CONTRACTOR shall agree to indemnify and hold harmless the State, its agents and 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 CONTRACTOR'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 CONTRACTOR, its officers, employees, or subcontractors in the performance of the Agreement, regardless of whether the State knew or should have known of such erroneous or negligent acts; unless the State of New Mexico, or any of its officers, employees or agents directed or affirmatively consented 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 publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes, regardless of whether the State knew or should have known of such publication, translation, reproduction, delivery, performance, use, or disposition unless the State of New Mexico, 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 21.3 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, or any of its officers, employees, or agents and is not deemed to be a waiver of any and all of CONTRACTOR's legal rights to pursue indemnity actions and/or disputed claims arising from allegations involving the actions of the HSD/MAD and the CONTRACTOR.

21.4 The CONTRACTOR, including its subcontractors, agrees that in no event, including but not limited to nonpayment by the CONTRACTOR, insolvency of the CONTRACTOR or breach of this Agreement, shall the CONTRACTOR or its subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a member or persons (other than the CONTRACTOR) acting on their behalf for services provided pursuant to this Agreement except for any Medicaid population required to make co-payments under HSD/MAD policy. In no case, shall the State and/or members be liable for any debts of the CONTRACTOR.

21.5 The CONTRACTOR agrees that the above indemnification provisions shall survive the termination of this Agreement, regardless of the cause giving rise to termination. This provision is not intended to apply to services provided after this Agreement has been terminated.

21.6 The State shall notify the CONTRACTOR of any claim, loss, damage, suit or action as soon as the State 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 State, however, to deliver such notice shall not relieve CONTRACTOR of its obligation to indemnify the State under this Article. Prior to entering into any settlement for which it may seek indemnification under this Article, the State shall consult with the CONTRACTOR, but the CONTRACTOR need not approve the settlement. Nothing in this provision shall be interpreted as a waiver of the State's right to indemnification. The State shall permit CONTRACTOR, at CONTRACTOR's option and expense, to assume the defense of such asserted claim(s) using counsel acceptable to the State and to settle or otherwise dispose of the same, by and with the consent of the State, which consent shall not be unreasonably withheld. Failure to give prompt notice as provided herein shall not relieve CONTRACTOR of its obligations hereunder, except to the extent that the defense of any claim for loss is prejudiced by such failure to give timely notice.

ARTICLE 22 - LIABILITY

22.1 The CONTRACTOR shall be wholly at risk for all covered services. No additional payment shall be made by the State, nor shall any payment be collected

from a member, except for co-payments authorized by the State or state laws or regulation.

22.2 The CONTRACTOR is solely responsible for ensuring that it issues no payments for services for which it is not liable under this Agreement. The State shall accept no responsibility for refunding to the CONTRACTOR any such excess payments unless the State of New Mexico, or any of its officers, employees or agents directed such services to be rendered or payment made.

22.3 The CONTRACTOR, its successors and assignees shall procure and maintain such insurance and other forms of financial protections as are identified in this Agreement.

ARTICLE 23 - EQUAL OPPORTUNITY COMPLIANCE

The CONTRACTOR 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 CONTRACTOR 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, participation in, be denied the benefit of, or otherwise be subjected to discrimination under any program or activity performed under this Agreement. If the State finds that the CONTRACTOR is not in compliance with this requirement at any time during the term of this Agreement, the State reserves the right to terminate this Agreement pursuant to Article 8 or take such other steps it deems appropriate to correct said problem.

ARTICLE 24 - RIGHTS TO PROPERTY/PRODUCTS OF SERVICE

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

ARTICLE 25 - ERRONEOUS ISSUANCE OF PAYMENT OR BENEFITS

In the event of an error, which causes payment(s) to the CONTRACTOR to be issued by HSD/MAD, the CONTRACTOR shall reimburse HSD/MAD within thirty (30) days of written notice of such error for the full amount of the payment, subject to the provisions of Section 2.12 of this Agreement. Interest shall accrue at the statutory rate on any

amounts not paid and determined to be due after the thirtieth (30^{th}) day following the notice.

ARTICLE 26 - EXCUSABLE DELAYS

26.1 The CONTRACTOR 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 Agreement.

26.2 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 Agreement shall be suspended during the period that any circumstances of Force Majeure persists, or for a consecutive period of ninety (90) 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.

26.3 The CONTRACTOR shall be excused from performance hereunder during any period for which the State of New Mexico has failed to enact a budget or appropriate monies to fund the managed care program, provided that the CONTRACTOR notifies HSD/MAD, in writing, of its intent to suspend performance and HSD/MAD is unable to resolve the budget or appropriation deficiencies within forty-five (45) calendar days.

26.4 In addition, the CONTRACTOR shall be excused from performance hereunder for insufficient payment by HSD/MAD, provided that the CONTRACTOR notifies HSD/MAD in writing of its intent to suspend performance and HSD/MAD is unable to remedy the monetary shortfall within forty-five (45) calendar days.

ARTICLE 27 - PROHIBITION OF BRIBES, GRATUITIES & KICKBACKS

27.1 Pursuant to Sections NMSA 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.

27.2 No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Agreement. No individual

employed by the State of New Mexico shall be admitted to any share or part of the Agreement or to any benefit that may arise there from.

27.3 The State may, by written notice to the CONTRACTOR, immediately terminate the right of the CONTRACTOR to proceed under the Agreement if it is found, after notice and hearing by the Secretary of HSD or his/her duly authorized representative, that gratuities in the form of entertainment, gifts or otherwise were offered or given by the CONTRACTOR or any agent or representative of the CONTRACTOR to any officer or employee of the State of New Mexico with a view toward securing the Agreement or securing favorable treatment with respect to the award or amending or making of any determinations with respect to the performing of such Agreement. In the event the Agreement is terminated as provided in this section, the State of New Mexico shall be entitled to pursue the same remedies against the CONTRACTOR as it would pursue in the event of a breach of contract by the CONTRACTOR and as a penalty in addition to any other damages to which it may be entitled by law.

ARTICLE 28 - LOBBYING

28.1 The CONTRACTOR certifies, to the best of its knowledge and belief that it is in compliance with the Byrd Anti-Lobbying Amendment, that:

A. No federally appropriated funds have been paid or shall be paid, by or on behalf of the CONTRACTOR, 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 CONTRACTOR shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

28.2 The CONTRACTOR 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.

28.3 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 29 - CONFLICT OF INTEREST

29.1 The CONTRACTOR further represents and warrants that it has complied with, and during the term of this Agreement, will continue to comply with, and that this Agreement complies, with all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978. Without in any way limiting the generality of the foregoing, the CONTRACTOR specifically represents and warrants that:

A. in accordance with Section 10-16-4.3 NMSA 1978, the CONTRACTOR does not employ, has not employed, and will not employ during the term of this Agreement any HSD employee while such employee is employed by HSD and participating directly or indirectly in HSD's contracting process;

B. this Agreement complies with Section 10-16-7(A) NMSA 1978 because:

(1) the CONTRACTOR is not a public officer or employee of the State of New Mexico;

(2) the CONTRACTOR is not a member of the family of a public officer or employee of the State of New Mexico;

(3) the CONTRACTOR is not a business in which a public officer or employee or the family of a public officer or employee of the State of New Mexico has a substantial interest; or

(4) if the CONTRACTOR is a public officer or employee of the State of New Mexico, a member of the family of a public officer or employee of the State of New Mexico, or employee of the State has a substantial interest, public notice was given as required by Section 10-16-7(A) NMSA 1978 and this Agreement was awarded pursuant to a competitive process;

C. in accordance with Section 10-16-8(A) NMSA 1978:

(1) the CONTRACTOR is not, and has not been represented by a person who has been a public officer or employee of the State of

New Mexico within the preceding year and whose official act directly resulted in this Agreement; and

(2) the CONTRACTOR is not, and has not been assisted in any way regarding this transaction by, a former public officer or employee of the State of New Mexico whose official act, while in State employment, directly resulted in HSD's making this Agreement;

D. this Agreement complies with Section 10-16-9(A) NMSA 1978 because:

(1) the CONTRACTOR is not a legislator;

(2) the CONTRACTOR is not a member of a legislator's family;

(3) the CONTRACTOR is not a business in which a legislator or a legislator's family has a substantial interest; or

(4) if the CONTRACTOR is a legislator, a member of a legislator's family, or a business in which a legislator of legislator's family has a substantial interest, disclosure has been made as required by Section 10-16-9(A) NMSA 1978, this Agreement is not a sole source or small purchase contract, and this Agreement was awarded in accordance with the provisions of the Procurement Code [13-1-28 *et seq.* NMSA 1978];

E. in accordance with Section 10-16-13 NMSA 1978, the CONTRACTOR has not directly participated in the preparation of specifications, qualifications or evaluation criteria for this Agreement or any procurement related to this Agreement; and

F. in accordance with Section 10-16-3 and Section 10-16-13.3 NMSA 1978, the CONTRACTOR has not contributed, and during the term of this Agreement shall not contribute, anything of value to a public officer or employee of HSD.

29.2 The CONTRACTOR's representation and warranties in Sections 29.1 of this Article are material representations of fact upon which HSD relied when this Agreement was entered into by the Parties. The CONTRACTOR shall provide immediate written notice to HSD if, at any time during the term of this Agreement, the CONTRACTOR learns that the CONTRACTOR's representations and warranties in Sections 29.1 of this Article were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it later determined that the CONTRACTOR's representations and warranties in Sections 29.1 of this Article were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to HSD and

notwithstanding anything in this Agreement to the contrary, HSD may immediately terminate this Agreement.

29.3 All terms defined in the New Mexico Government Conduct Act have the same meaning in this Article.

ARTICLE 30 – CONFIDENTIALITY

30.1 Any confidential information, as defined in state or federal law, code, rules or regulations or otherwise applicable by the Code of Ethics, regarding Medicaid eligible recipients or providers given to or developed by the CONTRACTOR and its subcontractors shall not be made available to any individual or organization by the CONTRACTOR and its subcontractors other than the CONTRACTOR's employees, agents, subcontractors, consultants or advisors without the prior written approval of HSD/MAD.

30.2 The CONTRACTOR shall (1) notify the State promptly of any unauthorized possession, use, knowledge, or attempt thereof, of the State's data files or other confidential information; and (2) promptly furnish the State full details of the unauthorized possession, use of knowledge or attempt thereof, and assist investigating or preventing the recurrence thereof.

30.3 In order to protect the confidentiality of member information and records:

A. The CONTRACTOR shall adopt and implement written confidentiality policies and procedures which conform to federal and state laws and regulations;

B. The CONTRACTOR's contracts with practitioners and other providers shall explicitly state expectations about the confidentiality of member information and records; and

C. The CONTRACTOR shall afford members and/or legal guardians the opportunity to approve or deny the release of identifiable personal information by the CONTRACTOR to a person or agency outside of the CONTRACTOR, 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 CONTRACTOR shall notify the member and/or legal guardian of such action in a timely manner.

(2) The CONTRACTOR shall have specific written 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 member's status as a grievant.

30.4 The CONTRACTOR shall comply with HSD/MAD's requests for records and documents as necessary to verify the CONTRACTOR is meeting its duties and obligations under this Agreement, or for data reporting legally required of the State. Except as otherwise required by law, HSD/MAD may not request from the CONTRACTOR records and documents that go beyond ensuring that the CONTRACTOR is meeting its duties under this Agreement, 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 31 - COOPERATION WITH THE MEDICAID FRAUD CONTROL UNIT

31.1 The CONTRACTOR shall make an initial report to HSD/MAD HSD immediately, but no later than five (5) business days, when, in the CONTRACTOR's professional judgment, suspicious activities may have occurred. The CONTRACTOR shall then take steps to establish whether or not, in its professional judgment, potential fraud has occurred. The CONTRACTOR will then make a report to the State and submit any applicable evidence in support of its findings. If the State decides to refer the matter to the New Mexico State Medicaid Fraud Control Unit of the Attorney General's Office (MFCU), the State will notify the CONTRACTOR within five (5) business days of making the referral. The CONTRACTOR shall cooperate fully with any and all requests from MFCU for additional documentation or other types of collaboration in accordance with applicable law.

31.2 The CONTRACTOR shall cooperate fully in any investigation by the MFCU or subsequent legal action that may result from such investigation. The CONTRACTOR and its subcontractors and participating network providers shall, upon request, make available to the MFCU 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 shall be allowed to have access during normal business hours to the place of business and all records of the CONTRACTOR and its subcontractors and participating network providers, except under special circumstances when after hours access shall be allowed. Special circumstances shall be determined by the MFCU.

31.3 The CONTRACTOR shall disclose to HSD/MAD, MFCU, and any other state or federal agency charged with overseeing the Salud! and SCI programs, full and complete information regarding ownership, significant financial transactions or

financial transactions relating to or affecting the Salud! or SCI programs between the CONTRACTOR and persons related to the CONTRACTOR convicted of criminal activity related to Medicaid, Medicare, or the federal Title XX programs.

31.4 Any actual or potential conflict of interest within the CONTRACTOR's program shall be referred by the CONTRACTOR to MFCU. The CONTRACTOR also shall refer to MFCU any instance where a financial or material benefit is given by any representative, agent or employee of the CONTRACTOR to the State, or any other party with direct responsibility for this Agreement. In addition, the CONTRACTOR shall notify 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 Salud! or SCI programs or any other party with direct responsibility for this Agreement.

31.5 Any recoupment received from the CONTRACTOR by the State pursuant to the provisions of Article 7 (Enforcement) of this Agreement herein shall not preclude MFCU from exercising its right to criminal prosecution, civil prosecution, or any applicable civil penalties, administrative fines or other remedies. Any Medicaid funds identified in any action by MFCU or other prosecutorial agency, whether the action is civil or criminal, shall be returned to the State. The funds shall not be retained by the CONTRACTOR. The amount returned to the State shall be determined according to the adjudicated claims retained from the time the suspension of payment was initiated.

31.6 Upon request to the CONTRACTOR, MFCU shall be provided with copies of all grievances and resolutions affecting members.

31.7 Should the CONTRACTOR know about or become aware of any investigation being conducted by MFCU or the State, the CONTRACTOR, and its representatives, agents and employees, shall maintain the confidentiality of this information.

31.8 The CONTRACTOR shall have in place and enforce policies and procedures to educate members of the existence of, and role of, MFCU.

31.9 The CONTRACTOR 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 CONTRACTOR's organization is responsible for these activities, how these activities shall be conducted, and how the CONTRACTOR shall address cases of suspected fraud and abuse.

31.10 All documents submitted by the CONTRACTOR to the State, if developed or generated by the CONTRACTOR, or its agents, shall be deemed to be certified by the CONTRACTOR as submitted under penalty of perjury.

ARTICLE 32 - WAIVERS

32.1 No term or provision of this Agreement 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.

32.2 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 Agreement herein contained.

ARTICLE 33 - NOTICE

33.1 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.

33.2 All notices required to be given to HSD/MAD under this Agreement shall be sent to the HSD/MAD Contract Administrator or his/her designee:

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

33.3 All notices required to be given to CONTRACTOR under this Agreement shall be sent to:

Ben Slocum, CEO/President
Lovelace Community Health Plan
4101 Indian School Road, NE
Albuquerque, NM 87110

ARTICLE 34 - AMENDMENTS

34.1 This Agreement shall not be altered, changed or amended except by instrument in writing executed by the parties hereto and all other required signatories.

34.2 If HSD/MAD proposes an Amendment to this Agreement to unilaterally reduce funding due to budget or other considerations, the CONTRACTOR shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Agreement pursuant to the termination provisions contained herein, or to agree to the reduced funding.

ARTICLE 35 – SUSPENSION, DEBARMENT AND OTHER RESPONSIBILITY MATTERS

35.1 Pursuant to 45 C.F.R. Part 76 and other applicable federal regulations, the CONTRACTOR certifies by signing this Agreement, that it and its principals, to the best of its knowledge and belief: (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 Agreement, 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 35.1; (4) have not, within a three (3)-year period preceding the effective date of this Agreement, 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 U.S.C. § 1320a-7 and other applicable federal statutes. The CONTRACTOR 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; or

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 CONTRACTOR;

(2) a person with beneficial ownership of five percent (5%) or more of the CONTRACTOR's equity; or

(3) a person with an employment, consulting or other arrangement with the CONTRACTOR obligations under this contract with the State.

35.2 The CONTRACTOR's certification in Article 35.1 is a material representation of fact upon which HSD/MAD relied when this Agreement was entered into by the parties. The CONTRACTOR shall provide immediate written notice to HSD/MAD, if, at any time during the term of this Agreement, the CONTRACTOR learns that its certification in Article 35.1 was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances. If it is later determined that the CONTRACTOR's certification in Article 35.1 was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to the State, the State may terminate the Agreement.

35.3 As required by 45 C.F.R. Part 76 or other applicable federal regulations, the CONTRACTOR shall require each proposed first-tier subcontractor whose subcontract will equal or exceed twenty-five thousand dollars ($25,000), to disclose to the CONTRACTOR, 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 CONTRACTOR shall make such disclosures available to the State when it requests subcontractor approval from the State pursuant to Article 18.4. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any federal department or agency, the State may refuse to approve the use of the subcontractor.

ARTICLE 36 – NEW MEXICO EMPLOYEES HEALTH COVERAGE

36.1 If CONTRACTOR has, had, or anticipates having, six (6) or more New Mexico 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 (6) month period being at any time during the year prior to seeking the contract with the State of at any time during the term of this Agreement, CONTRACTOR agrees by signing this Agreement to have in place, and agree to maintain for the term of this Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees.

36.2 The CONTRACTOR agrees to maintain a record of the number of New Mexico 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 a representative of HSD.

36.3 The CONTRACTOR agrees to advise all New Mexico employees of the availability of State publically financed health coverage programs by providing each employee with, as a minimum, the following web link to additional information http://insurenewmexico.state.nm.us/.

ARTICLE 37 – MERGER

This Agreement 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 Agreement. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement. Except for those revisions required by CMS, state or federal requirements, revisions to the original Agreement shall require an amendment agreed to by both parties.

ARTICLE 38 – AUTHORIZATION FOR CARE

The CONTRACTOR shall, to the extent possible, ensure that administrative burdens placed on providers are minimized. In furtherance of this objective, the CONTRACTOR shall provide to HSD/MAD a report of all benefits and procedures for which the CONTRACTOR or any of its subcontractors require a prior authorization.

ARTICLE 39 – PENALTIES FOR VIOLATION OF LAW

The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statues impose felony penalties for illegal bribes, gratuities and kickbacks.

ARTICLE 40 – WORKERS COMPENSATION

The CONTRACTOR agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the CONTRACTOR fails to comply with the Workers Compensation Act and applicable rules when required to do so, this Agreement may be terminated by HSD/MAD.

ARTICLE 41 – INVALID TERM OR CONDITION

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

ARTICLE 42 – ENFORCEMENT OF AGREEMENT

A party's failure to require strict performance of any provision of this Agreement 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 right under this Agreement shall be effective to waive any other rights.

ARTICLE 43 – DUTY TO COOPERATE

The parties agree that they will cooperate in carrying out the intent and purpose of this Agreement. This duty includes specifically, an obligation by both parties, in the event they identify any possible errors or problems associated with the performance of their respective obligations under this Agreement.

ARTICLE 44 – ENTIRE AGREEMENT

This Agreement 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 Agreement. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement. Except for those revisions required by CMS, state or federal requirements, revisions to the original Agreement shall require an amendment agreed to by both parties.

ARTICLE 45 – AUTHORITY

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

ARTICLE 46 – PROVIDER AVAILABILITY

All hospitals owned (wholly or partially) or controlled by the CONTRACTOR, or any of the CONTRACTOR's related or affiliated entities (including their employed physicians), and any and all hospitals (including their employed physicians) that own (wholly or partially) or control the CONTRACTOR shall be encouraged by the CONTRACTOR, to the extent of its legal authority, to negotiate in good faith to become a network provider for any contractor that contracts with HSD/MAD for Medicaid managed care. HSD shall require such contractors to negotiate in good faith with the hospitals. Except as provided herein, in the absence of a contract with another contractor, the hospitals and employed physicians shall agree to accept one hundred percent (100%) of the established New Mexico Medicaid rate of reimbursement for such services to other contractor's contracted members and to provide services to such members at the same level of availability as the hospitals and employed physicians offer to the CONTRACTOR's members.

Notwithstanding the following:

(1) The provisions of this paragraph apply only to hospitals and employed physicians located outside the four-county metropolitan area including Bernalillo, Sandoval, Valencia and Torrance counties;

(2) Any hospital or employed physician that is contracted with a contractor as of August 1, 2010, shall not be subject to the requirements of this section with respect to that contractor until such later date as HSD implements new across-the-board contractor rate reductions; and

(3) Any hospital or employed physician required to provide services hereunder without a contract shall not be considered "in network" hospital for the purposes of meeting an MCO's access requirements.

ARTICLE 47 – FAIR AND EQUAL PAY FOR ALL NEW MEXICANS

The CONTRACTOR shall comply with all requirements of the Fair and Equal Pay for All New Mexicans – Executive Order 2009-049.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

IN WITNESS WHEREOF, the parties have executed this Agreement as set forth below.

CONTRACTOR

By: Terri Clinin Date: 7/6/12

Title: CFO

STATE OF NEW MEXICO

By: Sidonie Squier Date: 7/17/12
Sidonie Squier, Cabinet Secretary
Human Services Department

Approved as to Form and Legal Sufficiency:

By: Date: 7/11/12
Raymond W. Mensack, Chief Legal Counsel
Human Services Department

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

TAXATION AND REVENUE DEPARTMENT

ID Number: 02-021710-00-2

By: Date: 7-19-12